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The enforcement in Ireland of the rights of mentally disordered people under the European Convention on Human Rights

PhD

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This thesis examines the rights of people with mental disorder under Irish law against the background of the European Convention on Human Rights. It proposes that Irish law does not meet the minimum standards laid down by the Convention and that significant law reform is required to achieve this aim. The main issues concern the admission, detention and treatment of adults and children in psychiatric care and the safeguards provided in the Irish legal system. These matters are considered against the Convention requirements in the context of the current and ongoing process of law reform in Ireland.

The rights addressed are: the right to protection from arbitrary deprivation of liberty under Article 5, particularly the liberty of the compliant incapacitated patient. This includes an empirical study of the habeas corpus provision in Ireland. Article 8 and Article 12 rights are examined, specifically, the right to self-determination in a number of spheres including: consent to treatment, the right to marry, to have a sexual relationship and children and the right not to be sterilised. The right to protection from inhuman and degrading treatment in Article 3 includes consideration of positive state obligations to protect physical integrity in relation to conditions of detention, seclusion and aspects of treatment. The right in Article 2 to have one's life protected from foreseeable risks and the obligation on the state to investigate following death is examined. The restrictions on the removal of civil rights and obligations in relation to access to court to take civil action and to have control over one's property and affairs are examined for compliance with Article 6.

The outcome of the examination confirms the proposal that Irish law does not meet the minimum standards of the Convention.

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INTRODUCTION

This thesis examines the rights of people with mental disorder under Irish law against the background of the European Convention on Human Rights (the Convention). It is proposed that current law in Ireland does not meet the minimum standards laid down by the Convention and that significant law reform is required to achieve this aim. The importance of this work is threefold. It is the first time that these issues have been examined and following the recent adoption of the Convention into Irish law this work will contribute to a new area where knowledge is essential. Second, the empirical study on habeas corpus included in this work (Chapter 2) had never been done before and it establishes the facts on its use and provides a clear basis for reform and future research. Finally, the conclusions reached in this thesis will contribute towards statutory reform due in 2007.

The issues concerning admission and detention in psychiatric care and the safeguards provided in the Irish legal system will be weighed against Convention requirements in the context of the current and ongoing process of law reform. Ireland is going through a period of transition with both the Mental Treatment Act 1945 (1945 Act), as amended, and the Mental Health Act 2001 (2001 Act) in place, albeit that the 2001 Act is only partially in force.[1] This period of transition will continue until the full introduction of the 2001 Act.[2] Ireland has recently incorporated the Convention into Irish law with the enactment of the European Convention on Human Rights Act 2003. Prior to the 2003 Act the Convention applied to Ireland but not within Ireland. The incorporation is an opportunity to examine the standard of human rights protection within the State having regard to the fact that Ireland has lost nine cases before the European Court of Human Rights, six of which followed directly from constitutional

[1] The 1945 Act has been amended by the Health Act 1953, the Mental Health Act 1953, the Health and Mental Treatment Act 1957, the Health and Mental Treatment Act 1958, the Mental Treatment (Detained in Approved Institutions) Act 1961, the Mental Treatment Act 1961, Health and Mental Treatment Act 1966 and the Health Act 1970. Sections 1-5 incl., (definitions and statutory principles) section 7, and sections 31-55 incl. (setting up the Mental Health Commission and tribunals) of the 2001 Act are operational.

[2] The complete introduction is currently (Feb. 2006) being delayed by the refusal of consultant psychiatrists to become involved in new public service work until there is a government commitment to providing the necessary resources for the additional work involving extra work created by tribunal hearings.

decisions by the Supreme Court.[3] Two cases involving mental health detention reached a friendly settlement before the Strasbourg Court.[4]

The 1945 Act provides a statutory framework for the civil detention of people with mental disorder and for the administration of psychiatric services. This legislation was adopted at a time prior to the drafting of the Convention. Human rights were not a prime consideration and admission to hospital was often for life. The focus of treatment was on seclusion and restraint as forms of patient management. Although various medications were in use to control the symptoms of mental disorder, this was prior to the development of anti-psychotic and anti-depressant medication. Treatment without consent was not an issue which received attention in its own right. There are no safeguards relating to treatment without consent in the 1945 Act. The provisions of this legislation are described throughout this thesis as they arise in connection with the relevant Articles of the Convention. The 1945 Act as amended is a very inaccessible piece of law, particularly to professionals who need to operate its provisions. This situation has invited comment from the judiciary on the need for reform. For example, Kelly J. stated in the High Court, "I wish to record that I have the greatest sympathy for the medical and nursing personnel who are called upon to operate the provisions of the Act. It is now fifty five years old and badly in need of reform."[5] The 2001 Act was introduced to replace the 1945 Act.[6] This new Act comes in the wake of many previous attempts to reform the area of mental health law. The Irish Constitution, Bunreacht na hÉireann, is a fundamental aspect of this reform, guarding as it does the personal rights and the right to liberty of the people. The provisions of the Constitution are examined, where applicable, as part of the framework of safeguards lying outside the range of specific legislative provisions for mental health.

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[3] *Norris v. Ireland* (1991) 13 EHRR 186 (homosexuality), *Pine Valley v. Ireland* (1992) 14 EHRR 319 (aftermath of invalid planning permission), *Open Door Counselling Ltd. & Dublin Well Woman Centre Ltd. v. Ireland* (1993) 15 EHRR 244 (banning distribution of information regarding abortion clinics), *Keegan v. Ireland* (1994) 18 EHRR 342 (rights of natural fathers), *Heaney v. Ireland* (2001) 33 EHRR 264 (right to silence) and *DG v Ireland* (2002) 35 EHRR 1153 (detention of unruly juveniles).

[4] *O'Reilly v. Ireland* Application No. 24196/94 and *Croke v. Ireland* Application no. 3326/96.

[5] *Gooden v. Waterford Regional Hospital*, Unreported High Court, 14th December 2000.

[6] Apart from the exclusions in Part VIII and sections 241, 276, 283 and 284 of the 1945 Act dealing mainly with the jurisdiction of the High Court, both generally and in relation to wardship.

Reform of mental health law has been a prolonged and unsatisfactory process where there has been little political support or commitment from various governments over the years. Mental health represents the "Cinderella" service, providing for the marginalized in the health system, as is evidenced by the constant reduction in funding, the scant attention paid to the annual reports from the Inspector of Mental Hospitals and the continuing failure to introduce the 2001 Act.[7] Pressure for change has come from many sources, ranging from the service-user movement, professional bodies, non-governmental organisations (NGOs) to external sources promoting human rights, such as the United Nations and the Council of Europe.

Many of the factors that influence the discussion on reform of mental health law relate to a desire for autonomy by mentally disabled people and the opportunity to participate fully in society. Such participation has been hindered by the traditional psychiatric care system with its emphasis on social control and paternalism. The rights of disadvantaged groups, particularly those with negatively ascribed statuses like psychiatric patients, were not included in the rights discourse elsewhere until the 1970s and 1980s. In Ireland, change is slower than in many similar jurisdictions and the acceptance of new principles relating to empowerment, self-determination and participation is only beginning.

Influences on law reform

One of the purposes of mental health legislation is to ensure adequate and appropriate care and treatment and the protection of the human rights of people with mental disorders. The World Health Organisation states,

> The fundamental aim of mental health legislation is to protect, promote and improve the lives and mental well-being of citizens, ... progressive legislation can be an effective tool to promote access to mental health care as well as to promote and protect the rights of persons with mental disorders ...[8]

[7] As discussed above, the government would defend itself on this issue by blaming consultant psychiatrists, most of whom are refusing to become involved in the tribunals as a means to get extra resources necessary for additional workload.

[8] World Health Organisation, *WHO Resource Book on Mental Health, Human Rights and Legislation,* Switzerland, 2005, p1.

The use of other legislative mechanisms to supplement mental health legislation includes anti-discrimination measures such as the Employment Equality Acts 1998-2004 and the Equal Status Acts 2000-2004, intended to redress inequality by prohibiting discrimination on grounds that include mental disorder. The Disability Act 2005 may provide a source for accessing health and education services.

Growth of the service- user movement

The 1996 report of the Government Commission on the Status of People with Disabilities resulted in a turning point in relation to people with disabilities in Ireland.[9] The Commission included an equal representation of people with disabilities along with able-bodied people. The report placed the person with the disability at the centre of planning and recommended a rights-based approach. This document has proved to be an important touchstone for policy and legislative development. The growing importance of service-users as partners in policy and planning is now being recognised at government and non-governmental level.[10] The Department of Health Expert Group on Mental Health Policy included service-users and many of the working subgroups included both service-users and carers.[11] The development of the government supported Irish Advocacy Network (IAN) and peer advocacy services have strengthened this position.[12] In addition, the health service executives have employed IAN to carry out a number of service audits to assess satisfaction with treatment provision, as well as models, methodologies and the systemic barriers to well-being and recovery. The mainstreaming of service-users in the mental health care system in this way has provided quality feedback on the impact of mental health legislation and the inadequacies that need to be addressed. Negative attitudes to mental disorder creating stigma are believed to stem from a lack of awareness, fear and misconceptions about the nature of mental illness. The National Disability Authority survey on attitudes to disability revealed that attitudes to people with mental disorders were less positive than those expressed towards people with physical

[9] Department of Justice, The Report of the Commission for the Status of People with Disabilities, *A Strategy for Equality,* Government Publications, Dublin, 1996.
[10] Partnership agreements have referred to the involvement of service-users in policy-making.
[11] Department of Health & Children, Expert Group on Mental Health Policy, *Speaking Your Mind,*- A Report on the Public Consultation Process, Dublin, 2004 and *What we heard* – A Report on the Service User Consultation Process., Dublin, 2004.
[12] The Irish Advocacy Network exists to promote and facilitate peer advocacy on an island-wide basis.

disabilities.[13] Negative stereotyping compounds the difficulties for people seeking early treatment and acts as a barrier against the use of services, particularly when these services are inadequate or non-existent. Mental health legislation that does not focus on human rights adds to these difficulties. The person-centred approach along with the growing service-user movement should contribute to a greater focus on these issues.

English influence on Irish law

The influence of English mental health law is significant with many Irish statutes modelled on English equivalents due to the historic and unavoidable ties between the two countries. The common law system is an important factor in English case law having a persuasive influence in Irish law.[14] The 1945 Act is a copy of the English Mental Treatment Act 1930, which was extended to Northern Ireland in 1932. Current law reform is modelled somewhat on the Mental Health Act 1983, though in less detail, and it does not include provisions for mentally disordered offenders, wards of court, guardianship and adult care orders. The incorporation of the Convention into Irish law came well after the enactment of the Human Rights Act 1998 in England and Wales which has been a rich source of jurisprudence and may influence the development of Irish law.

International human rights standards

The Irish government is obliged under international human rights law to ensure that their policies and practices in relation to the protection of people with mental disorders conform to binding international law. The UN *Declaration on Human Rights,* together with the *International Covenant on Civil and Political Rights* (ICCPR) and the *International Covenant on Economic Social and Cultural Rights* (ICESCR) form the International Bill of Rights and all include a prohibition on discrimination. The protection of the right to dignity and the need for affirmative action to protect the rights of persons with disabilities including people with mental

[13] NDA Research Unit & Research Evaluation Services, *Attitudes to Disability: Preliminary Findings of a Survey commissioned by the National Disability Authority'*, Dublin, October, 2001.
[14] *R v. Airdale Trust ex parte Bland* [1993] 1 AII ER 821.

disorders is affirmed in both the ICESCR and the ICCPR. The concluding observations of the Human Rights Committee of the ICCPR in 2000 required Ireland to take further action to ensure full enjoyment of the rights by people with disabilities.[15] The report of the Committee of the ICESCR in 2002 was critical of Ireland and the continued discrimination against people with physical and mental disabilities in many areas including health, employment, social welfare, education and in sheltered accommodation. The Committee expressed concern that principles of non-discrimination were not included in the Health Strategy 2002.[16] The UN *Principles for the Protection of People with Mental Illness and the Protection of Mental Health Care*, which establish minimum human rights standards, have also been influential in the reform of mental health law in Ireland with the government openly acknowledging these principles by appending them to both the Green and White Papers on mental health reform.[17]

The Council of Europe documents that have influenced mental health law reform include *Recommendation 1235 on Psychiatry and Human Rights (1994),* which lays down criteria for involuntary admission, procedures and safeguards against abuse, *Recommendation 99(4) on Incapacitated Adults* and *Recommendation (2004) 10 Concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder,* which proposes improved protections of the dignity, human rights and freedoms of people with mental disorders, particularly those who are subject to involuntary placement or involuntary treatment. Commentators frequently discuss the standards in the *Convention on Human Rights and Biomedicine* 1997, even though Ireland, like the United Kingdom, is not yet a signatory.[18] *The Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment* (1987) through its Committee for the Prevention of Torture, Inhuman and Degrading Treatment (The CPT) has visited psychiatric hospitals and residential care centres in

[15] http:/www.unhchr.ch/pdf/report.pdf . Next report is due end 2005.
[16] Department of Health and Children, *Quality and Fairness, A Health System for You,* Government Publications, Dublin, 2002. Other issues commented on by the Committee impact indirectly on mental health including: housing, adequacy of standards of living and poverty issues.
[17] Department of Health and Children, *Green Paper on Mental Health,* 1995 PL 8918, *White Paper A New Mental Health Act* 1995 PL 1824.
[18] Mills S., *Clinical Practice and the Law,* Butterworths, Dublin, 2002 para 18.11, Madden, *Medicine, Ethics and the Law,* Butterworths, Dublin, 2002.

Ireland and commented on the poor conditions in some locations.[19] The role of the CPT is examined in the context of Article 3 of the Convention. The CPT visits to Ireland have resulted in a greater focus on planning for change and some progress relating to conditions of detention both for people in high security detention and for highlighting conditions in residential care for people with intellectual disabilities.[20]

Formal Recognition of the European Convention on Human Rights

The Irish Constitution provides for the incorporation into domestic law of international treaties intended to be in harmony with or similar to the principles of the Constitution.[21] The Convention has formed part of Ireland's international legal obligations since 1953. The decisions of the European Court of Human Rights (The Court) in relation to breaches of the Convention's provisions are binding on the State. Until the enactment of the European Convention on Human Rights Act 2003 (The ECHR Act 2003), the Convention was law for Ireland but not actually law in Ireland.[22] More recently, there has been a growing tendency for the Irish judiciary to refer to the jurisprudence of the Convention in reaching their conclusions in contrast with earlier cases when the Courts were decidedly more negative and dismissive of references to the Convention. During the past two decades, the Irish courts have acknowledged a presumption that Irish law is in conformity with the Convention.[23] This change has been evident in a number of cases, including *Glencar Exploration Plc's v. Mayo Co. Council* in which the High Court stated,

> The judgments of the Court of Human Rights may be a useful source of persuasive authority where they contain reasoning ... relevant to the interpretation of legal rights guaranteed by the Convention and which our courts have to apply.[24]

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[19] Reports of CPT visit to Ireland in 2001 on www.irlgov.ie Report also available at www.cpt.coe.int or at www.irlgov.ie.

[20] Visits were made to the Central Mental Hospital, St Ita's Hospital intellectual disability unit, and a number of other residential centres for people with intellectual disabilities.

[21] Article 29.6. Ireland was among the first nations to adopt the Convention in 1950 and ratified it in 1953, and along with Sweden, was first to adopt the right of individual petition.

[22] A total of seven cases resulted in decisions against Ireland ranging from the need for civil legal aid, rights of non-marital children, decriminalisation of homosexual behaviour, abortion information, property rights, rights of natural fathers and the right to silence. See fn 3.

[23] Hogan & Whyte, *J.M. Kelly: The Irish Constitution*, Butterworths, Dublin, 2003, paras 5.3.120. and 7.1.157. Budd J. in *Croke v. Smith* Unreported High Court, July 31st 1995, *Gooden v. Waterford Regional Hospital* Unreported Supreme Court, February 21st 2001.

[24] [2002] 1 IR 84 p152.

The Supreme Court in *Murphy v. IRTC,* acknowledged that the Convention was not part of Irish law, but regard could be had to its provisions when considering a fundamental right and the limitations that could be imposed on such rights.[25] In *Gooden v. Waterford Regional Hospital,* the Supreme Court cited with approval the views expressed in an earlier case that the Convention might be a useful source for an Irish judge attempting to identify unspecified rights guaranteed by Article 40.3 of the Constitution.[26]

The Constitution provides that the sole law-making body of the State is the Oireachtas.[27] Arguments regarding Convention rights were not of persuasive effect and generally were not raised or permitted to be raised before the courts.[28] This is similar to the situation that applied in the English courts before the incorporation of the Convention. The House of Lords ruled in *R v. Secretary of State for the Home Department, ex parte Brind* that those invested with ministerial powers under legislation had no obligation to take the Convention into account when exercising a discretion which Parliament had conferred on them.[29] No action was available in the domestic courts to challenge in judicial review proceedings the exercise of a power on the ground that it was contrary to the Convention. Vindication of Convention rights required exhaustion of all national remedies before presenting the case in the Strasbourg Court.[30] The failure to exhaust all available national remedies resulted in the first of three cases being deemed inadmissible by the Commission.[31] In the other two cases, a friendly settlement was reached with Ireland.[32]

The Northern Ireland Peace Agreement 1998, commonly known as the Good Friday or Belfast Agreement, was the catalyst for the introduction of the ECHR Act 2003. It was intended that human rights protection would accord with best international

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[25] [1997] IRLM 467 p476.
[26] Unreported Supreme Court, 21st February 2001. Also *Doyle v. Commissioner of An Garda Siochana* [1999] 1 IR 249 p268.
[27] Irish Constitution, Article 15 .2.1 vests the sole and exclusive power for making laws in the Oireachtas.
[28] *Croke v. Smith (No.2)* [1998] 1 IR 101.
[29] [1991] 1 AC 696.
[30] Article 35 of the Convention.
[31] *O'Dowd v. Ireland* Application no. 10296/83.
[32] *O'Reilly v. Ireland* Application no. 24196/94 (1997), *Croke v. Ireland* Application no.33267/96 (2000). These cases are discussed in more detail in chapters 1 & 2.

standards and there would be an equivalence of human rights protection north and south of the border.

> ... [the] incorporation of the ECHR should be viewed not as an inconvenience to be endured in fulfilment of a loose obligation (probably of a political nature) under the Belfast Agreement 1998 but, rather, as the beginning of a more fruitful 'dialogue' between international human rights obligations and municipal law.[33]

The method of incorporation has been viewed as unsatisfactory in that it stopped short of giving full direct legislative effect to the Convention. The Report of the Constitution Review Group in 1996 rejected the notion of direct incorporation of the Convention into the Constitution on the basis of the high degree of overlap with Convention rights already in existence.[34] The second objection was that there could be a diminution in some individual rights in the Constitution. The Report stated that the substantive rights provided by the Convention were already recognised by the Constitution, specifically, or as an unenumerated right under Article 40.3.1, the personal rights section. Partial incorporation was seen as the solution by way of addition or replacement in the following circumstances: where the right was not expressed in the Constitution, where the standard of protection was superior in the Convention and where the wording of the Constitution in relation to the specific right might be improved.[35]

The interpretative or indirect incorporation is considered to be a minimalist response with limited legal redress for litigants.[36] The approach has been criticised due to its "weaknesses, anomalies and drawbacks", echoing the views of the Human Rights Commission.[37] The legislature rejected the notion of incorporation by means of a

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[33] O'Connell D., "Ireland" in Blackburn & Polakiewicz (eds.) *Fundamental Rights in Europe: The European Convention on Human Rights and its Member States, 1950-2000*, OUP, Oxford, 2000.
[34] Government Publications, *Report of the Review Group of the Constitution,* PN 2632, 1996.
[35] "For years we were able to hide our semi-detached relationship to the Convention behind the substantial bulk of our nearest neighbour, the United Kingdom." Farrell, "Semi-detached or Joined-up Rights? Making the European Convention a Reality for Irish Lawyers-and their Clients". Paper delivered at Law Society of Ireland Conference, 14th October 2000.
[36] *Op. cit.,* 23 p24.
[37] Binchy W., "The European Convention on Human Rights Bill, the Advantages and Disadvantages of the Approach Taken, and the Possible Alternatives", Paper presented to the Law Society of Ireland 19th October , 2002. Also a submission to the Government on the Bill, O Connell D., said that Ireland followed the British approach in the Human Rights Act 1998, (1998 Act) without having the same reasons for doing so and arguably adopted a weaker form of incorporation, in "Human Rights

Referendum to amend the Constitution. Other commentators believe that there was no other choice,

> ... short of a constitutional amendment ... it is plain that the Oireachtas could not have gone any further than it did in the European Convention on Human Rights Act 2003. ....if it had purported to give the courts power to declare a law *invalid* –as opposed to a declaration of *incompatibility* (which leaves the offending law in place pending later legislative amendment or repeal) – on the ground that it contravened the Convention, there would have been a significant risk that the 2003 Act itself would have been found to be unconstitutional on the ground that it purported to create a form of parallel Constitution.[38]

Incorporation was seen by some commentators as being most important on a symbolic level and that the impact on constitutional jurisprudence will be limited due to "a striking degree of overlap between the respective guarantees – (as judicially interpreted) contained in the Constitution and the ECHR."[39] Another reason is that there are a number of Supreme Court decisions referring to the equivalence of protection in the Constitution with that in the Convention and where the Constitution does not go as far as the Convention, the interpretation of the Constitution in light of the Convention may result in little substantial difference.[40] A third reason posited is that the judicial review system and remedies under the Constitution provide a superior remedy and will remain a first choice.

European Convention on Human Rights Act 2003

The purpose behind the legislation is to facilitate bringing cases of alleged breaches of rights under the Convention before the Irish courts leading to a more expeditious approach than previously applied. Ensuring compatibility with the Convention is at the centre of the requirements of the 2003 Act.[41] The interpretation of the law must be

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Commission Bill: A Critical Perspective", Paper presented at Political Association Conference of Ireland, Wexford, 1999.

[38] Hogan & Whyte, *JMKelly: The Irish Constitution* (4th ed.) Butterworths, Dublin, 2003, Preface to Fourth Edition.

[39] Hogan G., 'The Belfast Agreement and the Future Incorporation of the European Convention on Human Rights in the Republic of Ireland' (1999) *Bar Review* 205 at 208

[40] *Gooden v. Waterford Regional Hospital* Unreported Supreme Court, 21st February 2001, *Enright v. Ireland* Unreported High Court, December 18th 2002.

[41] O'Connell D., "The Incorporation of the European Convention on Human Rights into Irish law: Clever and Elegant or Too Clever by Half" Brian Walsh Memorial Lecture 2002 for the Irish Society for European Law.

carried out in a manner compatible with the State's obligations under the Convention provisions.[42] The 2003 Act provides for "organs of the State" to perform their functions in a manner compatible with the Convention.[43] The definition of "organs of the State" is narrow and refers to,

> 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 State are exercised.[44]

The Mental Health Commission and Mental Health Tribunals set up under the 2001 Act are covered by the Act. Changes to the definition of "organs of the state" had been suggested to encompass the courts and semi-public authorities such as regulatory bodies, privately owned hospitals and schools. Clarification is needed on whether the "organs" include wholly private organisations. This could have an impact on the area of psychiatric care in private hospitals, independent providers of community services, and the standards of the medical and nursing regulatory bodies. In *Dublin City Council v. Fennell, the AG & Irish Human Rights Commission (as amicus curiae)* the Supreme Court ruled that the 2003 Act did not have retrospective effect with regard to the actions of public bodies.[45]

Section 5 of the Act reflects the disappointing approach to incorporation; it provides that the High Court or the Supreme Court may, "where no other legal remedy is adequate," make a declaration that a piece of legislation or rule of law is incompatible with the Convention. The litigant has no other source of legal redress and the legislation or rule of law remains in force. This is not the same as a declaration of invalidity and will "not affect the validity, continuing operation or enforcement of the

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[42] European Convention on Human Rights Act 2003, section 2.
[43] *Ibid,* section 3.
[44] *Ibid,* section 1(1).
[45] Unreported Supreme Court, 12th May 2005. The case involved the eviction of tenants and the requirements under the Convention that the public authority would give reasons for the action. The proceedings regarding the eviction commenced prior to the enactment of the 2003 Act and therefore they were not subject to the requirements of the Convention.

statutory provision or rule of law in respect of which it is made."[46] In addition, the Government will be under no obligation to pay compensation but the successful litigant may apply to the Attorney General for compensation and this will be considered by the Government, which has discretion to appoint an advisor to make an *ex gratia* payment. The Taoiseach is then obliged to lay a copy of the declaration before the Dáil and Seanad within 21 days, but there is no obligation to have a remedial plan. The 2003 Act provides that where a person has suffered a loss or damage as a result of a violation of the Convention and where no other remedy in damages is available, he or she can institute proceedings in the courts to recover the damages.[47] Other forms of redress are not available such as an injunction or orders for release from custody. The Strasbourg Court has held that a discretionary remedy is no remedy.[48] The Human Rights Commission has been critical of this aspect of the legislation saying that,

> It clearly contemplates a situation where a litigant may have gone all the way to the Supreme Court to obtain a declaration of incompatibility, which may be of no practical use to him or her and which may not entitle him or her to any other relief ... It is unacceptable to place the courts in a position where they can identify a breach of human rights and not be in a position to give an effective remedy. The whole procedure ... is of questionable constitutional validity.[49]

The restrictive time limit of six months associated with complaints to Strasbourg would also be a factor in a decision to forego the inadequate national remedies because of the length of time to pursue an action here, against the inadmissibility due to the time constraint. In effect, despite the incorporation of the Convention and taking into account the enormous costs of such litigation in Ireland with no guarantee of a remedy on a finding of incompatibility, it seems litigants might fare better by going straight to Strasbourg for a more effective remedy. The limitation on this approach of course is that litigants are obliged to exhaust their domestic remedies before being entitled to approach the Strasbourg Court.

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[46] *Ibid.*
[47] *Ibid,* section 3(2)
[48] *Keenan v. United Kingdom* (2001) 33 EHRR 913.
[49] Human Rights Commission, *Submission to the Joint Oireachtas Committee on Justice, Equality, Defence and Womens Rights* 2001, p4.

The Irish Human Rights Commission

The Human Rights Commission is an independent national human rights body set up under the Human Rights Commission Act 2000 with the task of protection of human rights in Ireland and in the context of the whole island.[50] The links between the Human Rights Commission and the incorporation of the Convention into Irish law are important.

> The Human Rights Commission Act 2000 places the institution at the intersection of national and international rights protection in its clear designation of the interpretation to be accorded to the term "human rights." Human rights are "the rights, liberties and freedoms conferred on, or guaranteed to, persons by the Constitution, and the rights, liberties or freedoms conferred on or guaranteed to, persons by any agreement, treaty or convention to which the State is party."[51]

The functions of the Commission include reviewing law and practice relating to human rights and consulting with relevant national and international bodies with knowledge or expertise in human rights. There are limitations in the reviewing power in that the Commission does not have an automatic right to vet legislation.[52] The Commission is expected to make appropriate recommendations on measures to strengthen, protect and uphold human rights in the State and to promote understanding and awareness of human rights. The Commission has a role in the conduct of enquiries and information gathering and, where necessary, to have recourse to the courts. It can prepare and publish reports on its research and enquiries. The Commission can undertake legal proceedings to vindicate human rights and provide legal aid as experts in the court and as *amicus curiae* or friend of the court in human rights matters. The growing awareness of international human rights and the impact of the Convention, particularly in other jurisdictions, were driving forces behind law reform elsewhere.[53] The more recent developments involving the

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[50] The membership had been initially selected through competition from a specially convened independent board and later the government sought to impose some of its own choices instead.
[51] Byrne, "Human Rights" in Byrne & Binchy, *Annual Review of Irish Law 2000,* Round Hall Sweet & Maxwell, Dublin, 2001, p272.
[52] An example is the Immigration Bill 2004 which at first reading contained controversial provisions regarding entry requirements, one of which permitted an immigration officer to decide if someone had a mental disorder as per the definition under the Mental Health Act 2001. This would appear to contravene the *Winterwerp* principles. The offending section has since been removed.
[53] Mental Health Act 1983, Mental Health (Northern Ireland) Act 1986.

incorporation of the Convention into Irish law and the establishment of the Human Rights Commission represent the growing awareness of human rights in Ireland.

Mental health law reform

The process of reform began with the Commission of Inquiry into Mental Illness in 1966 that recommended a community approach to mental health and that inpatient care would take place in small units attached to general hospitals. The proposals foundered due to a failure to propose a suitable framework for development of community care. However, these recommendations had a certain influence on the direction of service provision adopted by the Health Boards under the Health Act 1970. This Act provided for the restructuring of the health services and focused primarily on community care for mental disorder, with mental health policy being driven by the move to de-institutionalise mental health services.[54] Other jurisdictions were planning to reform mental health legislation and Ireland followed suit with the Health (Mental Services) Act 1981, which was intended to repeal the 1945 Act.

Had the 1981 Act been introduced, it would have focused on the rights of patients and introduced, *inter alia*, review tribunals and limited provisions on consent to treatment. The 1981 Act provided for the narrowing of the criteria for detention and clearer procedures leading to detention as well as automatic review of long-term detention. Despite the narrowing of the criteria, it would have permitted detention where the person had a mental disorder "in the interests of the person's health, safety or for the protection of others or property." The inclusion of property as a ground for detention would have breached Convention requirements. Some of the provisions lacked the required level of independence under the Convention such as the safeguards for consent to treatment.[55] The review of detention included a right of appeal against the tribunal to the Minister for Health which would not have satisfied the requirement of independence of the executive. Many aspects of the 1981 Act had been surpassed by reforms elsewhere, the provisions did not meet international obligations and the Act was never enforced. The Mental Treatment (Amendment) Bill 1992, a private

[54] Government Publications, *Planning for the Future,* PL 3001 Dublin 1984.
[55] The Act stated that the Medical Council would draw up the rules for consent.

members bill, was initiated to provide for review tribunals and to abolish the restriction in the 1945 Act on leave to take civil action.[56] This Bill was defeated.

The government subsequently published the *Green Paper on Mental Health* 1992 which set out the fundamental objectives of policy on the care of the mentally ill and included a discussion on the need for reform of mental health legislation and invited submissions from interested parties.[57] The focus for legislative change was on the 1945 Act and the recognition that Ireland did not adhere to international obligations, including the Convention. This was followed by the White Paper on Mental Health Legislation, *A New Mental Health Act,* in 1995 which outlined detailed proposals for new mental health legislation.[58] It provided extensive recommendations on mental health legislation. Following the introduction of the Mental Health Bill 1999, the Minister for Health and Children acknowledged that a number of issues which had been discussed in the White Paper had been omitted from the proposed Act but that "these issues would not be overlooked or forgotten". The Minister stated that,

> legislation was not the only means by which to effect change in the health service. The most acute problem for the mental health services for many years has been inadequate resources and, as I have indicated earlier, I am taking steps to ensure that the position is improved on that front.[59]

The Mental Health Bill 1999 was the embodiment in legislation of many of the White Paper proposals and subsequently enacted in the 2001 Act.[60] The main impetus for the immediate introduction of the 2001 Act was the friendly settlement reached in *Croke v. Ireland,* requiring the government to introduce the Act without delay.[61] This case underlines the rare occasion when there are real gains from the Convention. Two Irish cases had been deemed admissible before the Strasbourg Court: *O'Reilly v. Ireland,* concerning arbitrary deprivation of liberty under Article 5(1)(e) and *Croke v. Ireland,*

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[56] Deputy Nuala Fennell introduced this private members Bill.
[57] Department of Health *PL* 8918.
[58] Department of Health, *Pn* 1824. July 1995. The Minister for Health and Children, Minister Martin referred to the Bill as "a culmination of a long and detailed process of consultation and careful consideration." (517 *Dail Debates* Cols.997-998). The Act omitted many of the White Paper proposals including procedures affecting the detention of children, the omission of adult care orders, safeguards relating to the right to communicate, and relating to seclusion and clinical trials.
[59] (517 *Dail Debates* Col.1004).
[60] A total of 108 amendments were made to the Bill.
[61] Application no. 3326/96.

concerning the sufficiency of the protections under Article 5(4).[62] In both cases a friendly settlement was reached. The pressure to introduce legislation that complied procedurally and substantively with the requirements of the Convention was no longer avoidable.

The most significant aspect of the 2001 Act is the shift in focus from the medical discretion model encompassed in the 1945 Act to a rights-based approach where the patient will have statutory entitlement to various protective measures which have been standard in many other jurisdictions since the 1980s. Many of the rights included in the 2001 Act are a recognition of what the Strasbourg Court referred to in *Herczegfalvy v. Austria* as "the particular situation of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals."[63] During the debates on the Bill, the Minister for Health and Children said,

> as a group these people are among the most vulnerable people in our society. They are often unable to speak for themselves. It is incumbent on us as a society to recognise our obligations in relation to these people.[64]

The 2001 Act has a dual purpose. First, is to provide a modern framework for the involuntary admission to approved centres of those suffering from mental disorder and in need of treatment and protection, either in their own interests or the interests of others.[65] The second purpose of the Act is to put in place mechanisms by which the standards of care and treatment in the mental health services can be monitored, inspected and regulated. This modern framework includes the establishment of a Mental Health Commission, mental health review tribunals and the replacement of the existing Inspector of Mental Hospitals with an Inspector of Mental Health Services, having a broader remit.[66]

The narrowing of the criteria for detention will lead to compliance with the requirements under the Convention in *Winterwerp v. Netherlands*.[67] The Act introduces mental health tribunals to review initial decisions to detain and to review

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[62] Application no. 24196/94. Application no. 3326/96.
[63] (1992) 4 EHRR 188.
[64] (166 *Seanad Debates* Col. 1446).
[65] The Minister for Health and Children (517 *Dail Debates* Col. 997).
[66] Mental Health Act 2001, sections 32, 48 & 50.
[67] (1979) 2 EHRR 387.

continuing detention, and includes the right to legal representation.[68] The right to self-determination in regard to consent to treatment is recognised to some extent in the Act, along with a right to a second opinion. Information rights, which were clearly absent from the 1945 Act, are in marked contrast with the emphasis on such rights in the 2001 Act. The Act provides for both voluntary and involuntary admission of children under 18 years, in contrast with the 1945 Act, which provides only for voluntary admission of children under 16 years. The courts will be involved in all detentions of children with mental disorders.[69]

The 2001 Act has been deemed to be a minimal response, in that it provides safeguards only for those who are detained, about 11% of all admissions to psychiatric care, and creates no obligations regarding the provision of community services.[70] The Mental Health Commission is already involved in a wide range of activities including: the preparation of a code of practice, the power to register approved centres, and the establishment of the Inspectorate of Mental Health Services to ensure quality of care and treatment for all residents.[71] The Inspector is responsible to the Commission and monitors the standards of care and treatment in all approved centres. Statutory regulations will be drafted concerning the standards in mental health centres including: the standard of accommodation, the care of the residents, staffing levels and the provision of individual care plans. These requirements give statutory force to many of the guidelines in the Department of Health *Guidelines on Good Practice and Quality Assurance in Mental Health Services* (1998) which have provided guidance on best practice in areas like consent to treatment and other issues not addressed in the 1945 Act. One of the principal functions of the Mental Health Commission under the 2001 Act is to produce a code of practice.[72] This code of

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[68] The 1945 Act provided for a ministerial review, with the assistance of the Inspector of Mental Hospitals, of all detention orders, but this was later repealed by the Mental Treatment Act 1961. This provision would not have satisfied the independence requirement under Article 5 of the European Convention on Human Rights. See chapter 2 for full discussion of this issue.

[69] See chapter 9 for full discussion of Irish mental health law and children.

[70] Amnesty International, *Mental Illness: the Neglected Quarter* (Dublin 2003), the author's own opinion in, Keys M., "Issues for the New Mental Health Act," (2001) *Medico Legal Journal of Ireland* 97. Department of Health and Children, *Report of the Inspector of Mental Hospitals for year ending 2003,* Government Publications, Dublin, 2004. Figures for 2003 indicate that there were 18,969 admissions and of these approximately 11% or 2,527 were compulsory admissions.

[71] Mental Health Act 2001, sections 50-55. The first report was published in July 2005.

[72] *Ibid,* section 33(3)(e).

practice will be a vital adjunct to the legislation and many of the inadequacies in the legislation will have to be dealt with in the code.

Vulnerable adults

The protection of vulnerable adults and their recognition in the legal system, including safeguards to protect their rights to dignity, autonomy and self-determination has been the subject of recent or on-going law reform in many jurisdictions. The trend in some jurisdictions, like England, Wales and Scotland, is for separate statutory regimes for the treatment of mental incapacitated people without consent and for the management of their property and affairs.[73] The formal legal procedures currently available in Ireland are the Ward of Court system and the Enduring Power of Attorney. These provisions are examined for compliance with the Convention.[74] The lack of a modern legal framework for decision-making for vulnerable adults is currently under consideration by the Law Reform Commission which proposes a whole new approach to capacity assessment and guardianship orders.[75] This is the first indication from the Government of their intention to fill the gap which currently excludes many vulnerable adults from the decision-making process. The effect of such a vacuum results in a failure to protect their autonomy and privacy in many areas including personal relationships.

Summary of contents

This work will address the requirements of the Convention under Articles 2, 3, 5, 6, 8 and 12 as they apply to people with mental disorder and examine Ireland's level of compliance with the Convention. The order in which these Articles are considered in the body of this work does not follow the sequence in the Convention, but is ordered in a manner thought to provide a logical sequence. This includes a separate chapter on children that considers the impact of Articles 3, 5, and 8 of the Convention and the safeguards for children in Irish law. The transitional state of Irish law is

[73] Mental Capacity Act 2005 and in Scotland the Adults with Incapacity (Scotland) Act 2000.
[74] See chapters 3 and 6 of this work for further discussion.
[75] The Law Reform Commission Reports, *The Law and the Elderly* (LRC CP 23-2003), *Vulnerable Adults and Decision-Making* (LRC CP 25 2005)

acknowledged in the examination of two statutes currently in force, the 1945 Act and the 2001 Act.

Chapter One examines the right to liberty in the context of Irish law against the requirements in Article 5. Article 5 is at the core of this work, as it is the only Article of the Convention that refers to "persons of unsound mind" and also because all the other rights may be affected by the removal of the right to liberty. The provisions of the legislation, both the 1945 Act and the 2001 Act, are outlined with regard to compulsory admission and the chapter includes an examination of the criteria and procedures leading to detention. A number of cases have established a failure to comply with the 1945 Act and these will be discussed.[76] The question of the appropriate environment for mental health detention is raised as to whether there are conditions of detention in Ireland that might destroy the therapeutic purpose and thereby breach Article 5. The question of what constitutes a deprivation of liberty in Irish law involves a discussion of the safeguards for some voluntary patients and whether Article 5 might apply to them. The provision of information in both Acts about the right to challenge detention is considered in light of Article 5(2).

Chapter Two addresses the right to review of detention under Article 5(4), a right long established in other jurisdictions. Review of detention is a core right for people detained in psychiatric care and both the 1945 Act and the 2001 Act are examined for compliance with Article 5(4). The use of habeas corpus and judicial review, as the only means available currently for independent review of detention, are considered against Article 5(4) requirements. The results of a study on the accessibility of habeas corpus to people in mental health detention will be included in this chapter. The right to review of detention and the procedures involved under the 1945 and 2001 Acts will be assessed for compliance with the right to a fair hearing and a speedy review under Article 5(4).

Chapter Three focuses on an examination of the right to respect for private life in Article 8, addressing in particular the right to self-determination in relation to medical treatment for mental disorder. The safeguards concerning the right to consent to

[76] *Melly v. Moran & NWHB,* Unreported Supreme Court, May 28th 1998, *Kiernan v. Kiernan & Harris & MWHB* Unreported High Court, May 12th 1998, *Bailey v. Gallagher* [1996] ILRM 433.

treatment and to make advance directives, driven by efforts to uphold autonomy and dignity and supported by Article 8, will be discussed together with the use of seclusion in Irish mental health law. The right to confidentiality is another important aspect of private life that will be addressed in this chapter. Other aspects of the right to respect for private and family life that are discussed include proxy decision-making for children and incapacitated adults. Recognition in Irish law of the right to respect for home and correspondence is also considered.

Chapter Four deals with the impact of the prohibition on inhuman and degrading treatment in Article 3 and compliance in Irish law. The role of the CPT is examined together with its implications for defining what is inhuman and degrading treatment for people with mental disorder and for prisoners.[77] The key questions raised in this chapter are whether the conditions in which mentally disordered people are detained could reach the minimum level of severity to come within the scope of Article 3, whether medical treatment could amount to inhuman and degrading treatment, whether the side effects of treatment could be severe enough to engage Article 3 and whether the failure to treat an individual could amount to a breach of Article 3.

Chapter Five deals with the nature of civil rights and obligations under Article 6, the requirement to have a fair and public hearing in a reasonable time affecting access to court. The right to litigate under Irish law is examined as well as the right to legal representation and legal aid. The restrictions on access to court under the 1945 Act and the 2001 Act are examined through case law to see if they are proportionate to the aims sought to be achieved.

Chapter Six considers Article 6 requirements in the context of the provisions relating to the law on the management of the person or property and affairs of mentally incapacitated adults under Irish law. The ward of court system, which is paternalistic, cumbersome and totally restrictive of individual autonomy, is examined against the background of Article 6. These provisions include capacity assessments and proxy decision-making for incapacitated adults where necessary. The enduring power of attorney is an example of the right to self-determination in anticipation of incapacity.

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[77] Council of Europe, CPT *Standards on Health Care Services in Prisons*, Extract from the 3rd General Report [CPT/Inf (93) 12].

The Law Reform Commission proposals for reform of this area of the law include a comprehensive system of proxy decision-making for incapacitated adults, as well as procedures for the removal of an individual's capacity to make decisions and the protections of vulnerable adults.[78]

Chapter Seven considers the right to life and the obligations on the State to safeguard this right under Article 2. People in detention are vulnerable and create an onus on the state to protect their lives. This obligation is particularly important in relation to people who die in custody where there is knowledge both of the vulnerability of such individuals and the higher suicide risk associated with them. The key questions that will be addressed under Article 2 are: the action of state agents and non-state agents in the deaths of individuals in their custody, individuals taking their own lives and the risk to the public from mental disorder. The duty on the State to investigate any death arising in these circumstances will be examined and compared with the obligations under Article 2.

Chapter Eight deals with the right to marry and found a family under Article 12 and examines Irish law against the requirements in relation to people with mental disorder. The focus of this chapter is on the legal basis of the right to marry and the scope of the restrictions imposed on people who have a mental disorder. The right to found a family and the limits on this right in relation to having a sexual relationship and reproduction are also considered. The Law Reform Commission has made proposals for reform in this area based on the right to autonomy and self-determination and these are examined.

Chapter Nine considers the admission of children to psychiatric care and the safeguards in Irish legislation to comply with the Convention in relation to deprivation of liberty, the right to respect for private and family life, including the right to self-determination, and the right to protection from inhuman and degrading

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[78] Law Reform Commission Consultation Paper, *Law and the Elderly* (LRC CP-23 2003) recommends the abolition of the system and replacement with a whole new system. The operation of the system in relation to the welfare of the person and medical treatment will be dealt with under Article 8. See chapter 3.
Law Reform Commission Consultation Paper, *Vulnerable Adults and the Law: Capacity,* (LRC CP 37-2005).

treatment. The fact that children are generally subject to parental control and also have child-care laws applying to them necessitates a somewhat different approach. The recognition of parental authority under Article 5 and also under the Constitution is discussed.[79] The safeguards for consent to treatment for children are examined in relation to Article 8 and the particular problems associated with older children and their right to self-determination under the 2001 Act are addressed. The influence of international and regional human rights instruments support the decision-making autonomy of children as a factor associated with age and maturity.[80] These covenants also require that children are treated in an appropriate environment.[81] Children and vulnerable adults are treated similarly under the Convention and need independent representatives to advocate for them when they are receiving psychiatric treatment and to prevent them from being exposed to unwarranted interferences by the state, or other private individuals.

Finally, the question that arises in relation to reform of Irish mental health legislation is whether the Mental Health Act 2001 will obviate the need to have to resort to the human rights legislation to affirm safeguards for psychiatric patients, to provide support for and to assist across a spectrum of civil rights and obligations.

> ... if there is a single moral imperative to which we must respond in the context of mental health law it is the human rights obligation to translate the core ethical principles of respect for personal autonomy, justice, and paternalistic caring into the legal code ... law has an essential role to play in this area.[82]

Irish mental health law will now be examined using the Convention as a yardstick against which to measure human rights compliance.

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[79] *Nielsen v. Denmark* (1988) 11 EHRR 175, *North Western Health Board v. HW & CW* Unreported Supreme Court, November 8th 2001.

[80] UN Convention on the Rights of the Child, Article 12 and Convention on Human Rights and Biomedicine 1997, Article 6(2).

[81] Council of Europe, Committee of Ministers *Recommendation (2004) 10 on the protection of the human rights and dignity of persons with mental disorder.*

[82] Cooney T., "Psychiatric Detainees and the Human Rights Challenge to Psychiatry and Law: Where Do We Go From Here?", in Heffernan, (ed.), *Human Rights A European Perspective*, Round Hall Press, Dublin, 1994, p127.

Chapter 1

ARTICLE 5 AND THE RIGHT TO LIBERTY UNDER IRISH MENTAL HEALTH LAW

Introduction

This chapter considers the right to liberty under Article 5 of the Convention and the provisions in Irish law regarding compulsory admission and detention of patients. Article 5 is the only Article of the Convention that refers to "persons of unsound mind" and it impacts on many other rights due to the removal of the right to liberty. The provisions of the legislation, both the 1945 Act and the 2001 Act are outlined with regard to compulsory admission, including the criteria and procedures leading to detention. For the purpose of detention on the grounds of unsoundness of mind, detention must take place in a hospital, clinic or similar institution. The question of the appropriate environment for mental health detention is raised as to whether there are conditions of detention in Ireland that might destroy the therapeutic purpose and breach Article 5(1)(e). What constitutes a deprivation of liberty in Irish law is considered in light of the problems arising under both Acts regarding the compliant incapacitated person in the context of the decisions in *HL v. United Kingdom* and *Storck v. Germany* and the State obligations arising as a result.[1] The provision of information in both Acts about the right to challenge detention is considered in light of Article 5(2). The right to review of detention in Article 5(4), as an aspect of the right to liberty in Irish law, will be considered in Chapter 2.

Article 5(1) provides,

> 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:

[1] *HL v. United Kingdom* (2005) 40 EHRR 32 5th October 2004, and *Storck v. Germany* Application no.61603/00 16th June 2005.

(e) the lawful detention of persons for the prevention of the spreading of infectious diseases, persons of unsound mind, alcoholics or drug addicts or vagrants.

Article 5(2) Everyone who is arrested shall be informed promptly, in a language, which he understands, of the reasons for his arrest and of any charge against him.

Article 5 (1) protects the "right to liberty and security of the person" and is referred to as the "liberty" Article; it is designed to prevent arbitrary deprivation of liberty. In *Winterwerp v. Netherlands,* the Court referred to the importance of the aim underlying Article 5 in a democratic society subscribing to the rule of law, "that no-one should be dispossessed of his liberty in an arbitrary fashion."[2] The state is prohibited from depriving an individual of his or her liberty except in one of the circumstances listed in Articles 5(1). Article 5 covers all forms of detention and it is the only Article that expressly refers to persons of unsound mind comprising one of the exceptions to the right to liberty. The right to liberty is not absolute, but a person can only be detained in accordance with domestic law and while this is primarily a question for the national courts, domestic law must be consistent with the standards of the Convention, including its general principles.[3] The Court, in *Litwa v. Poland*, referring to the least restrictive alternative, emphasised the seriousness of detention that it is only justified where other less severe measures have been looked at and found to be insufficient to safeguard the individual or public interest, so that "the deprivation of liberty must be shown to have been necessary in the circumstances."[4] Many of the other Convention rights are somewhat based on Article 5 because of the effect detention has on an individual, particularly with regard to private and family life. Along with the curtailment of liberty, the state has power to impose restrictions that impact on various fundamental rights, such as the right to privacy, autonomy, self-determination, freedom of expression and association. Safeguards are provided by which a person who is detained is entitled to information concerning his detention and the right to initial and regular review of continuing detention.

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[2] (1979) 2 EHRR 387 para 37.
[3] *Ibid*, para 39.
[4] (2001) 33 EHRR 53 para 78.

In order to comply with the lawfulness requirement in Article 5(1) domestic legal procedures must be followed correctly, so that an examination of the lawfulness of detention for Convention purposes requires consideration of whether this has been the case. These domestic procedures must accord with Convention standards of lawfulness and principles such as proportionality. In the Irish courts, failure to comply with the requirements of the 1945 Act has been established in cases dealing with the examination for detention,[5] the use of the second opinion procedure[6] and the use of documents that are out of date.[7] These cases arose in the context of applications to the High Court for leave to take civil action and, in each case, the detention procedures were found to be invalid and leave to proceed was, therefore, granted.

Article 5(1) Deprivation of liberty

The essence of Article 5(1) is that any detention must be in keeping with a procedure prescribed by law and this lawfulness covers procedural as well as substantive rules. In *Engel v. Netherlands,* the Court referred to the fundamental right of "unhindered physical freedom" or physical liberty.[8] The right to freedom cannot be removed in an arbitrary manner because detention that is arbitrary cannot be regarded as "lawful."[9] Fennell comments that the "... primary impact of the Convention on psychiatric patients has been in relation to protection against arbitrary detention under Article 5, unsoundness of mind being one of the permitted grounds of deprivation of liberty under Article 5(1)(e)."[10] There are no minimum procedural guarantees laid down in 5(1)(e); it is left to the discretion of national laws. However, in *Winterwerp v. Netherlands* and in *Reid v. United Kingdom,* the Court held that the safeguards must be of a kind which are appropriate to the deprivation of liberty in question and include rights to representation.[11] No right to treatment can be derived from Article 5(1)(e), though Gostin comments that "lawful"

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[5] *Melly v. Moran & NWHB* Unreported Supreme Court, May 28th ,1998.
[6] *Kiernan v .Kiernan, Harris & MWHB* Unreported High Court, May 12th, 1998.
[7] *Bailey v. Gallagher* [1996] ILRM 433.
[8] [1976] 1 EHRR 647 para 58.
[9] *Guzzardi v. Italy* [1980] 3 EHRR 333.
[10] Fennell P., "The Third Way in Mental Health Policy: Negative Rights, Positive Rights, and the Convention." (1999) 26(1) *Journal of Law and Society* pp103-127.
[11] (1979) 2 EHRR 347, Application no 50272/99.

detention may require a minimal therapeutic environment on the basis of the connection between the purpose of detention and treatment.[12] In order for Article 5 to be engaged, there must be a deprivation of liberty.

The primary focus of Article 5 is deprivation of liberty, and "a deprivation of liberty which does not fall within one of the six categories listed in Article 5(1)(a) to (f) will, without more, be unlawful under the Convention".[13] There is a distinction between a deprivation of liberty to which Article 5 applies and a restriction on liberty, which is protected by Article 2 of Protocol No. 4 to the Convention.[14] A significant body of case law from the Convention considers the meaning of deprivation of liberty under Article 5 and the distinction between this and the protections under the Fourth Protocol. One of the early landmark decisions is *Guzzardi v. Italy* where the Court held that the distinction between these two factors is "merely one of degree or intensity, and not one of nature or substance".[15] In *Ashingdane v. United Kingdom* the applicant's detention under the Mental Health Act 1959 in an open ward constituted continuing deprivation of liberty even though he was free to move within the hospital grounds.[16] The Court held that his liberty had been circumscribed both in fact and in law. In considering whether a deprivation of liberty has taken place, the starting point or test is the concrete situation of the individual in question and the Court has affirmed in both *Guzzardi* and *Ashingdane* that, in assessing that concrete situation, account must be taken of a whole range of factors,

> such as the type, duration, effects and the manner of implementation of the measure in question. The distinction between deprivation of and restriction upon liberty is merely one of degree, and not one of nature or substance.[17]

In *HM v. Switzerland,* the applicant complained that she was placed by court order, of unlimited duration, in a foster home while she was able to care for herself in her home

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[12] Gostin "Human Rights of Persons with Mental Disabilities, The European Convention of Human Rights", (2000) 23(2) *Int.J.L.& P.*. p143.
[13] (1987) 9 EHRR 297 para 125.
[14] This Protocol is included in the European Convention on Human Rights Act 2003.
[15] (1981) 3 EHRR 333 para 93.
[16] (1985) 7 EHRR 528.
[17] *Ibid,* para 41.

and this was a breach of her rights under Article 5.[18] The Court had to consider if this amounted to deprivation of liberty and, if so, whether it complied with the requirements of Article 5(1)(e). The applicant also pointed out that Article 5 referred to "vagrancy" and not "neglect", which was the reason for her removal. The foster home was an open institution with complete freedom of movement and the applicant was never in a closed ward. She could have personal contacts and communicate with others by phone or letter and the only restriction she had was to be available at certain hours for medical treatment. There was evidence that she welcomed the environment and agreed to stay of her own free will, so much so that the order was lifted. The Court followed *Ashingdane v. United Kingdom* in holding that "the distinction between a deprivation of and restriction upon liberty is merely one of degree or intensity, and not one of nature or substance" and held that she was not detained for the purpose of Article 5(1).[19]

The dissenting judgment of Loucaides J. raises issues worth noting.[20] The first issue he addressed was whether *HM* was willing to be admitted and he followed the Court in *De Wilde, Ooms & Versyp v. Belgium*[21] by saying they should not use voluntariness to disguise what was a mandatory deprivation of liberty. The willingness of the patient to submit to a deprivation of liberty cannot be the sole reason for losing the benefit of Article 5. He was also critical of the Swiss Court's apparent reliance on the applicant's best interests as a reason for her placement. He considered this to be irrelevant. He cited *Winterwerp* in support of his decision and referred to the lack of medical examination to support the finding of a mental disorder.

The Court later in *HL v. United Kingdom* adopted much of the reasoning employed by Louciades, in what was the first opportunity for the Court to examine whether a compliant but incapacitated person admitted informally under the English Mental Health Act 1983 and then subjected to the hospital regime was actually deprived of liberty under

[18] (2004) 38 EHRR 17.
[19] (1985) 7 EHRR 528 para 41.
[20] *HM v Switzerland* (2004) 38 EHRR 17. Application no. 39187/98 26th Feb. 2002, pp 16-20 Loucaides J.
[21] (1971) 1 EHRR 373.

Article 5.[22] In the domestic courts, the majority of the House of Lords specifically distinguished actual restraint of a person (which would amount to false imprisonment) and restraint, which was conditional upon his seeking to leave (which would not constitute false imprisonment). The Court did not consider such a distinction to be of central importance under the Convention. It did not accept as determinative the fact relied on by the Government that the regime applied to the applicant (as a compliant incapacitated patient) did not materially differ from that applied to a person who had the capacity to consent to hospital treatment, neither objecting to their admission to hospital. In fact, this would seem to totally ignore the fundamental differences between these two groups. The Court referred to the importance of not undermining the benefit of the Convention because a person is compliant, especially when it is not disputed that that person is legally incapable of consenting to, or disagreeing with, the proposed action. The Court believed that, like the *Ashingdane* judgment, "the health care professionals exercised complete control over his movements and care from the outset."[23] The hospital staff had complete and effective control over his assessment, treatment, contacts, his movements and his residence. He had been sedated and his foster family were unable to meet him or take him home. The argument regarding the "locked or lockable" ward was not a deciding factor in whether someone was deprived of liberty or not.[24]

> Accordingly, the concrete situation was that the applicant was under continuous supervision and control and was not free to leave. Any suggestion to the contrary was, in the Court's view, fairly described by Lord Steyn as "stretching credulity to breaking point" and as a "fairy tale."[25]

The Court concluded that *HL* was detained and this was consistent with *Neilsen v. Denmark* where parental rights permitted the mother to remove her son at any time following his voluntary admission at her behest.[26] The fact that the hospital had to rely on the common law doctrine of necessity and, subsequently, on the involuntary detention provisions of the 1983 Act "demonstrates that the hospital did not have legal authority to

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[22] *HL v. United Kingdom* (2005) 40 EHRR 32 5th October 2004 para 89.
[23] *Ibid,* para 91.
[24] *Ashingdane v. United Kingdom* (1984) 6 EHRR 69 paras 24 and 42.
[25] *Ibid,* para 91.
[26] (1989) 11 EHRR 175 para 93.

act on the applicant's behalf ..."[27] The Court, therefore, concluded that the applicant was deprived of his liberty within the meaning of Article 5(1) of the Convention.

In order to establish that a deprivation of liberty has occurred, the Court must be satisfied regarding the actual situation of the individual, that the degree or intensity of such deprivation results in the individual being subject to a level of control that he is not free to leave and is subject to supervision, even when in an open ward. In *Storck v. Germany,* the Court referred to the requirement of an objective and a subjective element to satisfy the notion of deprivation of liberty.[28] The objective element involves a person's confinement in a particular restricted space for a not negligible length of time. The applicant had been placed in a locked ward, had been under the continuous supervision and control of the private clinic personnel and had not been free to leave during the twenty months at the clinic.[29] She had attempted to flee on several occasions and had to be fettered in order to ensure she remained. On one occasion, she had to be brought back by the police. She had been unable to maintain contact with the outside world and the court regarded this as satisfying the objective element of deprivation of liberty. The subjective element requires that the person has not validly consented to the confinement in question. The applicant had capacity to consent, but there was no evidence that she had agreed to her continued stay at the clinic.[30] Affirming the statement in *HL*, the Court stated that "the right to liberty is too important in a democratic society for a person to lose the benefit of the Convention protection for the single reason that he may have given himself up to be taken into detention."[31] The decision follows on the decision in *HL* and is distinguished from *HM* on the basis that the applicant in that case was undecided about staying in the nursing home, thereby permitting the conclusion that she did not object.

In each of these cases, the Court examined the elements of a deprivation of liberty which requires an examination of the specific situation of the individual in question. This involves consideration of a range of factors, such as the type, duration, effects and

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[27] *HL v. United Kingdom* (2005) 40 EHRR 32 5th October 2004 para 93.
[28] Application no. 61603/00 16th June 2005 para 74.
[29] *Ibid,* para 73
[30] *Ibid,*paras 75-76.
[31] *Ibid,* para 75.

manner of implementation of the measures in question. The factual, or objective, element of a deprivation of liberty involves the confinement of a person to a particular limited area for a period of time where the evidence indicates the person has not validly consented to such confinement. Even if the person has seemingly consented to being in detention initially, the safeguards of the Convention will not be lost to him or her based on the importance of the right to liberty.

Irish law and deprivation of liberty

Mental Treatment Act 1945

The provision in the English Mental Health Act 1983 whereby a person is admitted as an informal patient and is later prevented from leaving is replicated in the voluntary admission provisions of the 1945 Act.[32] The 1945 Act provides for a degree of formality in voluntary admission to hospital in that adults, people over 16 years, are required to make their own application for admission and the application must be accompanied by a recommendation from a doctor based on an examination carried out in the previous seven days. The situation of a compliant incapacitated elderly person being admitted in this way is that he would be unable to assert a right to leave hospital or refuse treatment. The hospital staff are constantly present, and if the person attempted to leave he would be brought back. There is control over the assessment, treatment, movement and residence, in that the applicant would only be released when the hospital deemed it appropriate and frequently would be involved in a decision on the most appropriate residence.[33] Accordingly, the factual situation of these patients is that they are under continuous supervision and control and are not free to leave. The 1945 Act makes provision where a person is not capable of being a voluntary patient as follows,

> **Section 195.** -Where a person who has been treated in an approved institution as a voluntary patient becomes mentally incapable of expressing himself as willing or not willing to remain in the institution, he shall be discharged from the institution

[32] Mental Health Act 1983 section 131, Mental Treatment Act 1945, section 190.
[33] *HL v. United Kingdom* (2005) 40 EHRR 32 5th October 2004, para 91.

into the custody of such person as the person in charge of the institution approves of not later that twenty eight days after becoming so incapable unless he sooner becomes capable of expressing himself as aforesaid or a Reception Order relating to him is obtained.

This section recognises that the patient may not be truly voluntary and mandates that the compliant incapacitated person is either detained or discharged to a more suitable environment. This clearly is not the practice as there are many patients who are *de facto* detained and not capable of deciding to leave or remain.[34] A second problem with the section is that the procedure does not have to be instigated for 28 days during which time the patient is *de facto* detained and the power to have complete control over such patients for this period is enshrined in the section. While it appears to be a safeguard on one level, the excessive time limit permitted seems disproportionate to the aim of ensuring the patient does not remain as a voluntary incapacitated patient. There is no guidance on whether the person can be compulsorily treated during this period. The notice of intention to leave increases the possibility for the imposition of restrictions on such patients and provides,

Section 194(1) A person not less than 16 years of age who is being treated in an approved institution as a voluntary patient may give written notice that he wishes to leave the institution not earlier than seventy-two hours from the giving of the notice and he shall be entitled and shall be allowed to leave the institution on or at any time after the expiration of the said seventy-two hours.

The power to detain during this period was raised in *Gooden v. Waterford Regional Hospital,* involving a habeas corpus application where the applicant argued unsuccessfully that he should not be subject to detention after the expiration of the 72 hour notice period.[35] The Supreme Court stated that a voluntary patient who has given notice may not be released prior to the expiration of the notice period, but may be permitted to leave on or at any time after its expiry. Rejecting a literal interpretation of section 194(1) which would have resulted in mandatory release of ill patients after the

[34] Evidence for this practice comes from the author's own work experience in addition to information given at mental health conferences. On a visit to a large psychiatric hospital many of the patients were on voluntary admission forms and these patients were deemed not to have the capacity to make such a decision.

[35] [2001] IESC 6 21st February 2001.

notice period had expired, the Supreme Court read sections 194 and 195 together to imply a power of detention for such patients. McGuinness J. referred to the "weaknesses in the current legislation" where no express provision is made for admitting voluntary patients who want to leave hospital but are too ill, and that "it had been necessary for the court to imply such a provision. This is not a satisfactory situation."[36] The provision implied was that it was possible to detain a voluntary patient following the expiry of the notice requirement in section 194(1) by reading it along with section 195 which permits the detention of voluntary patients who are no longer capable of being voluntary. There is no indication that section 195 was drafted to deal with patients wanting to leave hospital against advice and the impact of this decision means that the courts are forced to find a basis for detaining such patients. This decision exposes the arbitrariness in the current law and its unpredictability in such circumstances.

Apart from those voluntary patients who give notice of their intention to leave, the 1945 Act is clear that patients who are not capable of being voluntary should be discharged or detained. Failure to comply with this procedure amounts to a breach of national law and of the Convention. It also confirms that patients who are *de facto* detained require safeguards that are not available and as a result the 1945 Act is in breach of Convention requirements following *HL v. United Kingdom and Storck v. Germany.*[37] The uncertainty in these sections confirms that the law lacks the requirement of accessibility and precision under the Convention.

Mental Health Act 2001

The 2001 Act does not impose any formal admission requirements on voluntary patients, but has a 24 hour holding power pending a decision on detention where necessary and provides,

> **Section 29** -Nothing in this Act shall be construed as preventing a person from being admitted voluntarily to an approved centre for treatment without any

[36] *Ibid*, para 53.
[37] (2005) 40 EHRR 32 5th October 2004, Application no. 61603/00 16th June 2005.

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.

The use of the word "voluntarily" might be expected to embrace not only the truly voluntary patient with capacity, but also those patients without capacity as is the case in the Mental Health Act 1983. However, the 2001 Act may have a narrower intention and imply that the person has the capacity to understand that consent is being given to the admission, to remaining in hospital and to any treatment received. This interpretation is confirmed by the discussions of the section during the Dail debates on the introduction of the legislation.[38] The question here is whether only those who are truly voluntary will be admitted under this section and those without capacity will be detained. This outcome would be inconsistent with the expected workloads of the tribunals outlined during the debates prior to enactment.[39] There is no section similar to section 195 of the 1945 Act that recognises lack of voluntariness. The 2001 Act provides only that, if a voluntary patient wants to leave hospital and the staff are of the opinion that the patient has a mental disorder, he can be detained on a holding power for 24 hours in order to get a second opinion and can be then be formally detained on foot of this opinion or discharged.[40] This second opinion is not required to be independent and arguably creates a lower standard of safeguard for voluntary patients facing detention compared with someone in the community being detained who would have the benefit of an application for admission, as well as an opinion from the recommending doctor. It may expose an inequality that might engage Article 14 combined with Article 5 unless there is objective and reasonable justification for the difference in treatment.[41] This justificiation may be that the patient is already in hospital and subject to continuous assessment prior to formal detention.

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[38] In the debates in the Bill both junior and senior Ministers for Health and Children stated that unless the person was capable of being voluntary they should be detained. (536 *Dail Debates* Cols 1455-1459).
[39] The expected volume was discussed in the Dail Debates. (536 *Dail Debates* Cols 1439-1443).
[40] Mental Health Act 2001, sections 23(1) & 24.
[41] Wintermute R. "'Within the Ambit': How Big *Is* the 'Gap' in Article 14 European Convention on Human Rights?" [2004] 4 *EHRLR* pp366-382. He considers the greater use of Article 14 as a means of providing general protection against discrimination by recognising that not only an opportunity denied, but a ground for denial may fall within "the ambit" of another Article of the Convention .

The limited approach to the issue of voluntariness in the 2001 Act creates uncertainty about how the compliant incapacitated patient will be dealt with when the Act is in operation. Such patients will continue to be admitted with no additional safeguards provided. However, where such admissions meet the requirements to establish a deprivation of liberty, procedures are needed to ensure that these are lawful. These procedures include the presentation to a competent authority of objective medical evidence of a true mental disorder which is of a kind or degree justifying detention, and regular rights to review of detention.

Article 5 (1)(e) Criteria for detention

The purpose behind Article 5(1)(e) is to protect persons of unsound mind against arbitrariness in the deprivation of their liberty.[42] Therefore, any removal of liberty must be in keeping with the specific purposes laid out in Article 5(1)(e). The purpose of psychiatric detention is therapeutic and it must be clearly established before a competent authority that the person is of unsound mind. Exceptions to this requirement are made in emergencies and the Court has afforded a discretion or margin of appreciation to national authorities in evaluating the evidence presented to them.

The links between the four categories of people referred to in Article (5)(1)(e) have been acknowledged by the Court on the basis that all of them can be detained under domestic law, provided it accords with the requirements of Article 5. The term "vagrant" was addressed by the Court in *De Wilde, Ooms & Versyp* and the Court acknowledged the definition in national law, referring to persons of no fixed abode as those who had no means of subsistence, trade, or profession.[43] The Court held that anyone coming within this Belgian definition was in principle a vagrant for the purpose of Article 5(1)(e). In *Litwa v. Poland,* the Court referred to the link between all the categories and stated,

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[42] *Herczegfalvy v..Austria* (1993) 15 EHRR 437, *Winterwerp v. Netherlands* 2 EHRR 387, *X v. United Kingdom* (1981) 4 EHRR 181.
[43] (1971) 1 EHRR 373.

> ... There is a link between all those persons in that they may be deprived of their liberty either in order to be given medical treatment or because of considerations dictated by social policy, or on both medical and social grounds. ... a predominant reason why the Convention allows the persons mentioned in paragraph 1(e) of Article 5 to be deprived of their liberty is not only that they are dangerous for public safety but also that their own interests may necessitate their detention". [44]

Articles 5(1)(e) groups together those who are largely marginalized in society and who can be forcibly detained without a criminal conviction. Gostin is critical of this grouping and refers to the lack of justification for state intervention with these categories and finds justification on public health grounds only in relation to infectious diseases.[45] He refers to the other groups as a series of "personal health statuses based on health or socio-economic status."[46] These would not of themselves necessitate detention without the justification of a finding of dangerousness and possible benefit from receiving treatment and could expose potential for conflict with Article 3, on inhuman and degrading treatment, as well as Article 3 read with Article 14 on possible discrimination.[47]

In *Winterwerp v. Netherlands* the Commission stated that no one may be confined as person of unsound mind in the absence of medical evidence establishing that his mental state is such as to justify his compulsory hospitalisation.[48] There is no definition of "persons of unsound mind" in Article 5(1)(e), but the Court in *Winterwerp v. Netherlands* stated that,

> the Convention does not state what is to be understood by the words 'person of unsound mind' ... it is a term whose meaning is continually evolving as research in psychiatry progresses, an increasing flexibility in treatment is developing and society's attitude to mental illness changes, in particular so that a greater understanding of the problems of mental patients is becoming more widespread. [49]

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[44] (2001) 33 EHRR 53 para 60.
[45] *Op. cit.*, 12 p136.
[46] *Ibid.*
[47] See discussion on Mental Treatment Act 1945 sections 163(2) and 166(1) pp 41 and 42 this chapter.
[48] *Winterwerp v. Netherlands* (1979) 2 EHRR 387, Commission Report para 76.
[49] *Ibid,* para 37. This interpretation of 'person of unsound mind' was followed by Budd J. in the High Court in the Irish decision in *Croke v. Smith & Eastern Health Board,* Unreported High Court, July, 1995.

The Court confirmed that it is not possible to give a definitive meaning to "person of unsound mind" due to the evolving knowledge in psychiatric diagnosis and treatment. The interpretation of that phrase is to be gathered from domestic law and accord also with developments at an international level. A person cannot be detained "simply because his views or behaviour deviate from the norms prevailing in a particular society."[50] The applicant in *Koniarska v. United Kingdom* had been diagnosed as suffering from a psychopathic disorder and her detention was found to be needed as there was a danger of her injuring herself or other persons.[51] There could thus be said to be both medical and social reasons for her detention.

The applicant in *Winterwerp* had been committed to hospital initially for a short period, later for a longer term on a non-emergency procedure and a District Court order. He regularly sought his discharge.[52] The Commission was unanimous that there was no breach of Article 5(1) but there was a breach of Article 5(4). His detention could be justified under Article 5(1)(e) on the basis of unsoundness of mind. The Court agreed with the Commission that no one could be detained as a person of unsound mind in the absence of medical evidence to justify compulsory hospitalisation. The Court listed the well established three pronged *Winterwerp* requirements for lawful detention that apply, except in emergencies,

- There must be reliable evidence of a true mental disorder based on objective medical expertise and presented to a competent authority,
- The mental disorder must be of a kind or degree warranting confinement,
- The validity of the continued confinement depends on the persistence of such a disorder.

The Court confirmed that it is for national authorities to evaluate the evidence before them in a particular case and that the Court's task is to review the decisions of those authorities against this background.[53] The defendant state is allowed a margin of appreciation in making the assessment of the particular person's situation. In the case of

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[50] *Ibid,* para 37.
[51] (2000) 30 EHRR 139. Application no. 33670/96 12th October 2000.
[52] *Winterwerp v. Netherlands* (1979) 2 EHRR 387.
[53] *Ibid,* para 40.

the release of an individual where there is a concern regarding danger to the public, national authorities are entitled to exercise caution.[54] The test arising from such statements is whether it can be reliably shown that the patient suffers from a mental disorder sufficiently serious to warrant detention. Medical assessment must be based on the actual state of mental health of the person concerned and not solely on past events and is not sufficient to justify deprivation of liberty if a significant period of time has elapsed.[55]

The nature or degree of a mental disorder required for detention was raised in *HL v. United Kingdom.* There, the applicant maintained that he had a mental disorder, but it was not of such a nature or degree as to justify his subsequent admission to hospital or, alternatively, it ceased to be of such a degree shortly afterwards.[56] The Court held on the evidence that he had a mental disorder that was persistent and warranted continuous confinement.

In *Winterwerp* and in *X v. United Kingdom* the Court held that the requirement of objective evidence of a true mental disorder did not apply to emergency detentions.[57] The Court said that if domestic law provides for emergency detention where there is a danger to others, then it would not be practical to expect a thorough medical examination prior to detention. According to the Court, national authorities with power to order emergency detentions enjoy a wide discretion as they are better placed to evaluate the evidence adduced before them and the Court's task is limited to reviewing under the Convention the decisions they have taken.

Thorold refers to *Winterwerp* as the "first landmark interpretation of Article 5" regarding mental illness and the decision which held that "lawful" detention presupposed conformity with both domestic law and the Convention and covered procedural, as well

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[54] *HL v. United Kingdom* (2005) 40 EHRR 32 5th October 2004 para 98.
[55] *Varbanov v. Bulgaria* (2000) MHLR 263. Application no. 31365/96.
[56] *HL v. United Kingdom* (2005) 40 EHRR 32 5th October 2004.
[57] *X v. United Kingdom* (1982) 4 EHRR 188 para 42.

as substantive, rules.[58] Even if national law is clear and has been complied with, currently, deprivation of liberty will not be "lawful" if domestic law does not comply with the Convention and allows for arbitrary or excessive detention.

The *Winterwerp* criteria are unambiguous on the issue of the necessity for objective medical expertise to avoid arbitrariness in detention in non-emergency situations.[59] The lack of medical evidence in *Varbanov v. Bulgaria* was highlighted and the Court held there was a violation of Article 5(1).[60] While the Court acknowledged that in emergency cases such evidence may not be necessary, there was no such emergency in his case and while in detention he had not undergone psychiatric assessment. When the issue of danger arises as a consideration in detention and the required procedures have not been adhered to, the Court has shown considerable deference to national authorities in relation to the application of the *Winterwerp* criteria.

Failure to carry out a medical examination for recall at the end of a prison sentence was held to violate Article 5(1) in *Kay v. United Kingdom.*[61] The recall power lacked the required pre-condition of a medical recommendation and no medical report was sought by the Home Secretary indicating that the applicant needed hospital treatment. The power is far wider than Article 5 permits. The Home Secretary had the opportunity to have an assessment carried out in prison and to produce reports, but failed to do so. Thorold states that any use of the recall power, except in an emergency, without a medical recommendation will be likely to constitute a violation of Article 5.[62]

The issue of treatability was raised by the applicant in *Reid v. United Kingdom,* and the question arose as to whether his detention in psychiatric care, receiving only minimal medical treatment, infringed Article 5(1).[63] The Court referred to the need to establish that the person is suffering from a mental disorder of a kind or degree warranting

[58] Thorold O., "The Implications of the European Convention on Human Rights for the United Kingdom Legislation", (1996) *EHRLR* Issue 6 619.
[59] (1979) 4 EHRR 387.
[60] (2000) MHLR 263. Application no. 31365/96 5th October 2000.
[61] Application No. 11468/85 15th April 1988.
[62] *Op. cit.*, 56.
[63] *Hutchison Reid v. United Kingdom*,(2003) 37 EHRR 9. Application no.50272/99 para 47.

compulsory confinement and held that such confinement may be necessary where the person needs therapy, medication or other treatments to alleviate the condition and to have control and supervision to prevent harm to himself and others. There was objective evidence of a true mental disorder and due to the risks involved the disorder was regarded as being of a degree warranting compulsory confinement. The decision to detain him was not arbitrary and so not in conflict with Article 5(1). The Court held that,

> compulsory confinement, may be necessary not only where a person needs therapy, medication or other clinical treatment to cure or alleviate his condition, but also where the person needs control and supervision to prevent him, for example, causing harm to himself or others.[64]

One of the key questions in Article 5 is to understand the extent to which the Convention imposes positive obligations to detain mentally disordered people in institutions where they are offered suitable treatment. In *Winterwerp,* the applicant argued that Article 5(1) engenders for any individual confined as a person of unsound mind, the right to appropriate treatment in order to ensure that he is not detained any longer than absolutely necessary. He complained that the meetings with his psychiatrist were too short and infrequent and that the medication administered to him was unduly made up of tranquillisers. The Commission affirmed the view that Article 5(1)(e) was concerned with the question of actual deprivation of liberty of psychiatric patients and not their treatment. The Court held that a patient's right to treatment appropriate to his condition cannot, as such, be derived from Article 5(1)(e) and the evidence indicated no breach of the Convention provisions.[65] In *Dhoest v. Belgium,* the applicant argued likewise that there was a breach of Article 5(1)(e) because he was detained as a person of unsound mind and was entitled to appropriate treatment in order to ensure that he was not detained longer than was absolutely necessary, as his treatment was limited to drug therapy.[66] The Commission reaffirmed the principle that Article 5(1)(e) was concerned with the question of the actual deprivation of liberty and not with the notion of treatment. Article 12 of Council of Europe Recommendation (2004) 10 refers to "appropriate individually

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[64] *Ibid,* para 57.
[65] *Winterwerp v. Netherlands* (1979) 2 EHRR 387 para 51.
[66] *Dhoest v. Belgium* (1987) 12 EHRR 97.

prescribed treatment plans," though this document does not have the force of law.[67] The tension between autonomy and the right to impose detention and treatment is heightened by the lack of a guarantee of appropriate treatment.

The importance of the therapeutic environment was raised in *Aerts v. Belgium,* reaffirming the approach in *Ashingdane v. United Kingdom,* which held that although there must be a relationship between the ground of permitted deprivation of liberty relied on and the place and conditions of detention, Article 5(1) is not, in principle, concerned with treatment or conditions.[68] Where the absence of appropriate treatment has a serious impact on the person, it may be argued that this would breach the positive obligations on the state in Article 3 to prevent torture, inhuman and degrading treatment. In *Ashingdane,* the Court held that detention would only be lawful if carried out in an appropriate environment, such as a hospital or clinic.[69] Where the sole basis of detention is unsound mind, such an environment may breach Article 5(1)(e), even where it is not in breach of Article 3.[70] The prison where *Aerts* had been detained had been criticised by the Committee for the Prevention of Torture, Inhuman and Degrading Treatment (CPT) as unsuitable for the treatment of mental illness because it did not have regular medical attention or a therapeutic environment. The CPT report also stated that the standard of care fell below the minimum acceptable from an ethical and humanitarian point of view. The applicant complained that he was detained in breach of Article 5(1)(e) as there was a real risk of deterioration in the mental state of persons of unsound mind through continuing or prolonged detention in such place. It was argued that since "person of unsound mind" was the sole ground for detention, there had to be a relationship between the aim, the place and conditions of the detention, implying a therapeutic involvement with the patient. Breach of Article 5(1) occurred because of the delay in finding the applicant an appropriate hospital. The Court stated,

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[67] Council of Europe, Committee of Ministers, *Recommendation 2004 (10) on the protection of the human rights and dignity of persons with mental disorder.* Council of Europe Recommendation (83)2 refers to the need to administer treatment as a legitimate indicator for detention but it does not give rise to a right to treatment Article 3(b).

[68] (2000) 29 EHRR 50 para 49, (1985) 7 EHRR 528 para 44.

[69] *Ashingdane v. United Kingdom* (1985) 7 EHRR 528.

[70] Fennell P., "The rights of psychiatric patients under Articles 3, 5 and 6 of the European Convention on Human Rights" (1999) 7 *Med. L. Rev.* p355.

> ... There must be some relationship between the ground of permitted deprivation of liberty relied on and the place and conditions of detention. In principle, the detention of a person as a mental health patient will only be 'lawful' for the purposes of sub para (e) of 1 if effected in a hospital, clinic or other appropriate institution.[71]

There was no regular medical attention or therapeutic environment, and so, the proper relationship between the aim of the detention and the conditions in which it took place was deficient. Therefore, the only appropriate place was a hospital or other similar place. The Court found a violation of Article 3 in *Nevmerzhitsky v. Ukraine,* where the applicant developed a serious skin condition and the failure to provide treatment amounted to degrading treatment.[72] This decision raises questions for mental health care where the adequacy of medical treatment is in question, even if this much more difficult to establish compared with identifiable physical symptoms.

Irish law and criteria for detention

Mental Treatment Act 1945

There are two main categories of detention in the 1945 Act: the "person of unsound mind" (PUM) category and the "temporary" category, both of which are further divided into public and private categories with some associated differences in procedure.[73] The person of unsound mind category has origins in the 1800s and is now used relatively infrequently and totalled 91 admissions for 2003.[74] The PUM admission requires,

Section 163(2)

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[71] (2000) 29 EHRR 50 paras 46-49.

[72] Application 54825/00 para 87. See Chapter 4 pp162-164 for further discussion of this case and Article 3 implications.

[73] Mental Treatment Act 1945, sections 162 & 184.

[74] Department of Health, *Report of the Inspector of Mental Hospitals for Year ending 2003,* Government Publications, Dublin, 2004, Appendix 1, p310. The concerns around this type of admission are the permitted use of social factors as the basis for detention and the lack of review and time limit, contrary to the requirements under the Convention. In practice, these admissions are used as a means of getting Garda transport to hospital. The 2003 statistics indicate that 91 of these admissions took place mainly in services along the western seaboard.

(b) The recommendation shall contain a certificate that such person is of unsound mind, is a proper person to be taken charge of and detained under care and treatment, and is unlikely to recover within six months from the date of such examination.
(c) The recommendation shall contain a statement of the facts upon which the authorised medical officer has formed his opinion that such person is a person of unsound mind, distinguishing facts observed by himself and facts communicated by others.

The 1945 Act provides no definition of "unsound mind" and the standard to be met must satisfy "proper person" and "unlikely to recover within six months". It is almost impossible to meet these criteria with so little guidance from the statute. Some hints on the meaning of "unsound mind" are to be found in another section of the Act.

Section 166-(1)

Where the appropriate assistance officer is informed or knows that a person believed to be of unsound mind is not under proper care or control or is neglected or cruelly treated by any relative or other person having the care or charge of him, such officer shall apply in the prescribed form to the authorised medical officer for a recommendation...

This section indicates that social considerations, with no objective medical evidence of mental disorder, can lead to detention.[75] The 1945 Act permits detention on broad grounds including social grounds.[76] In practice, people are not detained nowadays on social grounds as this would not accord with acceptable professional standards and with best practice. However, this gap between law and practice presents the very real risk of arbitrariness where the rule of law does not apply; it leads to uncertainty, imprecision and lack of forseeability in the application of the law for the individual. It creates difficulties for professionals attempting to match current practice with legislation which is out of date.

There is a further subsection providing for the detention of persons of "no fixed residence" where the doctor examining the person has to ensure "it is proper to make the

[75] See p35 this chapter for discussion of Article 5(1)(e) groupings.
[76] Mental Treatment Act 1945, section 166.

recommendation," with no further guidance either.[77] These provisions are in breach of Article 5(1)(e) of the Convention as outlined by the Court in the *Winterwerp* judgment in that they do not satisfy the requirement of true mental disorder of a kind or degree warranting compulsory confinement and instead are based on social factors.[78] Apart from the time constraints, within which the application and recommendation are required to be made, the only substantive restriction applying in the section is that the doctor is expected to make his own assessment independently of other opinions.[79]

The temporary admission criteria provide,

> **Section 184 (4)(a)** that such person-
> (i) is suffering from mental illness, and
> (ii) requires, for his recovery, not more than six months suitable treatment, and
> (iii) is unfit on account of his mental state for treatment as a voluntary patient, or
> **(b)** that such person-
> (i) is an addict, and
> (ii) requires, for his recovery, at least six months' preventive and curative treatment.

An addict is defined as a person who,

> **Section 3**
> **(a)** By reason of his addiction to drugs or intoxicants is either dangerous to himself or others or incapable of managing himself or his affairs or of ordinary proper conduct, or
> **(b)** By reason of his addiction to drugs, intoxicants or perverted conduct is in serious danger of mental disorder.[80]

The term "suitable treatment" in section 184(4)(a)(ii) has never been interpreted but would comply with Article 5(1)(e) if treatment takes place in a hospital, clinic or other appropriate institution based on the decisions in *Ashingdane* and *Aerts*.[81] Unfitness on account of mental state is not based on any criteria and is open to broad interpretation

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[77] Mental Treatment Act 1945, section 166(2).
[78] (1979) EHRR 186. See p36 of this chapter for a full discussion of these requirements.
[79] Mental Treatment Act 1945, section 163(2)(c).
[80] Mental Treatment Act 1945, sections 3 & 184(4).
[81] (2000) 29 EHRR 50 and (1985) 7 EHRR 528.

when the difference between a detained patient and a voluntary one is more to do with compliance in the admission than severity of illness or mental state. This does not reflect the least restrictive alternative. The requirement of preventative and curative treatment for the addict seems to envisage a difference in treatment from someone with a mental illness. The definition of addict does not comply with the *Winterwerp* criteria and is far too broad and defined to include a person "incapable of managing himself or his affairs or of ordinary proper conduct" with no additional requirement of proportionality.[82] However, in *Litwa v. Poland,* the Court gave a wide discretion in relation to the detention of alcoholics and held that the purpose of Article 5(1)(e) cannot be interpreted as only allowing the detention of "alcoholics" in the limited sense of persons in a clinical state of "alcoholism".[83] The Court stated that persons who are not medically diagnosed as "alcoholics", but whose conduct and behaviour under the influence of alcohol pose a threat to public order or themselves, can be taken into custody for the protection of the public or their own interests, such as their health or personal safety. However, the Court also requires that such detentions must be a proportionate response to the situation.

Incapacity to manage one's person or affairs in the Act is not evidence of true mental disorder. The inclusion also of "ordinary proper conduct" without any definition provides such a wide sweep that would permit almost anybody to be detained and is in breach of Article 5(1)(e). The requirement of "being in serious danger of mental disorder" indicates that the person may not have a current mental disorder, but failure to admit might result in one. This seems to permit preventive detention and would also fall foul of Article 5(1)(e) and the *Winterwerp* requirements. The inclusion of perverted conduct as an aspect of addiction would not be a reason for detention according to *Winterwerp,* as mere deviance from society's norms is not enough to constitute mental disorder.[84] The requirement of a true mental disorder based on objective medical expertise would seem to rule out the inclusion of perverted conduct as a legitimate reason for detention.

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[82] *De Wilde, Ooms & Versyp v. Netherlands* (1971)1 EHRR 373.
[83] *Litwa v. Poland* (2001) 33 EHRR 53 para 61.
[84] *Winterwerp v. Netherlands* [1979] 2 EHRR 387.

Mental Health Act 2001

The criteria for detention in the 2001 Act are more specific and provide an umbrella definition of mental disorder which will cover specific categories: mental illness, significant intellectual disability and severe dementia.

> **Section 8(1)**
> A person may be involuntarily admitted to an approved centre pursuant to an application ... and detained there on the grounds that he or she is suffering from a mental disorder.

The section provides that the person may be detained in hospital, but there is no reference to treatment. The question is whether the section unintentionally provides a power of detention based on mental disorder, but without any treatment being necessary. This would be a major interference by the State with no acknowledgement of the therapeutic aim or of the exceptions to the deprivation of liberty provided for in Article 5(1) and also ignores the notion of reciprocity following the removal of liberty. This principle of reciprocity was raised by the Richardson Committee ???The decision of the Court in *Reid v. United Kingdom* held that it was not a precondition of detention under the Convention that there be an effective therapy and that a person may be detained where he needs control and supervision to prevent harm to himself or others.[85]

The umbrella term mental disorder is defined as follows,

> **Section 3(1)**
> In this Act "mental disorder" means mental illness, severe dementia and significant intellectual disability where-
> (a) because of the illness, disability, or dementia, there is a serious likelihood of the person concerned causing immediate harm to himself 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

[85] *Hutchison Reid v. United Kingdom*, (2003) 37 EHRR 9. Application no.50272/99 para 47.

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 the person to a material extent.

A person may not be involuntarily admitted "by reasons only of the fact that she or he is suffering from personality disorder, is socially deviant, or is addicted to drugs or intoxicants".[86] There are uncertainties in the various phrases used in the above section e.g., the severity of illness required to prove that there is a serious likelihood of the illness, as opposed to likelihood, is not clear, nor is the associated question of immediate harm, serious harm, or immediate and serious harm. Then, if one relates these requirements to the three categories, the question is if it will be possible to establish that there is a serious likelihood of immediate and serious harm because, for example, of the person's significant intellectual disability. The interpretation of some of the provisions may pose difficulties, terms like "serious likelihood of immediate and serious harm", indicates there will be reliance on the predictability of dangerousness which has not been shown to be accurate.[87] Recent behaviour is an important factor in such predictions, but there is no reference in the section to this factor.[88] It is not clear if this applies only to physical harm or there may be a possibility that it will also apply to emotional harm. The "appropriate treatment" provision is similar to the "suitable" treatment under the 1945 Act and the question arises that, if there is no possibility of appropriate treatment, will it be the most appropriate treatment available or the only treatment available?[89] There is no further elaboration, thereby leaving the scope of the provision open to broad interpretation.

The requirement that the admission would "benefit" the person requires some guidance on what this means and those carrying out the admission will have to have further

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[86] Mental Health Act 2001, section 8(2).

[87] Monahan et al, *Rethinking Risk Assessment: The MacArthur Study of Mental Disorder and Violence,* OUP, Oxford, 2001.

[88] Sromberg & Stone, "A Model State Law on Civil Commitment of the Mentally Ill", (1983) 20 *Harvard J on Legislation* p275.

[89] See chapter 9 on "The Impact of Articles 3, 5, and 8 for the Protection of Children with Mental Disorder in Irish Law" for discussion of appropriate treatment in relation to children.

information in order to apply this section. The addition of the requirement to "alleviate the condition... to a material extent" in section 3(1)(b)(ii) may provide some clue as to the meaning of the section overall and seems to require an identifiable potential result with the use of the word "material." It seems to be suggesting that there must be a clear benefit from compulsory admission over and above what might be gained by any other form of intervention. Where this is related to "appropriate treatment", or an appropriate environment, and there is only one form of treatment, though not necessarily the most appropriate, the question is if that will prevent the detention, or make it illegal. Treatability is not a pre-requisite of compulsory admission from the point of view of Article 5.[90] Treatment is defined broadly in the Act and includes "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."[91] The "other remedies" provision could include secure care for unmanageable behavioural conditions.

The three categories within mental disorder are defined as follows,

Section 3(2)(1) provides,

> "mental illness" means a state of mind of a person which affects the person's thinking, perceiving, emotion, or judgement and which seriously impairs the mental function of the person to the extent that he or she requires care, or medical treatment in his or her own interest, or in the interest of other persons.
>
> "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.

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[90] *Winterwerp v. Netherlands* (1979) 2 EHRR 387.
[91] Mental Health Act 2001, section 3(1).

The third category, significant intellectual disability, refers to a state of "arrested or incomplete development of the mind" which, it could be argued, is not really a developmental condition. The level of impairment of intelligence is not stated and impairment itself is not necessarily significant. Where there is significant impairment of social functioning, it is more likely to be associated with a behaviour disorder, personality disorder, or another cause rather than anything to do with a significant intellectual disability.[92] Aggression is not necessarily the product of an arrested or incompletely developed mind. The reference to "seriously" irresponsible conduct is also unclear as to how different in degree it is from "irresponsible" conduct. The use of the words serious, immediate, significant and severe throughout the criteria for detention indicate an exacting or high level of proof will be required for any detention.

Similar issues arose in a number of English cases and the Code of Practice of the Mental Health Act 1983. In the first of these, *R v. Hall*, the Court of Appeal interpreted the words "severe impairment of intelligence and social functioning" as ordinary English words "to be measured against the standard of normal persons" rather than those used by a professional.[93] Bartlett comments that this case may be accepted as a guide to the definitions in the Mental Health Act 1983 but that the differing contexts should be noted.[94] In contrast the Code of Practice emphasises multidisciplinary professional involvement in the assessment as to whether the behaviour falls into a "severe" category. In a later case, *Re F (Mental Health Act: Guardianship)*, the words "abnormally aggressive and seriously irresponsible" were raised.[95] The case concerned an application for a guardianship order under the Mental Health Act 1983 and the necessity to establish mental impairment. The court did not hold with the professional's view of the individual's behaviour as confirmation of incapacity even though F wishes to return to a very abusive and dysfunctional home. These varying standards have led to what Bartlett

[92] Eldergill A., "Mental Health Act 2001, An Outsider's Perspective," Paper presented at Law Society of Ireland Conference May 30th 2005.
[93] (1988) 86 Cr App R 159. The issue was the capacity of the person to consent to sexual intercourse.
[94] Bartlett & Sandland p45.
[95] [2001] 1 FLR 192.

refers to as examples of "ambiguities and uncertainties as to the role of medical professionals in the interpretation and administration of the Act."[96]

The decision of the US Supreme Court in *Addington v. Texas,* considering the proof requirement for loss of liberty and the stigma associated with such loss, held that the burden of proof falls somewhere between the civil standard and the criminal standard, which probably means clear and convincing evidence.[97] However, the vagueness throughout the criteria creates an opportunity for arbitrariness in application without the guidance in a code of practice as is the case under the Mental Health Act 1983. The definition of mental illness has been referred to as circular and based on paternalistic welfare philosophy.[98] The criteria are not defined in functional or behavioural terms and there is no requirement of incapacity as an essential threshold requirement for detention.

Finally, the criteria for detention in the 1945 Act, which are over inclusive, do not meet the requirements of Article 5(1)(e) and are not a proportionate response to the therapeutic aim of treating the mentally disordered person. Many of the provisions of the 1945 Act are not clear, foreseeable in their effect or precise. Their current application reveals a gap between law and practice, making the law even more difficult to predict and arbitrary in application. There are similar difficulties in the 2001 Act in relation to the vague criteria for mental disorder and these have been highlighted also in the Mental Health Act 1983. The interpretation of various words and phrases would seem to create ambiguity regarding the standard to be met and the level of proof required. It is essential that the proposed code of practice from the Mental Health Commission will provide some assistance to ensure some consistency on these points.

Procedure prescribed by law

A deprivation of liberty must be carried out "in accordance with a procedure prescribed by law," complying with the procedural and substantive rules of national law. Domestic

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[96] Bartlett p 46
[97] 441 US 418 (1978).
[98] O'Neill AM., *Irish Mental Health Law,* Firstlaw, Dublin, 2005, p104.

law must be of a particular standard involving clear and accessible rules that allow the state to remove an individual's liberty. Domestic law must, in addition, comply with the principles of law under the Convention.

The procedures leading to the detention of an individual must be clear and not arbitrary in their application. In *Winterwerp v. Netherlands,* the Court explained that that the notion underlying the terms "in accordance with a procedure prescribed by law" is one of "fair and proper procedure, namely that any measure depriving a person of his liberty should issue from and be executed by an appropriate authority and should not be arbitrary..."[99] In *HL v. United Kingdom,* the Court said that it must be established that the detention was in conformity with the essential objective of Article 5(1) of the Convention which is to prevent individuals being deprived of their liberty in an arbitrary fashion. This objective, and the broader condition that detention be "in accordance with a procedure prescribed by law", requires the existence in domestic law of adequate legal protections and "fair and proper procedures."[100]

The failure to hold a hearing prior to detention as required under Dutch national law was raised in *Van der Leer v. Netherlands* and held to be a breach of Article 5(1).[101] The legislation provided that the national court had power to dispense with the presence of the patient at the detention hearing only if it served no purpose or was contra-indicated for medical reasons. Otherwise, the person had to be heard. No opinion had been received from the applicant's psychiatrist objecting to such a hearing. The applicant's husband applied to have her committed and she was not present at the hearing and no reasons were given as required. The Commission found this was in breach of Article 5(1) as the detention was not in accordance with procedures prescribed by law. As a result, the applicant had not known of the decision concerning her detention because she did not have a hearing. The Dutch Government, in its defence, adopted a narrow approach and rejected the need to inform the applicant on the basis that this was not an arrest. The Court accepted the Commission's decision without comment and Warbrick refers to this

[99] *Winterwerp v Netherlands* (1979) 2 EHRR 387 para 45.
[100] *HL v. United Kingdom* (2005) 40 EHRR 32 5th October 2004 para 115.
[101] (1990) 12 EHRR 567.

as "a recognition of the importance of procedural protection when decisions are taken to interfere with an individual's liberty."[102]

Breach of a procedure under domestic law will automatically breach Article 5(1) as it fails to accord with a procedure prescribed by law. Compliance requirements were addressed in *HL v. United Kingdom.*[103] The Court referred to the "striking" contrast between the lack of any fixed procedural rules by which the admission and detention of compliant incapacitated persons is conducted, compared to the extensive network of safeguards applicable to psychiatric committals covered by the Mental Health Act 1983. In addition, there were no formalised admission procedures which indicate who can propose admission, for what reasons and on the basis of what kind of medical and other assessments and conclusions. The Court referred to the absence in *HL* of a requirement to fix the exact purpose of admission, assessment or treatment and, consistently, no limits in terms of time, treatment, or care, attached to the admission. The nomination of a representative of a patient who could make certain objections and applications on his or her behalf is a procedural protection accorded to those committed involuntarily under the 1983 Act and which would be of equal importance for patients who are legally incapacitated and have, as in this case, extremely limited communication abilities.

As a result of the lack of procedural regulation and limits, the Court observed that the hospital's health care professionals assumed full control of the liberty and treatment of a vulnerable incapacitated individual solely on the basis of their own clinical assessments completed as and when they considered fit.[104] While the Court did not question the good faith of those professionals or that they acted in what they considered to be the applicant's best interests, the very purpose of procedural safeguards is to protect individuals against any "misjudgments and professional lapses."[105] The Court held that the further element of

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[102] Warbrick, *European Convention of Human Rights Yearbook of European Law* (1990) Vol. 10, Oxford, pp538-348. Further examples of failure to follow procedures are found in the following cases: 27th Sept 1990 Series A. No. 185-A, *Application no.23807/94 28* (1999) 28 EHRR 509 and *Application no.* 58973/00, 24th March 2004. Similar issues arose in *DSE v. Netherlands App. No.23807/94* (1998) EHRLR 99.

[103] *HL v. United Kingdom* (2005) 40 EHRR 32 5th October 2004 para 120.

[104] *Ibid,* para 90.

[105] *Ibid,* para 121.

lawfulness, the aim of avoiding arbitrary deprivations of liberty on grounds of necessity, had not been satisfied.[106] Any procedure depriving a person of his liberty should issue from and be executed by an appropriate authority and should not be arbitrary.[107] This authority does not have to be a court and can be the hospital manager or the head of the psychiatric service and may vary from jurisdiction to jurisdiction.

In *Storck v. Germany,* a case involving detention in a private clinic, the Court, in deciding the question of whether a deprivation of liberty is imputable to the State, must look at the interpretation and application of Article 5(1), that it raised issues going to the merits of the case.[108] There were three aspects that could engage state responsibility for detention in a private clinic: the direct involvement of public authorities in the detention, where the courts in compensation proceedings fail to interpret the provisions of civil law in the spirit of Article 5 and where the state could have breached its positive obligation to protect the applicant against interferences with her liberty by private persons.[109]

In relation to the first point, the police, as part of the machinery of state authority, were involved towards the end of the applicant's placement and this was enough to engage State responsibility. Her detention, otherwise, would have ended then. In relation to the second point, the German Court of Appeal had taken a restrictive view of the moment at which time started to run for the purpose of limitation in a claim in tort, resulting in the applicant being time-barred. The Court compared this with the six month rule laid down in the Convention which requires that it is applied without excessive formalism, taking account of special circumstances, such as a mental state rendering a person incapable of making the complaint within the period prescribed and, which permits interruption of the limitation period. The difficulties of the applicant's situation during detention and afterwards were not considered by the German court and neither was her inability to access her medical records. The Court held that there was an interference imputable to the respondent State with the applicant's right to liberty as guaranteed by Article 5(1).

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[106] *Ibid*, para 124.
[107] *Winterwerp v. Netherlands* (1979) 2 EHRR 387 para 39.
[108] Application no. 61603/00 16th June 2005 para 89.
[109] Fennell P., " The Mental Capacity Act 2005, the Mental Health Act 1983 and the Common Law."(2005) *Journal of Mental Health Law* pp 163-168.

The State was held to have failed to meet its positive obligations to take measures providing effective protection of vulnerable persons, including reasonable steps to prevent a deprivation of liberty of which the authorities have or ought to have knowledge. The State could not "completely absolve itself of its responsibility by delegating its obligations to private bodies or individuals".[110] "Such institutions, in particular those where persons are held without a court order, need not only a licence, but also competent supervision on a regular basis of whether the confinement and medical treatment is justified."[111] This last statement of the Court has application to all residential centres where people are "held" and creates positive state obligations to safeguard their human rights.

Irish law and procedure prescribed by law

In order for a detention to be lawful, there are two requirements which Irish legal procedures must satisfy. The first requirement of lawfulness of detention depends on conformity with the procedural and substantive aspects of domestic law, as demonstrated in *Van der Leer*. The second requirement is that the relevant national law must meet the standard of "lawfulness" set by the Convention, which requires "that all law be sufficiently precise to allow the citizen - if need be, with appropriate advice - to foresee, to a degree that is reasonable in the circumstances, the consequences which a given action might entail."[112] This was outlined by the Court in the *HL* case. The detention must be in conformity with the essential objective of Article 5(1) of the Convention to prevent individuals being deprived of their liberty in an arbitrary fashion. This requires the existence in domestic law of adequate legal protections and "fair and proper procedures."[113] Irish courts have found that the failure to carry out any examination prior to making a recommendation for detention or where an examination for such recommendation for detention was based partly on a telephone conversation, did not

[110] *Ibid,* para 102, 103.
[111] *Ibid,* para 103.
[112] *HL v. United Kingdom* (2005) 40 EHRR 32) 5th October 2004 para 114.
[113] *Ibid*, para 115.

comply with national law.[114] The courts have held that using a recommendation for reception that is out of date in order to remove a person's liberty with a view to hospital detention is a breach of national law.[115] The failure to inform the patient that he is entitled to a second opinion prior to being taken to hospital was held to breach national law also.[116]

Mental Treatment Act 1945

[114] *Melly v. Moran & North Western Health Board,* Unreported Supreme Court, 28th May 1998, and *Kiernan v. Harris, Kiernan & Midland Health Board,* Unreported High Court, 12th May 1998.
[115] *Bailey v. Gallagher* [1996] ILRM 433.
[116] *Kiernan v. Harris, Kiernan & Midland Health Board,* Unreported High Court, 12th May 1998.

Many of the procedures leading to detention under the 1945 Act are vague, unforeseeable in their effect, imprecise and allocate wide discretionary powers. Starting with the applicants for a recommendation for detention, the range of applicants is over-inclusive, allowing anyone who is over 21, who has seen the person in the previous 14 days, and has a connection with the person to make an application under the "any other person" category.[117] This does not exclude spouses who are separated, or where there is serious marital disharmony, or relatives with whom there is conflict, as long as they come within the permitted degree of relationship.[118] The Act requires a statement of reasons as to why the application is being made by "any other person", not by the named categories, what the connection with the person is and the circumstances of the application.[119] Health service personnel, community welfare officers and gardai can make applications. Various other personnel in health boards, like senior administrative officers, have carried out this task. In *Gooden v. Waterford Regional Hospital,* the Supreme Court stated that "the community welfare officer was a perfectly proper person to make the application in the circumstances of the case."[120] A research study carried out on a cohort of cases between 1989-1991 found that relatives made 82% of the applications, followed by Gardai at 8% and others at 10%.[121]

However, in *Bailey v. Gallagher,* the High Court warned about the dangers of spouses in serious marital disharmony being involved as applicants and the risk of injustice arising in such circumstances.[122] The lack of forseeability for the patient with regard to the wide range of applicants may mean that this section is too broad and vague to meet the "fair and proper procedure" requirement. As far as domestic law is concerned, the Courts have used the shield of paternalism to affirm the procedures in the 1945 Act.[123] In *In re Philip Clarke,* involving a habeas corpus application challenging the lack of procedures,

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[117] Mental Health Act 2001, section 9.
[118] Mental Treatment Act 1945, sections 162(2)(3) and 184(4).
[119] *Ibid,* section 162(4).
[120] [2001] IESC 6 21st February, 2001 para 42.
[121] Carey & Owens, "Involuntary Admission to a district mental health service-implications for a new mental treatment act," *Irish Journal of Psychological Medicine* 10(3): 139-144.
[122] [1996] ILRM 433.
[123] *In re Philip Clarke* [1950] IR 235. See also Hardiman J. in *Gooden v Waterford Regional Hospital* [2001] IESC 6 21st February 2001.

specifically the lack of a judicial determination between the time of his arrest and his committal to hospital as being unconstitutional, the Supreme Court stated, [124]

> The impugned legislation is of 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. ... [Section 165] 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.[125]

This issue of medical assessment of the person prior to admission to hospital has been raised a number of times in proceedings before the courts.[126] The Act provides for the examination for detention of the Person of Unsound Mind (PUM) public patient as follows:

> **Section 163 (1)**
> **(a)** In cases where the medical practitioner to whom the application is made has visited and examined the person to whom the application relates within twenty four hours before the receipt of the application, either
> (i) if he is satisfied that it is proper to make the recommendation and is of opinion that the person to whom the application relates will, if received be a chargeable patient, he shall make the recommendation in the prescribed form, or
> (ii) in any other case he shall refuse the application.
> **(b)** In any other case,
> (i) The registered medical practitioner to whom the application is made, may, or if he is the authorised medical officer shall within twenty four hours after the receipt of the application, visit and examine the person to whom the application relates and
> (ii) after such examination either,
> 1 if he is satisfied that it is proper to make the recommendation and is of the opinion that the person to whom the application relates will, if received be a chargeable patient, he shall make the recommendation in the prescribed form, or
> 2 In any other case refuse the application.

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[124] [1950] IR 235.
[125] *Ibid,* p247.
[126] *O'Dowd v. NWHB,* [1983] 1 ILRM 186 *O'Reilly v. MWHB,* Unreported, Supreme Court, November 16, 1993. *Melly v. Moran & NWHB,* Unreported Supreme Court, May 28th, 1998.

It is clear that there are unsustainable differences in section 163(1)(b)(i). Where the registered medical practitioner "may" examine or where he is the authorised medical officer, he "shall" examine the person within 24 hours of receipt of the application.[127] There is no guidance in the first instance on what the options are for someone who "may"' examine within 24 hours. A further difference relates to private PUM patients who are detained on the order of two doctors following receipt of an application and prior to going to hospital.[128] This means that two inexperienced general practitioners, even those on locum or weekend work, are in a position to make a detention order which has no time limit. In reality, these orders are not used very often, but the point remains that they can be made and they do not have any safeguards, such as an expert hospital assessment. This raises the issue of asserting a true mental disorder on the basis of objective medical expertise and before a competent authority as required under the *Winterwerp* criteria. It is arguable that none of these requirements would be satisfied, as there is no guarantee of objective medical expertise of a true mental disorder if the doctors do not have any experience of psychiatry. In *Schurs v. The Netherlands,* the Court held that a recommending doctor can be a general practitioner rather than a psychiatrist. In my opinion, a locum general practitioner, unfamiliar with the patient or family, and with limited expertise in mental illness might well not meet the required "objective evidence of true mental disorder" standard in Article 5.[129] Second, the application and recommendation for detention are not presented to a competent authority as the same doctors make the detention order. These issues raise the possibility of discrimination under Article 14 read with Article 5 of the Convention where there is no objective or reasonable justification for the difference in treatment between public and private patients arising from the provisions. The decision in *Storck v. Germany* confirms that there is no diminution in the positive obligations on the state with regard to the detention of patients in private facilities.[130]

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[127] Many of these differences in title were eliminated by the Health Act 1970.
[128] Mental Treatment Act 1945, sections 177 & 178.
[129] 41 D & R 186. para 188-189.
[130] Application no 61603/00 16th June 2005.

The provisions for the detention of temporary patients are different and provide that the doctor examines the person not earlier than seven days before the date of the application and confirms whether the grounds for detention are satisfied.[131]

There is no definition of "examination" in the Act and practices have varied with the individual doctor and the circumstances of the case resulting in arbitrariness. In *O'Dowd v. North Western Health Board*, a PUM detention, the Supreme Court said that "when the doctor speaks of seeing a patient this is equivalent to saying that he examined him", and the Court accepted the examination of the doctor from a distance, for the purpose of making the PUM detention order, three hours after the patient had been sedated.[132] The statutory requirement is that a patient in this category should be examined "forthwith", but this did not influence the judgment. There were other legal requirements that were allegedly not complied with, including the failure to inform the patient he had the option of being voluntary. There were inconsistencies in the timing of the examination of the patient and the signing of the order. In a strongly dissenting judgment, Henchy J. referred to the formalities and obligatory aspects of the Act and, taken with constitutional rights, pointed to the similarity between the form for recommending detention in hospital and a warrant for arrest, where each part had to be strictly accurate.[133] Subsequently, in *O'Dowd v. Ireland,* the issue of emergency detention arose in the admissibility decision of the Commission, where the failure to carry out a medical examination prior to detention was the basis of the alleged illegality. The case was deemed inadmissible for non-exhaustion of domestic remedies, and the Commission re-affirmed the view held in *Winterwerp* on emergency detention, where a clear margin of appreciation with regard to fulfilling all procedures prior to detention is permitted.[134]

The nature of the examination required for a medical recommendation for admission was considered in *O'Reilly v. Moroney & Mid Western Health Board.* The Supreme Court ruled that the doctor's unseen and unknown observation of the patient from a distance of

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[131] Mental Treatment Act 1945, section 184(4).
[132] [1983] 1 ILRM 186 at p194. Mental Treatment Act, section 165(3).
[133] *Ibid,* pp 201-202.
[134] *O'Dowd v. Ireland* Application number 10296/83.

15 yards was sufficient to constitute an examination for a recommendation for admission.[135] The dissenting judgment of Blaney J. in the case, opining that the patient should have been examined physically and questions should have been put to her for the purpose of examining her mental and emotional state is worth noting. In addition, the principle of *audi alteram partem* required that the patient give her side of the story before any intervention took place.[136] Another case questioning the statutory medical examination arose in *Melly v. Moran & North Western Health Board,* where the Supreme Court held that telephone conversations were not adequate to form part of the examination for the purpose of certification under the 1945 Act and their inclusion for this purpose indicated a want of reasonable care.[137]

The failure to examine the plaintiff prior to signing the recommendation for admission certification arose in *Kiernan v. Harris, Kiernan & Midland Health Board,* in an application for leave to take civil action, and was held to constitute a want of reasonable care.[138] The Court granted leave on the examination ground and also on the failure to inform the patient that he was entitled to a second opinion prior to detention.[139] The requirement for a second opinion was not widely known until this case arose and was not generally used, partly because there is no particular space provided on the detention form for the second opinion.[140] The only accessible information on the second opinion is contained in small print at the end of the detention form. To this extent, this requirement is not only not foreseeable for patients, but crucially, is not either accessible of foreseeable for staff. An omission to meet the requirement in this procedure is serious enough to engage Article 5(1). The reliance on past medical examination was held not to meet Article 5 requirements in *Varbanov v. Bulgaria* in which the Court held that the assessment must be based on the actual state of mental health.[141]

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[135] Unreported Supreme Court, November 16, 1993. Subsequently, *O'Reilly v. Ireland* Application no. 24196/94 was the subject of a friendly settlement.
[136] *Ibid,* pp 17-20.
[137] Unreported, Supreme Court, May 28th, 1998.
[138] Unreported, High Court, May 12th 1998. The allegation that the patient had not been examined by the doctor for 15 years was not refuted.
[139] Mental Treatment (Amendment) Act 1953, section 5(3)(a)(i).
[140] Mental Treatment Act 1953, Section 5(3)(a)(i).
[141] [2000] MHLR 263 para 47.

The right to a second opinion was addressed by the Supreme Court in *Gooden v. Waterford Regional Hospital,* where McGuinness J. stated that "the right to request a second opinion and the necessity to be informed of such a right are extremely important protections in the case of a person who is facing involuntary detention in a mental hospital."[142] The Supreme Court referred to this second opinion which applies in particular circumstance when the patient is to be "conveyed" to hospital and not to all patients. The Supreme Court, referred to this as one of a number of "differences or discriminations" and "undesirable features" in the Act between public patients and those who can afford to pay for their own care and stated that,

> the crucial protection of a right to an independent second opinion does not extend to all "*chargeable*" or public patients, while two opinions are automatically required for all private patients. This is one of a number of invidious differences between the treatment of public patients which arise under the Act. Again this situation is far from satisfactory.[143]

The Supreme Court illustrated further weaknesses in the current legislation where voluntary patients wanted to leave hospital, yet were unfit to do so, but there was no express provision in the Act to deal with this event. The Court commented that this is not an infrequent occurrence. In fact, the number of voluntary patients whose status is changed is recorded at 455 for 2003.[144] This situation resulted in the Supreme Court having to imply the provision from the interpretation of the particular section along with another section in order to avoid an absurd conclusion on a literal interpretation, all of which was unsatisfactory.[145] The reaction of the Supreme Court confirms the lack of precision and forseeability of the current legislation in relation to "procedures prescribed by law" and that some of these provisions are not being complied with.

The Supreme Court in *Gooden* raised two important issues: the first is the difference in treatment between categories of public patients, and the second is the difference between

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[142] *Gooden v. Waterford Regional Hospital* [2001] IESC 6 21st February 2001 para 45.
[143] *Ibid,* paras 45 and 54.
[144] Department of Health and Children, *Report of the Inspector of Mental Hospitals for Year ending 2003,* Dublin, 2004, Appendix 1.
[145] *Ibid,* para 53.

public and private patients.[146] The second opinion procedure applies only to one category of public patient-those who are "conveyed" to hospital. The Court also referred to the right of all private patients who are being detained to a second independent examination for the recommendation for admission.[147] These were referred to as one of a number of "unnecessary and invidious differences between the treatment of public and private patients under the Act."[148] Such differences in treatment may be serious enough to engage Article 14 in conjunction with Article 5, unless there is an objective and reasonable justification for the differences. The law should be sufficiently precise and accessible to enable the person to foresee the consequences of these restrictions.[149] The prescribed legal procedures in relation to the examination of the patient and also the second opinion procedure were not complied with and such detentions would be illegal under both national law and Article 5(1).

Another provision that raises issues of precision and foreseeabilty is the 12 hour holding power under the temporary detention procedure pending the making an order. The 1945 Act does not state whether treatment can be imposed during this time or if the provision is for assessment and observation.[150] The common law would apply to treatment that was necessary during this period.

The Gardai are permitted to transport a patient to hospital on foot of a PUM public order only.[151] The reported figures for such involvement are not accurate and do not reflect the frequency of such orders. Anecdotal evidence suggests that a temporary order is also filled in by the recommending doctor and, on arrival at the hospital, the PUM order is dispensed with and not used to establish the patient's status. This fact was evident in *Bailey v. Gallagher* where the plaintiff had been removed by the Gardai to a Garda station on foot of a temporary order, despite the requirements of the 1945 Act, but the

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[146] *Gooden v.. Waterford Regional Hospital* [2001] IESC 6 21st February 2001 para 54. Mental Treatment Act 1945 as amended by the Mental Treatment Act 1953, section 5(3)(a)(i).
[147] *Ibid,* sections 178(1) and 185(4).
[148] *Gooden v. Waterford Regional Hospital* [2001] IESC 6 21st February 2001 para 54.
[149] *Sunday Times v. United Kingdom* (1979) 2 EHRR 245.
[150] Mental Treatment Act 1953, section 5(1)(b)(i).
[151] Mental Treatment Act 1945, section 165(1).

Court did not address the issue.[152] This failure to comply with the provisions of the 1945 Act is in breach of national law and of the Convention.

Mental Health Act 2001

The 2001 Act provides statutory principles that will apply to all actions carried out regarding admission, care and treatment and should inform the manner in which those involved carry out procedures under this Act. These principles apply to all patients, voluntary patients as well as detained patients and children.

> **Section 4**
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> (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.
>
> (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.
>
> (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.

One issue that may need to be clarified is whether it is possible to have the best interests of the person as the principal consideration, while at the same time having due regard to the interests of others, on the basis that there can only be one principal consideration. The notification requirement in the second paragraph will be adhered to as far as is practicable. It is not clear what the boundaries are with practicability and whether a wide margin of discretion will apply to the authorities in this regard.

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[152] *Bailey v. Gallagher* [1996] ILRLM 433.

Along with the principles, there will be tighter procedures regarding admission orders and certain categories of applicants will be excluded from the detention procedure. The list of applicants for examination for detention includes relatives and spouses as well as an authorised officer and the Gardai. The broad "any other person" category of applicant is also replicated in this Act.[153] A spouse is defined in the Act as a "husband or wife or a man or a woman who is cohabiting with a person of the opposite sex for a continuous period of not less than three years but is not married to that person."[154] The "spouse" category excludes those who are separated or where applications have been made under domestic violence legislation. It is arguable that the exclusions are too narrow and should also have excluded persons who have committed crimes against the prospective patient. These exclusions will also mean that staff in approved centres will be prevented from making applications.[155]

The role of the proposed authorised officer as an applicant is not clear and such position will permit a large measure of discretion throughout the country.[156] This is less than satisfactory when compared with the role of the approved social worker (ASW) in other jurisdictions, including the English Mental Health Act 1983. An ASW is recognised as a professional applicant providing a balance in the medical assessment through the recognition of the importance of social factors in detention.[157] The number of applications by an ASW, instead of family, in Northern Ireland has risen to 70% of applications compared with 30% by relatives in 2002.[158] It was hoped that this aspect of the detention procedure would be followed in the 2001 Act. Rather, a limited approach to the professional applicant has been adopted and this authorised officer will be of "a prescribed rank or grade" and selected within each health board.[159] The result is that the

[153] Mental Health Act 2001 section 2(1). There are various exclusions in the Act where a relative or doctor has a connection with the centre to which the person is being committed. The patient's 'relative' is defined in the 2001 Act as "a parent, grandparent, brother, sister, uncle, niece, nephew or child of the person or of the spouse of the person, whether of the whole blood, of the half blood, or by affinity."
[154] Mental Health Act 2001, section 2(1).
[155] *Ibid,* section 9(2)(c).
[156] *Ibid,* section 9(8).
[157] Mental Health (Northern Ireland) Order 1986 and the Mental Health Act 1983.
[158] Mental Health Commission Northern Ireland *Annual Report for 2002,* Belfast, 2002.
[159] Mental Health Act 2001, section 9(8). The Act refers to a person "of a prescribed rank or grade who is authorised by the CEO to exercise powers under the Act.

social context of mental health is regarded as irrelevant and merits no recognition in Irish law. It would benefit families and carers if the role of the applicant for detention could be assigned to someone outside the family to relieve such a burden on relationships. These are factors that are outside the remit of Article 5(1), but are important at national level and have been taken up for consideration by the Mental Health Commission.[160]

The examination requirement in the 2001 Act places a greater onus on the doctor to provide objective medical evidence of mental disorder and comply with the *Winterwerp* principles. The requirements are specific and the Act provides that

> "examination" in relation to a recommendation, an admission order, or a renewal order, means a personal examination carried out by a registered medical practitioner or a consultant psychiatrist of the process and content of thought, the mood and the behaviour of the person concerned.[161]

The 2001 Act requires that the person must be informed of the purpose of the examination, unless this would be damaging to his mental or emotional health.[162] Some concerns have been raised that such therapeutic privilege could be misused and that the section requires tighter control such as "serious" damage to the person's health.[163] Unlike the 1945 Act, there is no option for the patient to require a second opinion prior to hospitalisation. The provision of a right of response in the principles section is a factor that will have to be considered before any action is taken. Failure to comply with the principles may involve a breach of Article 5(1) unless there was justification, such as an emergency. The examination must be carried out within 24 hours of the receipt of the application. A copy of the recommendation must be given to the clinical director and to the patient.[164] The 24 hour holding power, which can be used as a form of assessment and also to prevent voluntary patients from leaving, does not elaborate on whether the patient can be forcibly treated during this period, although the common law would provide a

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[160] Mental Health Commission, *Discussion Paper on the Authorised Officer,* Dublin, 2005.
[161] Mental Health Act 2001, section 2(1).
[162] *Ibid*, section 10(2).
[163] *Op. cit.*, 90 p131.
[164] *Ibid,* section 10(4).

defence.[165] The provisions applying to a voluntary patient in these circumstances are different from an admission from the community in that there is no applicant or recommendation for detention. Instead, a second opinion in the hospital recommends admission.[166] It is arguable that the difference in treatment between these two categories of patient may be justified by the presence in the hospital of the voluntary patient, although the *Winterwerp* requirements will have to be satisfied.

Article 5(2) Introduction

The right to information giving the factual and legal basis of a detention arises under Article 5(2).[167] The information is intended to facilitate a challenge to the legality of detention and avail of the right guaranteed by Article 5(4). Article 5(2) contains an "elementary safeguard" that a person arrested should know the reasons for the arrest and the charges against him.[168] The word "arrest" includes all kinds of deprivation of liberty. It extends beyond the initial detention to where someone is recalled after his release.[169] The individual is entitled to be told in a language he can understand, "simple non-technical language", of the reasons for the arrest in order to be able to challenge the lawfulness of the detention as permitted under Article 5(4). The Court has stated,

> This provision is an integral part of the scheme of protection afforded by Article 5; by virtue of paragraph 2 any person arrested must be told, in simple, non-technical language that he can understand the essential legal and factual grounds for his arrest, so as to be able if he sees fit, to apply to a court to challenge its lawfulness in accordance with Para 4.[170]

Promptly

The information has to be given "promptly" and it does not have to be given entirely at the very moment of detention. A stricter requirement with regard to detail will apply to

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[165] Mental Health Act 2001, section 23(1).
[166] *Ibid,* section 24(1)(2).
[167] *Van der Leer v. Netherlands* (1990) 12 EHRR 567.
[168] *Fox, Campbell and Hartley v. United Kingdom* (1991) 13 EHRR 157.
[169] *X v. United Kingdom* (1982) 14 EHRR 188 para 66.
[170] *Kerr v. United Kingdom* Application no. 40451/98 7th December 1999.

information given afterwards. The applicant in *Van der Leer v. Netherlands* was a voluntary patient and had no official communication regarding a decision to have her detained.[171] She challenged the actions of the Dutch authorities in their failure to provide her with information concerning her detention. The Government conceded that she should have been informed promptly, but disputed that this obligation arose under Article 5(2) because of the reference to "arrest" and "charge" which they believed was relevant only to criminal law and not to psychiatric detention. The Commission held that these words should be interpreted autonomously in accordance with the aim of the overall Article 5, which is to protect everyone from arbitrary deprivation of liberty. The Court held that,

> The close link between Articles 5(2) and 5(4) supports such an interpretation and ... any person who is entitled to take proceedings to have the lawfulness of his detention decided speedily cannot make effective use of that right unless he is promptly and adequately informed of the reasons why he has been deprived of his liberty.[172]

The Court held that it was all the more important to bring the measures in question to the applicant's attention since she was already in hospital prior to the decision and it did not change her situation in factual terms. While the actual time lapse is a matter for each case, a delay of ten days in *Van der Leer* was held to breach Article 5(2). Whether the content and promptness of the information conveyed is sufficient will be assessed in each case according to the circumstances. Article 5(2) requirements overlap with those in Article 5(4), which also requires that a person be told "promptly" of the reasons for his detention.

The requirement to inform applies not only at the initial detention stage, but at later points also. The obligation on the authorities to inform a restricted patient of the reasons for recall to hospital arose in *X v. United Kingdom.*[173] The Commission found there was a violation of Article 5(2) by the failure to inform the person of the reasons for the recall.

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[171] (1990) 12 EHRR 567.
[172] (1990) 12 EHRR 567 para 28.

Following this decision, the English government introduced new information procedures for this group of patients.

Intelligible information

The person must know why they are being detained and the information must be detailed enough to show which category of detention applies. The information must be in a language the person understands and this may involve simplifying, translating or signing, in order to communicate the relevant information. Consideration must be given to the capacity of the individual to absorb and understand the information and often, at the point of entry to psychiatric care, this may not be possible. In these circumstances, it must be given to a legal representative or another person expected to act as proxy on the patient's behalf.[174] Recommendation 2004 (10) provides that the person should be informed regularly and appropriately of the reasons for the decision and the criteria for its potential extension or termination.[175] Information should also be given to the personal representative. The state is given a margin of appreciation in that the reasons for the detention do not have to be given in a particular format, such as in writing, as long as the essential facts are given.[176]

Irish law and Article 5(2)

Irish law and provision of prompt information

There is no right to information under the Mental Treatment Act 1945 regarding the initial decision to detain as required under Article 5(2). The only mandatory right to information relates to the extension of a detention order when the patient and the applicant must be informed that they have a right to send an objection to the Minister for

[173] (1982) 4 EHRR 188.
[174] *X v. United Kingdom* B 41 (1980) Commission Report para 111.
[175] *Op. cit.*, 65 Article 22.
[176] *X v. Netherlands* (Application no. 2621/65), (1966) 9YB 474 at p 480.

Health, the Inspector of Mental Hospitals and the President of the High Court.[177] While there are some limited statutory rights provided under the 1945 Act, such as the right to forward an unopened letter, there is no obligation to inform the person of these rights and notices regarding the information are at the discretion of the Minister for Health and Children.[178] The lack of information about the limited safeguards in the 1945 Act, or even the habeas corpus provision under the Constitution, would seem to breach Article 5(2).

The 2001 Act places significant emphasis on the provision of information. The principles in the Act provide a right to be notified of proposals about the admission and treatment under the Act where practicable.[179] This does not include the reasons for the detention which is a much more substantive piece of information that must be given as established in *Van der Leer v. Netherlands*.[180] The purpose of an examination for an admission or a renewal order must be disclosed to the person unless it might damage his mental health.[181] In addition, information must be given to the patient within 24 hours of an admission or a renewal order being made.[182] The 24 hour time limit will satisfy the "prompt" requirement. The patient must be told whether the detention is under an admission or a renewal order; that he is entitled to legal representation, to a general description of the proposed treatment, to contact the Inspector of Mental Health Services; and to have the detention reviewed with a right of appeal to the Circuit Court against the tribunal decision. The person must also be told he can choose to be a voluntary patient.[183]

The information provided in the 2001 Act at this point is not required to be in an accessible format, only that it be in writing. This raises concerns about compliance with Article 5(2) where there are literacy, language, or other difficulties. In contrast, adequate treatment information for consent must be given to the patient in a form and language the patient understands on the nature, purpose and likely effects of the treatment. The Act

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[177] Mental Treatment Act 1945, section 189 as amended by Mental Treatment (Amendment) Act 1961, section 18.
[178] *Ibid*, section 267.
[179] Mental Health Act 2001, section 4(2).
[180] (1990) 12 EHRR 567.
[181] *Ibid*, section 10(2).
[182] *Ibid*, section 16(2)(a)-(g).
[183] *Ibid*, section 16(2)(g).

requires that specific measures are taken to ensure information about such rights is communicated to patients as a condition of registration of the mental health centre.[184]

The essence of the right to information will be protected, provided the purpose of Article 5(2) is ensured, that the factual and legal basis of the detention be communicated to the patient in order to be able to challenge the detention under Article 5(4). It remains to be seen if the proposed code of practice provides that this must be in a form the patient or a representative understands and whether it will include access to advocacy for patients without capacity. The real challenge is to ensure that the provision of information is not a paper exercise and is actually transmitted to the person and continues throughout all the mental health services, not just inpatient services.

Conclusion

The chapter considered Articles 5(1) and 5(2) and the compliance of Irish law with these provisions. Four major areas were addressed under Article 5(1): the deprivation of liberty, the criteria for detention, the procedures prescribed by law and the right to information.

The provisions under the 1945 Act requiring the detention or discharge of incapable voluntary patients are not being complied with, thereby breaching both national and Convention law. Many of these patients may be under the control of the hospital to such an extent that they are actually deprived of their liberty, but without any safeguards, similar to the situation in *HL v. United Kingdom* and *Storck v. Germany.*[185] The limited approach to the issue of voluntariness in the 2001 Act may mean that the position of such patients will be no better because there are no safeguards expressly provided in the Act. Where such admissions satisfy the requirement of deprivation of liberty, proper procedures must be in place to avoid a breach of Article 5.

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[184] *Ibid,* section 64(6)(b)(vii).
[185] (2005) 40 EHRR 32 5th October 2004, Application no.61603/00 16th June 2005.

The criteria for detention in the 1945 Act are over-inclusive, do not meet the requirements of Article 5(1)(e) and are not a proportionate response to the mentally disordered person. Nor are the criteria provisions clear or precise. The application of these provisions reveals a gap between law and practice, rendering the law even more difficult to predict. Social considerations can lead to detention without any requirement of objective evidence of a true mental disorder in breach of Article 5(1)(e).[186] Many terms used in the Act, like "unfitness on account of mental state" for voluntary admission, are not based on any criteria and are open to broad interpretation. The definition of addict is far too broad, permitting detention on grounds that do not require evidence of a true mental disorder allowing the possibility of preventive detention, which would also breach Article 5 requirements. The difference between a detained patient and a voluntary patient is much more to do with compliance than severity of illness or mental state.

Under the 2001 Act, the right of response in the principles section is a factor that will have to be considered before an admission order is made or treatment imposed and guidance will be needed on the meaning of limiting words like "as far as is reasonably practicable", as well as the meaning of "such representations" from the patients. Failure to comply with the principles may involve a breach of Article 5(1) unless there is justification, such as an emergency. The 2001 Act meets the first two requirements in *Winterwerp* and complies with Article 5(1)(e). However, there may be difficulties with the interpretation of some of the provisions which, for example, refer to "harm" and "appropriate treatment" and their reliability as factors leading to detention. The "benefit" requirement needs further clarification and seems to be related to detention in an appropriate environment and the receipt of appropriate treatment, which is not always possible.

[186] *Ibid*, section 166(2).

Many of the procedures leading to detention under the 1945 Act have wide discretionary powers and are vague, unforeseeable in their effect and imprecise.[187] The Supreme Court has had to imply provisions into the 1945 Act in order to deal with statutory deficiencies.[188] The Supreme Court has referred to "differences and discriminations" in the Act and affirms the real possibility of discrimination under Article 14 by the application of different procedural safeguards to patients in similar circumstances and to public and private patients.[189] The provision whereby the detention of a private PUM patient under the 1945 Act requires two opinions prior to hospital admission appears to give greater respect to the admission of such patients compared with the requirement of one opinion for a temporary admission and contrasts with the position of the public PUM patient. In this instance, the recommendation is made by the medical practitioner and the order is subsequently made at the hospital by a psychiatrist. This difference was based on the belief that private patients needed extra safeguards for their wealth and against improper motives for the detention. Secondly, the different treatment meted out to similar patients under the 1945 Act arises in connection with temporary patients and the situations in which a right to a second opinion arises. Where the patient is to be conveyed to hospital along with the application form then he is entitled to a second opinion. However, where the admission form is taken to the hospital in advance of the patient in order to have the order made, as provided for in the Act, then there is no right to a second opinion.[190] This omission applies also where the patient is already a voluntary patient in hospital and is to be detained under a temporary order.

The procedures for Garda involvement in transporting patients to hospital indicate creative use of the law in the absence of clear procedures and may well breach both national law and the Convention. The proposal in the 2001 Act to have an authorised officer has been diluted to permit a potentially broad range of applicants throughout the country. This matter may be dealt with by the Mental Health Commission. The 2001 Act

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[187] The lack of a definition of examination has resulted in a number of court challenges. *Melly v. Moran & NWHB,* Unreported Supreme Court, May 28th , 1998, *Kiernan v. Kiernan, Harris & MWHB,* Unreported High Court, May 12th, 1998, *Bailey v Gallagher* [1996] ILRM 433.

[188] *Gooden v. Waterford Regional Hospital* [2001] IESC 6 21st February 2001.

[189] *Ibid.*

[190] Mental Treatment Act 1945, section 5(3)(a)(i).See pp59-60 for further discussion.

does not differentiate between public and private detention. There is a clear requirement in regard to the examination of the patient that should eliminate some of the difficulties under the 1945 Act. The procedures for the detention of voluntary patients are still vague with regard to the holding power.

The failure in the 1945 Act to provide information to the patient is in breach of Article 5(2), even if the right to challenge detention is limited to habeas corpus or judicial review. The 2001 Act emphasises the right to information in a number of sections and will largely comply with Article 5(2). There is one exception and it is the failure to require that the actual reasons for the detention be given to the patient, as required under Article 5(2).

Chapter 2

ARTICLE 5(4) AND THE RIGHT TO REVIEW OF DETENTION UNDER IRISH LAW

Introduction

This chapter considers the right to review of detention in Irish law against the background of Article 5(4) of the Convention and examines both the 1945 Act and the 2001 Act to see if they meet the required standard. The limited administrative provision for review of detention in the 1945 Act necessitates using habeas corpus and judicial review as the only means available to patients for an independent review of detention. Both habeas corpus and judicial review are not regarded as adequate or appropriate means of reviewing initial and continuing detention under the Convention. An empirical study on the use of habeas corpus by people in mental health detention was carried out as part of this examination and is included in the chapter. The 2001 Act provides a right to review of detention by introducing mental health tribunals and these will be assessed for conformity with the right to a fair hearing and a speedy review under Article 5(4).

Article 5(4) provides,

> Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful

Article 5(4) originated in the writ of habeas corpus and applies to each of the exceptions to the right to liberty listed in Article 5(1).[1] This includes Article 5(1)(e), the detention of persons of unsound mind. The rights contained in the Article include a right to speedy and regular review of detention and to be represented and heard before a court.[2] The opportunity for legal review must be provided soon after the person is taken into detention and at reasonable intervals where necessary. Article

[1] Harris, O'Boyle & Warbrick, *Law of the European Convention on Human Rights*, Butterworths, London, 1995 p145.
[2] *X v. United Kingdom* (1992) 14 EHRR 188 para 52.

5(4) is not satisfied by an administrative procedure based on unchallenged medical evidence. It can only be satisfied by a properly conducted judicial procedure adapted to dealing with psychiatric detention. This involves periodic review to see if the original grounds for detention still exist because the original decision to detain, even if carried out by a court, is not enough.[3] There is a requirement to have certain procedural safeguards in place, such as a fair hearing, as well as representation before the court. The existence of mental disorder must be proven in a fair and objective manner based on the criteria set out in *Winterwerp v. Netherlands.*[4] This "due process guarantee" has had admissibility success even though the subsequent proceedings might take a long period of time to reach a conclusion before the Court.[5]

Article 5 (4) covers all forms of arrest and detention and is closely related to Article 5(1) as it permits the person to challenge whether his detention is consistent with domestic law and the Convention and is not arbitrary.[6] In relation to psychiatric detention, the Court would examine the detention in accordance with the criteria laid down in *Winterwerp.* In *E v. Norway,* the limitations on the scope of Article 5(4) were described by the Court,

> Article 5(4) does not guarantee a right to judicial review of such a scope as to empower the court on all aspects of the case, including questions of pure expediency, to substitute its own discretion for that of the decision-making authority. The review should be wide enough to bear on those conditions which are essential for the lawful detention of a person according to Article 5(1).[7]

Article 5(4) does not guarantee a right to judicial control of the legality of all aspects or details of the detention. In *Ashingdane v. United Kingdom,* the applicant complained to the Commission about his inability to challenge the lawfulness of the refusal to transfer him to a less secure setting.[8] The claim that the applicant was prevented by operation of the Mental Health Act 1959 from pursuing a case before the

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[3] *Winterwerp v. Netherlands* (1979) 2 EHRR 387 para 55.
[4] (1979) 2EHRR 387.
[5] Harding "The Application of the European Convention of Human Rights to the Field of Psychiatry", (1989) 12 *Int.J.L.& Psych.* p247.
[6] *Van Droogenbroeck v. Belguim* (1982) 4 EHRR 443.
[7] *E v. Norway* (1990) 17 EHRR 30 para 50.
[8] (1985) 7 EHRR 528.

national courts did not fall within the scope of the judicial determination of "lawfulness" which Article 5(4) guarantees.[9]

Initial and regular review proceedings

The right to review of continuing detention following an initial order by a court was not considered necessary in the early case, *De Wilde Ooms and Versyp,*

> Where the decision depriving a person of his liberty is one taken by an administrative body,... Article 5(4) obliges the Contracting States to make available to the person detained a right of recourse to a court; but there is nothing to indicate that the same applies when the decision is made by a court at the close of judicial proceedings. In the latter case the supervision required by Article 5(4) is incorporated in the decision.[10]

In *Winterwerp,* this approach was not followed and the decision of the Commission held that the earlier conclusion by the Court was unsustainable in the case of detention of a person on the ground of "unsound mind" when it is for an indefinite period, stating,

> This is on the basis that the reasons initially warranting confinement of this kind may cease to exist ... Consequently, it would be contrary to the object and purpose of Article 5 ... to interpret paragraph 4 read in its context, as making this category of confinement immune from subsequent review of lawfulness merely provided that the initial decision issued from a court. Such deprivation of liberty required a review of lawfulness to be available at reasonable intervals.[11]

The first question to be addressed is whether the purpose and scope of the *Winterwerp* requirements one and two are still met in the initial and regular review of detention. In *X v. United Kingdom,* involving a recall to hospital, the applicant complained that habeas corpus would not provide a full investigation of the merits of the decision to detain him and would be limited to a procedural examination as to whether the recall complied with the Mental Health Act 1959.[12] The applicant in *X* believed Article 5(4)

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[9] Mental Health Act 1983, section 141.
[10] *De Wilde, Ooms & Versyp v. Belguim* (1980) 1 EHRR 373 para 76.
[11] *Winterwerp v. Netherlands* (1979) 2 EHRR 387 para 55.
[12] (1981) 4 EHRR 188. The case was taken by the Mind organisation.

had been violated as he had not been able to have the lawfulness of his detention decided speedily by a court and there was no system of review open to him.

Article 5(4) requires an oral hearing and the scope of the hearing should be wide enough to bear on those conditions which according to the Convention are essential for lawful detention and in the case of psychiatric detention this involves reviewing whether the condition that led to the initial detention is still present.[13] If not, there must be a power of release. The review is not limited to considering the merit or reasonableness of the initial decision to detain, but is more substantive.[14] The review body must establish whether the reasons which initially justified the detention continue to apply. In order for the hearing to be fair, there must be a guarantee of impartiality in the conduct, organisation and composition of the court or tribunal. Impartiality is an important feature of the court that must be determined by a subjective test, that is on the basis of the personal conviction of a particular judge in a given case, and also by an objective test, that is ascertaining whether the judge offered guarantees sufficient to exclude any legitimate doubt in this respect.[15]

The absolute minimum for judicial procedure for the detention of a person of unsound mind is the right of the individual concerned to present his own case and to challenge the medical and social evidence adduced in support of his detention.[16] Otherwise, he is deprived of the fundamental guarantees in matters of deprivation of liberty,

> Mental illness may entail restrictions or modifying the manner of exercise of such a right ... but it cannot justify impairing the very essence of the right. Indeed, special procedural safeguards may prove called for in order to protect the interests of persons who, on account of their mental disabilities, are not fully capable of acting for themselves.[17]

In *X*, the court did not allow a determination of the merits of the question as to whether the mental disorder persisted. Article 5(4) required an appropriate procedure allowing a court to examine whether the patient's disorder still persisted and whether

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[13] *X v. United Kingdom* 4 EHRR 188 para 57-58, *Ashingdane* v. *United Kingdom* (1984) 6 EHRR 69 para 52, *E. v. Norway*(1990) 17 EHRR 30 para 50, and *Hutchison Reid v. United Kingdom* Application no. 50272/99 20th May 2003 para. 64.
[14] *X v. United Kingdom* (1982) 4 EHRR 188 para 53.
[15] *DN* v. Switzerland (2003) 37 EHRR 21 para 44.
[16] *Winterwerp v. Netherlands* (1979) 2 EHRR 387 para 58.
[17] *Ibid,* para 60. The 2001 Act provides for legal representation before review bodies.

the Home Secretary was entitled to think that a continuation of the compulsory confinement was necessary in the interests of public safety.[18] The Court held that the habeas corpus proceedings brought by *X* did not meet the guarantees in Article 5(4) and the procedures in place were not independent, whether judicial or administrative. The tribunal did not have the power to order his release as required; that was the remit of the Home Secretary.[19]

Judicial review and habeas corpus are not adequate remedies to test the legality of the detention since they go to the lawfulness in a less substantive sense than is required by the Convention.[20] They have been held not to provide a sufficient remedy as they are commonly used to challenge procedural irregularity, not medical evidence. Habeas corpus does not empower the review body to test the substantive lawfulness of detention. The review should be sufficiently broad to deal with the essential requirements for detention on the grounds of unsound mind, as the original reasons for detention may no longer exist. The Court stated that it was not within its jurisdiction to decide on the best, or most appropriate, system of judicial review in this sphere. It was for the contracting states to choose different methods of performing their obligations.

The Court did not dismiss the utility of habeas corpus entirely and said that it can be an effective check against arbitrariness for emergency measures for the detention of persons on the ground of unsoundness of mind. Provided the measures are of short duration, they are capable of being "lawful" under Article 5(1)(e) even though they are not attended by the usual guarantees such as thorough medical examination. The Court allowed a wide margin of discretion in emergency detentions and court involvement is correspondingly reduced. In non-emergency circumstances, the limitations on the nature of the review in habeas corpus are not sufficient for circumstances like the *X* case.

The review of *X's* detention by way of habeas corpus passed the first test, because the High Court had the power to order discharge, but failed the second test, because

[18] *Ibid,* Para 58.
[19] *Ibid,* para 59.
[20] Fennell P., "Doctor Knows Best Therapeutic Detention under Common Law, The Mental Health Act and the European Convention", (1998) 7 *Med. L. Rev.* p 349.

habeas corpus did not consider the substantive merits of the detention, only its formal legality. The United Kingdom government accepted the consequences of this judgment and altered English, Welsh and Northern Irish mental health legislation to confer on the tribunal a power to discharge restricted patients in the position of *X*.

Specific tribunals have been set up to carry out this task under legislation in England, Wales and Northern Ireland and a similar system will be introduced in Ireland.[21] The review system must be able to carry out a substantive review of the detention and not solely whether the legalities have been complied with. Accordingly, this is why judicial review and habeas corpus are not equal to this task. The Tribunal must have power to order release if the detention is unlawful and the decision must be made speedily.[22]

In *Winterwerp v. Netherlands*, the Principle Delegate of the Commission, in his submissions, pointed out "the unreality of expecting a mentally ill person to take the initiative in commencing proceedings."[23] Subsequently, the Court stated that it should not be left to the individual patient to initiate a review of the detention and this point was later affirmed in *Meygeri v. Germany.*[24] The mere possibility of a safeguard was not enough. There had to be certainty that the proceedings would be applied in each case. In *Herczgefalvy v. Austria,* the Court stated "... 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."[25] There is, therefore, an onus on the state to ensure access to review proceedings to rule out arbitrariness.

Similar statements have been made in *HL v. United Kingdom* in relation to judicial review largely to the effect that it does not provide the depth of review that is

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[21] Mental Health Act 1983, Mental Health (NI) Order 1986, Mental Health Act 2001, sections 17, 18, 48 & 49.
[22] *X v. United Kingdom* (1982) 4 EHRR 188 para 64, para 138.
[23] *Winterwerp v. Netherlands* (1979) 2 EHRR 387. Muchlinski, "Mental Health Patients Rights and the European Human Rights Convention," (1987) 5 *Human Rights Review* p99.
[24] (1992) 15 EHRR 584.
[25] *Herczgefalvy v. Austria* (1993) 15 EHRR 437 para 82.

necessary for mental health detention.[26] Even with the application of the "super-Wednesbury" principles on judicial review,

> ...the bar of unreasonableness would at the time of the applicant's domestic proceedings have been placed so high as effectively to exclude any adequate examination of the merits of the clinical views as to the persistence of mental illness justifying detention...

The Court referred to the English decision involving the Human Rights Act 1998 in *R (Wilkinson) v. Broadmoor Hospital*, which affirmed these views in a case where the necessity for medical treatment against the wishes of the patient was contested by the patient.[27] The English court held that pre-incorporation judicial review of necessity in accordance with "the super-Wednesbury" criteria was not sufficiently intrusive to constitute an adequate examination of the merits of the relevant medical decisions.[28] The intensity of the review is greater under the proportionality approach and Lord Stein in *R v. Secretary for the Home Department, ex p. Daly* stated that this may necessitate the assessment by the court of the balance which the decision maker has struck, not just that it is a reasonable decision. In addition, it may require an examination of "the relative weight accorded to interests and considerations."[29] He stated that the heightened scrutiny or "super Wednesbury" test may not be appropriate to the protection of human rights.

Habeas corpus and Irish law

Habeas corpus is a safeguard for the right to liberty to challenge the legality of detention and the Constitution is now the most frequent legal basis for such applications.[30] Article 40.4.2 of the Constitution provides,

> Upon complaint being made by or on behalf of a person before the High Court or any judge thereof alleging that such person is being unlawfully detained, the High Court or any 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 or such person before the

[26] (2005) 40 EHRR 32 5th October 2004.
[27] [2000] EWCA Civ 1545.
[28] *Ibid,* para 139.
[29] [2001] 2 AC 532 (HL) at 547.
[30] Article 6 of the 1922 Constitution, Article 40.4.2 of the 1937 Constitution.

> 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.

Given the absence under the 1945 Act of opportunities for review of the lawfulness of detention by a tribunal, habeas corpus occupies a position of fundamental importance. The Irish Government has relied on the availability of habeas corpus to discharge its responsibilities under Article 5(4) to provide speedy review of the lawfulness of detention.[31] There is no legislative provision for review of detention by a mental health review tribunal under the 1945 Act and until the 2001 Act is fully in force, habeas corpus will continue to provide the sole mechanism for independent review of the lawfulness of detention.[32]

Access to information about the availability of the limited administrative review procedure is wholly arbitrary under the 1945 Act. This stems from the fact that there is no statutory obligation under the 1945 Act to inform people who are detained in psychiatric care of the limited rights that are available. The reliance on habeas corpus as a means for testing detention has been explored in a study, which will be discussed below, and the results indicate a low level of usage by people in psychiatric detention.[33] The Irish Government however, has contended in the admissibility decision in *Croke v. Ireland,* that habeas corpus is an effective remedy for the purpose of Article 5(4) of the Convention. In *Croke v. Ireland*, the applicant complained about the absence of an automatic and independent review of detention either before or after his initial detention and about the absence of a periodic, independent and automatic review of his ongoing detention. The Government pointed, *inter alia*, to Article 40.4

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[31] Application No. 33267/96.

[32] The Mental Health Act 2001 was signed in July 2001 and a limited number of sections were commenced in April 2002. Sections 1-5, 7, 31-55 were introduced pursuant to S.I. No. 90 of 2002 and deal with the criteria for detention, principles to guide the legislation including that of the 'best interests' of the person, the organisation and appointment of the Mental Health Commission and the Review Tribunals. The Act will eventually provide for automatic review of detention of all patients with the exception of those who have been sent by the courts or transferred from prison to the Central Mental Hospital and who do not come within the terms of the Act..

[33] See later in this chapter. There was slightly more use of the procedure by patients detained in the Central Mental Hospital. Detention in the CMH takes place in two ways: through various routes within the criminal justice system and following transfer from local psychiatric hospitals.

of the Constitution as satisfying the requirements of Article 5(4) reviews with regard to "speedy access."[34]

Habeas corpus applications are given priority in the High Court which must conduct an inquiry "forthwith" into the lawfulness of the detention. The Court must be satisfied that the detention is in accordance with the law and that, in the case of psychiatric detention, the procedures outlined in the 1945 Act have been complied with. There is no limitation on access to the courts except where the decision has been made to refuse the order and a new application does not have fresh evidence to support it.[35]

The applicant in *In Re Philip Clarke* challenged his detention by the Gardai, by way of habeas corpus, on the grounds that there was no judicial determination between his detention in the Garda Station and later removal to hospital under the 1945 Act.[36] Relying on the paternalistic basis for the Act, the Supreme Court held that it did not violate the personal rights of the citizen.[37] The Supreme Court decided that the Constitution did not require a judicial inquiry or determination before a person could be detained in psychiatric care. The Court decided the sections applying to such detentions did not constitute an unjust attack on the personal rights of the citizen, but rather vindicated and protected the rights of citizens concerned by providing for their care and treatment. The relevant sections were not repugnant to the Constitution, Therefore, the substantive issue of whether or not the applicant had a mental illness was not regarded as relevant to the review. The concentration of the Court was on whether on not the 1945 Act permitted the action taken and so was confined to the formal legality of the action.

The first of two applications for habeas corpus involving the same applicant arose in *Croke v. Smith O'Connor, Eastern Health Board, Ireland and the AG*[38] and resulted from the applicant's escape from temporary detention and later transfer to the Central

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[34] *Croke v. Ireland* Application number 33267/97.
[35] *Re Mc Donagh* Unreported High Court 24th November 1969 (ninth application).
[36] [1950] IR 235.
[37] *Ibid,* pp 247 & 250.
[38] [1995] 3 IR 525 and *Croke v. Smith O'Connor, Eastern Health Board, Ireland and the AG (No. 2)* Unreported High Court, July 31st 1995.

Mental Hospital(CMH).[39] The applicant in *Croke* applied for an order of habeas corpus on the basis that he had been detained in excess of the six months applying in the original temporary detention order and that the subsequent transfer to the CMH had not been properly authorised.[40] As a result, he alleged he was not properly detained and did not have the safeguards built into the legislation against arbitrary detention. In addition, there was no limitation on the period of detention and the CMH was not a lawful place for those transferred under the 1945 Act for the purpose of special treatment not available in the original hospital, which he alleged he had not received. The High Court refused the order and, on appeal, the Supreme Court granted the order on the basis that he was not properly detained in the CMH and he was released but readmitted immediately.[41]

A second application for an inquiry under Article 40.4.2 of the Constitution arose in *Croke v. Smith (No. 2),* the basis of which was a two-pronged challenge to the 1945 Act.[42] The grounds of challenge were first, that there was no provision for either judicial intervention or a process to determine the rights of the involuntary patient, and second, that there was no independent review mechanism.[43] The High Court held that the applicant was properly detained in accordance with the provisions of the section but that the section fell below the norms required by the constitutional guarantee of personal liberty. Budd J. acknowledged that even though the habeas corpus inquiry pursued under Article 40.4 "may probe more deeply than the common law habeas corpus procedure, it was not a regular, or automatic form of review."[44] The judge concluded that the absence of an independent review of the decision to detain and the lack of an automatic review of the long-term detention meant that the provisions authorising the admission were repugnant to the Constitution.[45] Budd J. quoted extensively from Costello J. in *RT v. Central Mental Hospital* in support of his decision,

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[39] [1995] 3 IR 525, section 184 of the 1945 Act

[40] There are no time limits on detention in the CMH, therefore extensions to detention would not apply while detained there.

[41] [1995] 3 IR 525.

[42] Unreported High Court, July 31st 1995.

[43] The sections challenged were sections 163, 171 and 172 which provide for the detention and removal of a PUM patient and the time frame which is either discharge, or death.

[44] *Croke v. Smith, O'Connor, Eastern Health Board and AG* Unreported High Court, 31st July 1995 p47.

[45] Mental Treatment Act 1945, section 172. This section provides for the detention of persons of unsound mind including social considerations and indefinite detention.

> ... 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 ... the constitutional imperative [right to liberty]... 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.[46]

In *RT v. Director of the Central Mental Hospital,* where a habeas corpus application challenged the transfer procedure from psychiatric hospital to the CMH, the High Court referred to the serious consequences for temporary patients as a result of the defects in these procedures:

> [T]here 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 ... render the section unconstitutional because they mean that the State has failed adequately to protect the right to liberty of temporary patients.[47]

Budd J., in *Croke v. Smith,* stated that statutes, like the 1945 Act, should be very strictly and narrowly construed, that a law which "trammels liberty must be consistent with a legal order based on democratic principles and be protective of fundamental rights" and there had to be proper safeguards to prevent the risk of abuse or error when dealing with such patients.[48] He outlined two relevant principles requiring a different approach by the Court. The first recognised that human rights evolve over time and therefore necessitated the application of contemporary norms, rather than an originalist approach from the time of the drafting of the Constitution in 1937. The second principle followed from the first and cast doubt on the certainties espoused in *Clarke's* case in 1949 due to the growing knowledge of psychiatry, the nature of mental illness and changing patterns of behaviour.[49]

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[46] *RT v. Director of Central Mental Hospital* [1995] 2 IR 65 p79.
[47] *RT v. Director of Central Mental Hospital* [1995] 2 IR 65 p81, *Croke v. Smith, O'Connor, Eastern Health Board and AG* Unreported High Court 31st July 1995 p45.
[48] *Croke v. Smith O'Connor, Eastern Health Board and AG* [1995] IEHC 6 (31st July, 1995) p51.
[49] *Ibid,* p48.

The Court acknowledged that a wide-ranging inquiry could take place under Article 40.4, but said it could present practical difficulties for someone detained in a psychiatric hospital who does not have a family,

> ... the situation of a mental patient who is illiterate, harmless and without kith and kin to initiate such an inquiry on his behalf by way of habeas corpus perhaps poses the problem in a stark form. Such a patient may not be aware of his or her rights to seek habeas corpus and may be incapable of the necessary written or verbal communication to trigger such an inquiry.[50]

In a strongly worded statement, Budd J. confirmed that habeas corpus is not suitable as a means of review of detention,

> In no way can this procedure, of possible availability only, be equated with or amount to a regular, periodic, automatic and independent scrutiny of the continued lawfulness of, and necessity for, the patient's detention.[51]

Budd J. said that the State has to be particularly "solicitous and vigilant" in the protection of the citizen's rights, particularly the right to liberty, when dealing with a person who is vulnerable and disadvantaged, such as a patient suffering from mental disorder.[52] In addition, the legislators have to be careful, when framing statutes which deprive such a person of liberty, to ensure that proper safeguards are in place to lessen the risk of error or abuse. He held that this lack of automatic review of long-term detention was repugnant to the Constitution. Therefore, he referred the question of the constitutionality of the section to the Supreme Court by way of case stated.[53] The Supreme Court overturned the High Court decision, while emphasising that those in authority are obliged,

> ... to act in accordance with the principles of constitutional justice, and are not entitled to act in an unlawful manner, are not entitled to act arbitrarily, capriciously, or unreasonably and must have regard to the personal rights of the patient, including the right to liberty which can be denied only if the patient is a person of unsound mind and in need of care and treatment who has not recovered and must be particularly astute when depriving or continuing to deprive a citizen, suffering from mental disorder of his or her liberty. [54]

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[50] *Ibid,* p18.
[51] *Ibid,* p47.
[52] *Ibid,* p51.
[53] Article 40.4.3 provides where the person is lawfully detained but the law is invalid according to the provisions of the Constitution then it can be referred to the Supreme Court for a decision as to legality.
[54] *Croke v. Smith, O'Connor Eastern Health Board &* AG (No. 2) [1998] 1 IR 101 p 121.

The Court held that the section was not constitutionally flawed because of the protections and safeguards in the Act and the lack of any systematic failure regarding these safeguards. The decision to set aside such a detention order could be made by a court on application for judicial review, or under habeas corpus. The Court did not acknowledge State efforts to introduce independent review mechanisms in recognition of the inadequacy of the system. The abandoned Health (Mental Services) Act 1981 and the Green and White Papers on Mental Health reflected state awareness of the outcome in *X v. United Kingdom*.[55] Instead, the Court held that "such detentions did not require automatic review by an independent tribunal because of the statutory and inherent obligation on the person in charge to regularly and constantly review such patients and to discharge a patient who had recovered."[56] In effect, the Court accepted the medical and administrative review as adequate, even though it is not independent and does not provide due process safeguards. The annual reports of the Inspector of Mental Hospitals have referred to many omissions in this regard, despite the view of the Supreme Court.[57] The following is an extract from the 2002 Report,

> ... it is often impossible to ascertain the date of a patient's admission to, or discharge from, in-patient care or from the case notes to determine a patient's legal status. Furthermore, the date of the making of a temporary patient reception order is often not apparent from the record so that there is no clear indication when that order should be extended or renewed. To worsen matters, as likely as not there will be no entry indicating that the order has been extended and why, on clinical grounds, it was deemed necessary to renew or extend the involuntary order rather than convert to voluntary status.[58]

An application for an oral hearing was subsequently made in *Croke v. Ireland* before the Strasbourg Court.[59] The applicant claimed breaches of Articles 5(1), 5(1)(e) and 5(4) of the Convention.[60] The Government relied on habeas corpus as providing both

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[55] Department of Health *PL* 8918 1993 and *Pn* 1824. July 1995. (1981) 4 EHRR 188.
[56] *Croke v. Smith, O'Connor, Eastern Health Board & AG* (No. 2) [1998] 1 IR 101 p131.
[57] Department of Health and Children, *Reports of the Inspector of Mental Hospitals for year ending 2001,* Government Publications Dublin, 2002. See also reports for years 2002 and 2003.
[58] Department of Health and Children, *Report of the Inspector of Mental Hospitals for year ending 2002,* Government Publications, Dublin, 2003, p11.
[59] Application no. 3326/96 21st December 2000.
[60] One of the questions posed by the applicant to the Irish Government was, "Why does the government deny it is in breach of the applicant's rights under the Convention when at the same time the government admits that it is in breach of the Convention in terms of its mental health legislation?" The question was not answered.

a substantive and speedy review, arguing that the review under Article 5(4) is "not required to be automatic but rather that an opportunity exists for such proceedings to be taken by the patient."[61] This presupposes that access to information regarding the review exists. Those who are detained may not be aware of their rights or of the possibility of High Court applications and there is no procedure by which the patient is informed. In response to the allegation of a lack of review at reasonable intervals, the government argued that, in habeas corpus proceedings, the only matter that is *res-judicata* is the constitutionality of the section of the Act and that there is no bar to the applicant taking further proceedings at reasonable intervals. The Supreme Court itself has held that repeat applications will be permitted only where new evidence arises.[62] A friendly settlement was reached, one of the terms of which was a commitment by the Irish Government to introduce the Mental Health Act 2001.

Habeas corpus is clearly not adequate in offering substantive and regular review of initial and continuing detention under Article 5(4) of the Convention. The study conducted by the author and outlined in the next section on habeas corpus demonstrates the dearth of cases challenging detention in psychiatric care and the lack of access to the procedure in Ireland.

Study into the applications for habeas corpus from 1923-1999

The aim of this study was to determine the extent to which habeas corpus is used by psychiatric patients.[63] The study established that habeas corpus is little used by those in local psychiatric hospitals compared with prisoners, but that there is increased use of the procedure at the interface between detention in a high security hospital through the criminal justice system, and detention in such hospital following transfer from a local psychiatric hospital.

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[61] *Croke v. Ireland* Application no. 33267/96 21st December 2000 p15.
[62] *Re McDonagh* 29th November 1969.
[63] Keys M., "Challenging the Lawfulness of Psychiatric Detention under Habeas Corpus Law in Ireland", (2002) 24 *Dublin University Law Journal* pp26-57 for a more detailed discussion of these issues.

Methodology

The data on applications from those in psychiatric detention was collected from the central records held at the Four Courts in Dublin relating to the period from 1963 to 1999. Records relating to pre-1963 applications for habeas corpus were available from the National Archives.[64] The records had to be traced in the entry books or register containing all stateside orders and had to be filtered out from the bail and judicial review applications. This was done by selecting and examining all those records containing either the word "detention" or the name of a hospital as the indicator that the entry may well involve a habeas corpus application, Irrelevant records were excluded and the records examined were the total available matched with the case entry registers.[65] The total number of files examined was 275 and this resulted in 111 applications on record for habeas corpus from those in psychiatric detention during that period.

The data identification and collection of prisoner applicants was completed at the Four Courts and records for the period 1998 and 1999 were available on computer. The data on prisoners was examined in order to compare the manner in which others who experience detention and loss of liberty use the habeas corpus provision.[66] The decision to confine the figures to these two particular years was made on the basis that the main focus of the study was the use of habeas corpus by those in psychiatric detention and a recent two year period for comparative purposes was deemed adequate.[67] The habeas corpus procedure is used by both groups to seek an examination of the legality of their detention. Two separate Data Analysis Schedules were prepared, one for psychiatric detention and one for prisoners and the common factors in both cases focussed on the availability of legal representation, the outcome of the applications, and the age and gender of the applicants

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[64] These records were obtained following an initial examination of the record books to identify possible cases; some by reference to words like 'detention' and others which mentioned the name of a hospital.
[65]The record book did not always indicate if the application involved psychiatric detention; frequently it turned out to be a habeas corpus application involving a child custody dispute.
[66] The total number of committals to prison for 1998 and 1999 was 22,141 , Government Publications, *Irish Prison Service Report* 1999 & 2000 p78.
[67]. The total number of applications made by or on behalf of people detained in psychiatric care was 111 for the 76 year period from 1923 to 1999. 94% of applicants were male and 6% female.. This compares with a total number of applications for prisoners for the two year period from 1998-1999 of 113; 97% were male and 3% female.

Extent of the use of habeas corpus

Table 1

Prison		Hospital[68]	
1998 and 1999		1998 and 1999	
Total committals	22.006	Total detentions	4,900
Total applications	113	Total Applications	5
Percentage of total	0.5%	Percentage of total	0.09%

The number of applications on record for habeas corpus between 1923 and 1999 was examined.[69] This resulted in 111 applications on record for habeas corpus applications from those in psychiatric detention during that period.[70] Data on prisoners was examined in order to compare the manner in which the habeas corpus provision is used by other people who experience detention and loss of liberty.[71] Table 1 shows the total number of applications for 1998 and 1999 by patients and prisoners, together with the total number of patients and prisoners during those years.

The study revealed that habeas corpus is little used by those in local psychiatric inpatient facilities and that there is slightly more use of the procedure by patients detained in the high security hospital, the Central Mental Hospital (CMH).[72] The Irish Government has contended that habeas corpus is an effective remedy for the purposes

[68] Department of Health and Children, *Report of the Inspector of Mental Hospitals for year ending*, 1998, Government Publications, Dublin 1999. See also Report for year ending 1999. Note, in 1998 there were 2,500 detentions and in 1999 there were 2,400, (given in the reports as approximate figures).

[69] The method of research was to examine the central records of habeas corpus applications to compare patient applications with prisoner applications focussing on the availability of legal representation, the outcome of the applications, and the age and gender of the applicants. Records on applications for habeas corpus for psychiatric patients were available in the court records from 1923 onwards.

[70] This figure of 111 was extracted from a total of 275 files which were examined based on reference in the title to a hospital.

[71] Records on prisoners applications for the period 1998 and 1999 were computerised and the total was 113 applications. The total prison population for 1998 and 1999 was 22,500. It was decided to confine the data to these two years for this group as being sufficient for the purpose of the study. The total number of applications made by or on behalf of people detained in psychiatric care was 111 for the 76 year period from 1923 to 1999. 94% of applicants were male and 6% female. This compares with a total number of applications for prisoners for the two year period from 1998-1999 of 113, 97% were male and 3% female.

[72] Detention in the CMH takes place in two ways: through various routés within the criminal justice system and following transfer from a local psychiatric hospitals.

of Article 5(4) of the Convention, but this study indicates otherwise.[73] It is useful to compare these figures with the number of Mental Health Review Tribunal hearings for patients in England. In 2000, there were 11,535 hearings and 1,100 orders for discharge (10-11%)[74]

Source of applications to the High Court

The applications came from the individual patient in 65% of cases, though it was evident in the applications from the CMH that many of these were made in the handwriting of one individual, possibly on behalf of fellow patients, though this could not be absolutely ascertained.[75] The assistance of a solicitor was evident in 28% of applications and friends or family accounted for the remaining 7%.

Legal representation

Of the total sample, 31% had legal representation while, in 69% of cases, there was no information concerning legal representation. The figure for legal representation for prisoners confirmed that 44% had legal representation. During the period 1990-1999, 18 of the 22 applications for habeas corpus from psychiatric detention had legal representation.

Spread of applications

The number of psychiatric hospitals and treatment units attached to general hospitals, public and private, in 1999 was 50, including the CMH. This figure has changed over the years with the closure of some large hospitals and the development of smaller units attached to general hospitals instead.[76] The greatest number of applications,

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[73] *Croke v. Ireland Application no. 33267/96* 21st December 2000.
[74] Mental Health Act Commission, *Eighth Biennial Report 1999*. HMSO, London, 2000. The figure includes civil and criminal patients.
[75] There were 29 applications for habeas corpus in the handwriting of one individual in the period from 1969-1974. One file seemed to belong to that individual, no. 29ss, however, it is possible, but improbable, that a member of staff, or a relative could have made the applications on behalf of the 29 people.
[76] Finnane, *Sanity and the Insane in Post-Famine Ireland,* Croom Helm, London 1981. In the early 1900s there were 18 Asylums in the country. Department of Health, *Report of the Inspector of Mental Hospitals for years 1977-1979* Government Publications, Dublin, 1980, indicated that there were 22

63%, came from the CMH.[77] Applications came from less than 40% of psychiatric hospitals and psychiatric units attached to general hospitals. The results confirm that no applications for habeas corpus were received from over 60% of hospitals and units.

Central Mental Hospital

The CMH is the only high security psychiatric hospital in the country and the people are sent there in various circumstances. Patients may be transferred from local psychiatric hospitals to the CMH based on the need for a more secure environment.[78] Prisoners, including a significant number of remand prisoners, may be transferred to the CMH temporarily, when they have a serious mental disorder. Defendants who are found unfit to plead in criminal trials are detained at the CMH until found fit to plead. Those who are found guilty but insane on indictment are detained there at the pleasure of the government.[79] These last three categories formed almost 70% of the total in-patient population of the CMH in 2000.[80]

The CMH accounted for 63% of all applications from those who had been sent there from a number of other services. Among these patients, the greatest number of applications, 48%, came from those who had been transferred from prisons, many of whom were on remand. This further diminished the use of the provision from those applicants who were not connected with the criminal justice system. A further 44% of the applicants had been transferred from local psychiatric hospitals. The remaining

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public psychiatric hospitals and 13 private hospitals. In the period 1995-1998 there were nine private hospitals registered with the Department of Health and Children, two of which closed during this period. The growth in the number public psychiatric in-patient facilities to a current figure of 49 (excluding the CMH) reflects the policy change to move from large hospitals to a greater number of smaller units attached to general hospitals and to reduce inpatient numbers over the years in the move to community care.

[77] The next highest number of applications came from St Brendan's Hospital, Grangegorman in Dublin with a figure of 10%, followed by St. Luke's Hospital, Clonmel. Various other hospitals had two and three applications each and six hospitals had just one application from each of them.

[78] *Croke v. Smith, O'Connor, Eastern Health Board & AG (No 2)*[1998] I IR 101 and *RT v. Central Mental Hospital*, [1995] 2 ILRM 354.

[79] This is a special verdict that is effectively an acquittal. Proposals for reform of this area of law have been ongoing since the Third Interim Report of the Interdepartmental Committee [chaired by Mr. Justice Henchy] on Mentally Ill and Maladjusted Persons. *Treatment and Care of Persons Suffering from Mental Disorder who Appear before the Courts on Criminal Charges.* (Dublin: 1978). These have culminated in the proposed Criminal Law (Insanity) Bill 2003. *Gallagher v. Central Mental Hospital, Minister for Justice and the AG* [1996] 3 IR 1.

[80] Department of Health and Children, *Report of the Inspector of Mental Hospital for the year ending 2000*, Government Publications, Dublin, 2001, p24.

8% indicated they had been sent from Garda Stations, though there is no legal basis for such direct transfer. There may have been an interim court disposal, details of which were omitted from the files.[81]

One mechanism used to transfer a patient to the CMH was the section 207 procedure in the 1945 Act which provided that a district court judge held a hearing in the hospital to establish if the patient would be charged with an indictable offence, usually an assault on another patient or member of staff. When the evidence given constituted prima facie evidence that the person had committed the offence and would, if put on trial, be unfit to plead, the judge made an order stating that the patient was suitable for transfer to the CMH. This order was conveyed to the Minister for Health, who requested that the Inspector of Mental Hospitals would visit and report on the mental state of the person. The final decision on transfer would be left to the Minister. There were many difficulties with the procedure, such as the right to legal representation, no criteria for Ministerial involvement, the status of such "offence," whether it went into abeyance following transfer and the issue of indefinite detention in the CMH. The procedure was deemed unconstitutional by the High Court in *RT v. Central Mental Hospital.* [82] A transfer procedure under section 208 has been used instead. Transfer can lead to indefinite detention and no statutory protections are in place yet for review of continuing detention.[83] The system of transfer from local psychiatric hospitals to the CMH under section 207 was used more frequently in the 1960s and Creaby et al recorded a figure of 112 transfers between 1955-1994.[84] During this period, two patients had been released on habeas corpus and three had been discharged previously, but were later readmitted under section 207.[85] At the end of this period, 15 of these patients remained in the CMH. Their study observes that section 207 referred only to "detained" patients being transferred from the local

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[81] An examination of the method of transfer revealed that a total of 35% of cases were sent directly by the courts, following either a guilty but insane verdict, or where the person was found unfit to plead and would be detained until deemed fit. Section 207 of the 1945 Act was used in 40% of transfers from local psychiatric hospitals to the CMH. There was no information recorded in the files on the method of admission in a further 25% of cases.

[82] [1995] 2 ILRM 354

[83] See *Croke v. Smith, O'Connor, EHB Ireland and the AG* [1994] 3 IR 525, *Croke v. Smith(No 2)* [1998] 1 IR 101.

[84] Creaby, Huthinson, O'Malley, O'Connor, "Section 207 of the Mental Treatment Act 1945 A Critical Review of Its Use 1955-1994" (1995) *MLJI* 11.

[85] Mental Treatment Act 1945 section 207 is now unconstitutional and section 208 is used and does not specifically refer to detained patients. This section was not intended to be used to transfer patients to the CMH.

psychiatric hospitals; the files in this study revealed four voluntary patients who had been transferred this way. This is a surprising finding in view of the fact that the legislation is unambiguous in stating that only detained persons can be transferred to the CMH, but it accords with Creaby's findings.[86]

Outcome of all the applications for habeas corpus

Release was ordered in 11% of cases and was refused in 43% of applications. There was no reference to the outcome in the remaining 46%. More releases were ordered in the cases arising from the applications in the 1990s; 56% of all orders for release occurred during this period. During this period, 54% of the applicants had legal representation, when compared with the overall figure which indicated that 31% of all applicants had legal representation. [87] Hoggett has commented in relation to tribunal hearings in England and Wales that "the involvement of lawyers as advocates for patients should focus minds on the proper legal issues; it should lead to a more careful scrutiny of assumptions about the future made on the basis of past events ..."[88]

The court ordered transfer from the CMH to a local hospital in 4% of cases, but the legal basis for such an order is not clear. The transfer procedure in the 1945 Act would have permitted the Minister for Health to return the person to the local hospital from the CMH. This section was deemed unconstitutional in *RT v. Central Mental Hospital* [89] and a compromise section is now used instead.[90]

Conclusions from study

The key finding in this research is the low rate of applications for habeas corpus from patients in local psychiatric hospitals and the difference between the prisoners and the patients in the rate of applications for the comparative period.[91] Differences between

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[86] Mental Treatment Act 1945, section 207.
[87] The information on file was limited; 16% were recorded as having appealed the decision of the High Court and release was ordered in three cases.
[88] Hoggett B., *Mental Health Law*, 4th ed., Butterworths, London, 1996, p202.
[89] [1995] 2 ILRM 354.
[90] Section 208. The reports of the Inspector of Mental Hospitals have outlined the procedures to be followed in the transfer of patients to the CMH and these are appended to the recent reports.
[91] The applications from psychiatric detainees came from local hospitals and from the CMH.

local hospitals and the CMH were exposed in relation to the frequency of use of the provision between those from local hospitals and those from the CMH. The total figure of 111 for all applicants for habeas corpus between 1923 and 1999 is stark when compared with a total figure of 113 applicants from prisons for 1998 and 1999. The results in Table 1 indicate that, as a percentage of prisoners and hospital detentions for the years 1998 and 1999, the rate of applicants in both categories is low, 0.5% of all prisoners made applications and 0.09% of all patients made applications. The question must be raised as to whether the situation is as it should be. The rate of applications may be low because people in detention decide it is not relevant to them. Alternatively, other reasons, such as lack of information as to the rights available to people in detention, impact on the rates.

From 1990-1999 there were eighteen separate habeas corpus applications, (not part of a cluster), indicating a growing awareness of the procedure as the only available opportunity for independent review of detention.[92] However, the total is still small by comparison with the figure for prison applications for the two year period. It is clear that part of the problem is the information deficit arising from the absence of any statutory requirement to inform patients of their rights to challenge detention in this way.[93] This has been recognised in previous studies and Creaby et al, in recognition of the low level of legal representation for their patients, stated, "in recent years we have strongly advised all patients to avail of the services of a solicitor."[94] They acknowledge also that, despite the fact that two patients in their study were released under habeas corpus, "most patients (and doctors) are unaware of this avenue and it is not often used." This observation is an indication of the true position for many patients, even those at the interface with the criminal justice system where there is a perception that greater awareness of legal rights exists.

Habeas corpus is the only form of independent review of continuing detention in Irish law. Yet a total of 111 applications by, or on behalf of, psychiatric patients over an 85 year period hardly suggests an effective and accessible means of redress against psychiatric detention. This figure was exceeded in a two year period in 1998-1999 by

[92] The Mental Treatment Act 1945 does not provide any system for independent review of detention as required under Article 5(4) of the Convention.
[93] *Croke v. Smith, O'Connor, Eastern Health Board & AG* [1995] IEHC 6 31st July 1995 p51.
[94] *Op. cit.*, 84. Note that the authors were working as psychiatrists in the CMH.

113 prisoner applications. When one adds to this the influence of clusters of applicants from the CMH, such as the 29 applications made by one individual in the late 1960s and early 1970s [95] and nine repeat applications by another patient in the CMH,[96] it becomes clear that the remedy is not widely used and the true number of applicants from psychiatric detention is probably even lower than documented here.

Many factors might be at play here, including the lack of information about rights and the lack of a "rights culture" in psychiatric hospitals. One of the ingredients of a rights culture is the belief that there is a point to asserting one's rights. Given the low success rate then this may well have an influence on a decision to pursue such a course of action. The difficulty of accessing legal representation is a factor that cannot be ignored either. Added to this aspect is the possibility that some detained people may be apathetic and lacking in motivation to pursue such action and believe it is pointless. The statement of the Court in *Herczgefalvy v Austria* is worth repeating here,

> The Court considers 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.[97]

Undoubtedly, the lack of rights based mental health legislation that does not comply with the Convention has had an impact on this situation with no provision for access to information regarding the rights available in the 1945 Act. This information deficit includes a lack of information on the availability of habeas corpus and might explain, to some extent, the fact that the number of prisoner applications were more than five times the total of applications from patients. Prisoners usually have lawyers who have defended them at trial. This would explain the fact that 44% of the prison applicants had legal representation, compared with 31% of the applicants in psychiatric detention. There is a certain rights culture in prisons emanating from having been involved with the criminal justice system. This might account for the fact that the CMH, with its significant population of mentally disordered prison transfer patients, had the greatest number of habeas corpus applications in the patient group. Recent

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[95] In relation to one such applicant it was stated in the medical evidence that "The patient is feeble minded, is unable to order himself or his affairs, another patient had compiled and written the letter."
[96] *In re McDonagh*, Unreported, High Court, 24 November 1969. The issue arose in court as to whether there should be a limit on the number of such repeat applications by one individual.
[97] (1992) 15 EHRR 437 para 82.

reports confirm those who have been through the criminal justice system make up almost 70% of the inpatients.[98] The CMH patients accounted for 63% of the total applications from patients, with the remaining 37% spread over all other local hospitals.

The manner in which the detained person reaches the High Court is an important one in that it gives an indication of the level of access to constitutional rights by those in detention. Access to habeas corpus is dependent on having information about the procedure and, without information, this right to have recourse to the courts cannot be availed of by patients, particularly those in the local psychiatric hospitals. The findings in this study, if taken along with the fact that there is no system of independent review under the 1945 Act, reinforce the belief that this provision has been inaccessible as a legal right. In effect, it is a denial of a constitutional right. Obviously, there is need for change in a system which perpetuates this level of inequality. The next section will address the alternative system available for review of detention under Irish law.

Judicial review and Ireland

The option, in appropriate circumstances of applying for judicial review of detention may be an alternative to habeas corpus. The link between these two procedures arose in the context of a practice whereby habeas corpus applications to the High Court were converted into applications for judicial review and leave for such review was granted instead of an inquiry under Article 40.4. In *Sheehan v. O'Reilly,* the Supreme Court held the practice to be wrong,

> Such an application in its urgency and importance must necessarily transcend any procedural form of application for judicial review or otherwise. Applications which clearly, in fact raise an issue as to the legality of the detention of a person must be treated as an application under Article 40, no matter how they are described.[99]

[98] Department of Health and Children, *Report of Inspector of Mental Hospitals for Year ending 2003*, Government Publications, Dublin 2004.
[99] [1993] 2 IR 81 p89.

This statement clearly confirms the difference between the two procedures, one is urgent and directed particularly at the right to liberty, compared with judicial review and its "consequential procedural delays" which is "quite inappropriate."[100] This view of the Supreme Court on judicial review is directly relevant to review of mental health detention and demonstrates, at the least, that it would not be a speedy means of review.

The question of whether judicial review in Ireland can offer a substantive review sufficient to satisfy Article 5(4) requirements is also doubtful. The test of "unreasonableness" in Irish law is whether the impugned decision "plainly and unambiguously flies in the face of fundamental reason and common sense"[101] A number of Supreme Court decisions demonstrate that the test will be strictly applied "and suggest that it will be difficult to set aside an administrative decision on the grounds of unreasonableness or irrationality."[102] The onus for establishing unreasonableness should be on the party alleging it and the circumstances in which a court could intervene in an administrative decision on the basis of irrationality are "limited and rare." [103] It would be necessary to satisfy the court that the administrative body "had before it no relevant material which would support its decision."[104] These elements have been described as "formidable obstacles," as it would be difficult for the applicant to get the documentation held by the decision maker.[105]

The intensity of the intervention may vary according to the subject matter. The test in *R v. Ministry for Defence ex p. Smith,* an English case, held that the more substantial the interference with human rights, the more the court will require by way of justification before it is satisfied that the decision is reasonable and the court should carry out a heightened scrutiny, the "super Wednesbury test."[106] This approach would lower the boundaries of intervention and allow the court to consider substantive issues as well as procedural ones. The High Court, in *Bailey v Flood*, accepted the test laid

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[100] *Ibid,* p92.
[101] *State (Keegan) v. Stardust Victims' Compensation Tribunal* [1986] IR 642 per Henchy J. p658.
[102] Delaney H., *Judicial Review of Administrative Action: A Comparative Analysis,* Round Hall Sweet & Maxwell, Dublin, 2001, p75.
[103] *P & F Sharpe Ltd.v. Dublin City and County Manager* [1989] IR 701, *O'Keeffe v. An Bord Pleanala* [1993] 1 IR 39.
[104] *O'Keeffe v. An Bord Pleanala* [1993] 1 IR 39.
[105] *Op. cit.,* 1 p76.
[106] [1996] QB 517.

down in *Smith* as one which the Court "ought to apply when reviewing a decision that impinges on constitutionally guaranteed rights."[107] In the English case, *R (Wilkinson) v. Broadmoor Hospital*, where the patient's Article 3 rights were in danger, Hale LJ held that "super Wednesbury" review was not enough.[108] The appellant was entitled to a proper hearing on the merits of whether the grounds permitting treatment against his will were made out.[109]

In *HL v. United Kingdom,* the Strasbourg Court confirmed that a "super Wednesbury" type review would not be adequate as the threshold for a finding of irrationality was too high to permit an examination on the merits of the evidence of persistence of mental disorder justifying continuing detention.[110] On this basis, and having considered the restrictive Irish position on judicial review, it would not meet the requirement for substantive review. Reliance on these provisions as providing adequate review of detention under the 1945 Act is in breach of Article 5(4). Access to an independent judicial body, such as a court, is a necessary part of review.

Access to court

The person detained must have access to a court. In *X v. United Kingdom* the meaning of the word "court" arose. The Court described it as a body with judicial character, offering certain procedural guarantees. The court does not have to be "a court of law in the classic kind integrated within the standard judicial machinery of the country."[111] It must be independent of the executive and of the parties to the case to rule out any conflicts of interest. There must also be guarantees appropriate to the kind of deprivation of liberty in question.[112] In addition, the judicial character requires that it must have the power to order release if the detention is unlawful. *X v United Kingdom* established that a recommendation to this effect is insufficient.[113] The Strasbourg Court considered that the sheriff may be regarded as a "court" for the

[107] Unreported High Court 6th March 2000. This decision was upheld by the Supreme Court 14th April 2000.
[108] [2001] EWCA Civ 1545 para 83.
[109] Bartlett & Sandland, *Mental Health: Law Policy and Practice*, OUP, Oxford, 2004, p233.
[110] (2005) 40 EHRR 32 5th October 2004 para 139.
[111] *Weeks v. United Kingdom* (1988) 10 EHRR 293 para 61.
[112] *X v. United Kingdom* (1982) 4 EHRR 188 para 53.
[113] (1982) 4 EHRR 188 para 61.

purposes of Article 5(4) satisfying the requirements of independence and impartiality and offering judicial guarantees of an adversarial procedure.[114] The person must have the opportunity to present his own case and the right to challenge all the evidence presented. *X* was detained as a restricted patient in Broadmoor and a conditional discharge was ordered by the Home Secretary. He was unsuccessful in seeking his release either through habeas corpus or following a tribunal hearing. Even if the tribunal had recommended discharge the final decision would rest with the Home Secretary. He alleged breaches of Articles 5(1) and 5(4). Both the Commission and the Court held there was no violation of 5(1), but there was violation of 5(4).

Placing the burden on the patient to establish that his continuing detention is not necessary is not compatible with Article 5(4). The imposition of the burden of proof on the patient with regard to appealing the tribunal decision has been criticised by many commentators. Thorold believes that there may be uncertainty if the person is on medication that it is controlling an underlying mental disorder.[115] Where the person is unmedicated, there can be a suspicion, but no proof, as to the persistence of the illness. The onus of proof was raised in *Reid v. United Kingdom* and the Court held that it was implicit in the case law that it was for the authorities to prove that an individual meets the conditions for detention.[116]

The Court stated in *Winterwerp* that the judicial proceedings in Article 5(4) need not always be attended by the same guarantees as those required under Article 6(1) for civil or criminal litigation. The individual must have access to a court and the opportunity to be heard in person or through representation. Warbrick comments that the Court should be cautious in allowing decisions having serious consequences for the individual to be taken on the basis of the statements of persons where all the contents are not revealed and there is no confrontation.[117]

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[114] *Hutchinson Reid v. United Kingdom* (2003) 37 EHRR 9 Application no.50272/99 20th February 2003 para 67.
[115] Thorold O., "The Implications of the European Convention on Human Rights for the United Kingdom Legislation", (1996) 6 *EHRLR* 619, p629.
[116] *Hutchinson Reid v. United Kingdom* (2003) 37 EHRR 9.
[117] Warbrick C., *European Convention of Human Rights Yearbook of European Law,* (1990) Vol.10, Oxford, pp338-348.

Irish law and review of detention

Mental Treatment Act 1945

There is no automatic right to review under the 1945 Act and habeas corpus is used instead to challenge the legality of the detention. The 1945 Act provides a limited form of administrative review of detention and related safeguards.[118] The Inspector of Mental Hospitals has a particular duty to detained patients where he has reason to doubt the propriety of their detention.[119] The Inspector must also ascertain whether the periods of detention of any temporary patients have been extended since his previous visit. If so, he must give particular attention to the patients concerned. Any person may apply to the Minister for Health and Children for an examination order for the examination of a detained person by two medical practitioners and the Minister, on consideration of their report, may direct the discharge of the patient.[120] Any relative or friend of a person detained may make an application for the discharge of a patient to his or her care.[121] When the period of detention of a temporary patient is extended, the patient's psychiatrist is expected to advise the patient and the person who applied for the original reception order that either of them may make their objections known to the Inspector of Mental Hospitals, the HSE, and the President of the High Court.[122] On receipt of an objection, the Inspector must take such steps as he deems necessary to satisfy himself of the propriety or otherwise of the continued detention of the patient. Every patient has the right to have a letter forwarded unopened to the Minister for Health & Children, the President of the High Court, the relevant health services executive, the Inspector of Mental Hospitals or, if the patient is a ward of court, to the Registrar of Wards of Court.[123]

The President of the High Court may require the Inspector to visit and examine any patient detained as a person of unsound mind and to make a report, but it is not known if this ever happens.[124] The Act specifically prevents any power being exercised in

[118] Mental Treatment Act 1945, section 240
[119] *Ibid,* section 240.
[120] *Ibid,* section 222.
[121] *Ibid,* section 220.
[122] *Ibid,* section 189.
[123] *Ibid,* section 266.
[124] *Ibid,* section 241.

relation to wards of court by providing a saver clause relating to the power of the High Court, which means that the limited provisions of the Act do not apply to them.[125] There are 100 wards of court detained in psychiatric care based on the most recent reports.[126] The position of wards potentially breaches Article 5(4) given that there is no regular review carried out. It raises issues under Article 14 unless there is objective and reasonable justification for the difference in treatment, which is based on their different legal status, compared with other detained patients.

The safeguards of the 1945 Act do not conform to Article 5(4) requirements as there is no provision for independent review of either the initial decision to detain, or of continuing detention. As recently as 1997, the Supreme Court held that this lack of safeguards did not offend against the Constitution.[127] This was due mainly to the presumed availability of the habeas corpus procedure in Article 40.4 of the Constitution, that it met the requirement of substantive review. This included the Court's over-reliance on the perceived obligations of the medical staff to review the patient's continuing illness on a regular basis. This is not a satisfactory form of review.

Mental Health Act 2001

The 2001 Act will provide a right to independent review of the initial decision to detain and of each decision to extend a detention order.[128] This will not include wards of court who will be monitored by the President of the High Court and are not entitled to review of continuing hospitalisation, which itself is in breach of Article 5(4). In all other detentions, a tribunal will carry out the review. The main function of the tribunal is to provide initial and continuing review of the detention of patients. Other functions include a role in decisions regarding psychosurgery and in relation to transfers to the CMH.[129] The members of the tribunal will be appointed by the Mental Health

[125] Mental Treatment Act 1945, section 283.
[126] *Op. cit.*, 98.
[127] *Croke v. Smith O'Connor & Eastern Health Board (No. 2)* [1998] 1 IR 101.
[128] Mental Health Act 2001, section 18.
[129] *Ibid,* sections 21(2)(b) and 58(3).

Commission. Membership will consist of a consultant psychiatrist, a lawyer and a lay person.[130] Decisions of the tribunal will be by majority vote.

The independent psychiatrist appointed by the Commission to report to the tribunal must visit, interview and report back to the Tribunal within 14 days and the tribunal has a further seven days to make its decision.[131] There is provision for a first extension of time of 14 days, either at the behest of the tribunal, or the patient and for a second extension at the behest of the patient only.[132] The tribunal will have to be satisfied that the patient is suffering from a mental disorder and that the required procedures have been complied with under the Act.[133] Where there is a failure to comply with any of the provisions and it does not affect the substance of the order, or does not cause an injustice, then the order can be affirmed.[134] The extent, or boundary of this discretion is of concern, as it is not defined and may not survive a legal challenge if an application for habeas corpus were made to the High Court. The Convention requires that the law must indicate the scope of any discretion conferred on the authorities and the manner of its exercise with sufficient clarity to give protection against arbitrariness.[135] Where the tribunal is not satisfied, the order can be revoked and the patient discharged.[136]

The patient will have a right to attend the tribunal unless, in the opinion of the tribunal, it would damage their "mental health, well-being or emotional condition".[137] There is no statutory right to an independent medical report for the tribunal hearing. There is a right to legal representation before the tribunal, but the patient may engage his own legal representative. If the patient objects to the lawyer appointed by Commission there is no obligation to provide a replacement.

It is not clear if the tribunal is inquisitorial, but arguably it is. The tribunal is based on the provision that questions are asked by the tribunal on the one hand, and by the

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[130] *Ibid,* section 48(2)-(3).
[131] Mental Health Act 2001, section 17(1)(c)iii.
[132] *Ibid,* section 18(4).
[133] *Ibid,* sections 9,10,12, 14,15,16.
[134] *Ibid,* section 18(1)(a)(ii).
[135] *Malone v. United Kingdom* (1985) 7 EHRR 14 para 68.
[136] Mental Health Act 2001, section 18(1)(b).
[137] *Ibid,* section 49(11).

patient or his lawyer on the other hand. There is no specific reference to the question of the burden of proof, but it rests with the authorities to demonstrate the presence of mental disorder and adherence to the procedures. The tribunal has no statutory power to make a conditional discharge, defer a discharge, or direct that a patient's disorder be reclassified. When a patient is being discharged before a tribunal hearing, the psychiatrist must notify the patient of his right to continue with a review.[138] If the patient wishes to continue, he must notify the Commission within 14 days of discharge. Otherwise, the review will be discontinued.

The decisions of the tribunals can be reviewed by way of judicial review and this will probably be a significant source of case law in future. Some of the possible reasons for such review might be that the tribunal was acting *ultra vires* its statutory powers, breached the rule against bias (*nemo iudex in causa sua*), breached the principle of *audi alteram partem*, breached formal or procedural requirements or failed to give adequate reasons for its decision. The tribunal must comply with rules of natural justice and this includes giving proper and adequate reasons for its decisions.[139] The tribunal must also give reasons why it accepted particular evidence where there is a conflict.[140] One of the concerns of staff is that patients will be discharged by a tribunal against their wishes, but, based on English law, a new admission order can be made soon after tribunal discharge, provided that those involved in the admissions act objectively and *bona fide*.[141]

Where the patient is discharged before the review has commenced, the review will not go ahead unless the patient has contacted the Mental Health Commission within 14 days of discharge.[142] It is reasonably predictable that many patients will not pursue a right to review in these circumstances. Having regard to the decisions in *Winterwerp* and *Meygeri,* leaving the initiative to the patient may not meet Article 5(4) requirements, though this is coloured by the fact that the patient is already discharged. Good practice would indicate that the number of such patients who fail to pursue that right should be carefully documented to ascertain the reasons for not pursuing such a

[138] *Ibid,* section 28(3)(b).
[139] *R v .MHRT ex p Clatworthy* (1985) 3 AII ER 699.
[140] *R v. Ashworth Hospital Authority, ex parte H.* [2002] EWCA Civ 923.
[141] *R v. South Western Hospital Managers, ex p. M.* [1994] 1 AII ER 161.
[142] Section 28(3)(b). Health Research Board, *Activities of Irish Psychiatric Hospitals 2003,* Dublin, 2004 confirm that 80% of all admissions are discharged within 17 days.

course of action, in order to rule out information deficits and any extraneous pressures. It is important also to ensure that the right to review is not usurped by early discharge.[143]

There will be a right of appeal to the Circuit Court against the decision of the Tribunal and an appeal is permitted to the High Court only on a point of law.[144] The burden of proof will rest with the individual to establish that he no longer has a mental disorder. The Circuit Court must not revoke the order "unless it is shown by the patient to the satisfaction of the Court that he or she is not suffering from a mental disorder ..."[145] Placing the onus on the patient is almost certainly in breach of Article 5(4) in light of the decision in *Reid v. United Kingdom*.[146]

Commentators on the tribunal system have suggested that the therapeutic relationship between psychiatrist and patient must be protected for the future.[147] Others were concerned that the preferred outcome was imposed on the evidence by tribunal members and that the decisions are dictated by psychiatrists and that there is little standardisation of procedures.[148] There is evidence that patients understand little of what the hearing is about.[149]

Finally, the lack of independent review in the 1945 Act is a clear breach of Article 5(4) and the specific exclusion of wards of court compounds the situation. The 2001 Act will meet the requirements of the Convention by providing a right of access to a tribunal that will satisfy the requirement of independence, but will not include wards of court. The scope of the discretion with regard to the failure to comply with some provisions of the Act is unclear. The question of early discharge to avoid engaging with the tribunal will have to be monitored when the 2001 Act is in place. A more

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[143]Blumenthal & Wessely, *The Patterns of Delay in Mental Health Review Tribunals.* HMSO, London, 1993.
[144] Mental Health Act 2001, sections 19(1) & (16).
[145] *Ibid,* section 19.
[146] *Hutchinson Reid v. United Kingdom* (2003) 37 EHRR 9 .
[147] *Obomanu and Kennedy*, "Juridogenic harm: statutory principles for the new mental health tribunals" (2001) *Psych. Bulletin.* 25, 331-333.
[148] Peay J., *Tribunals on Trial: A Study of Decision-Making under the Mental Health Act 1983*, Clarendon Press, Oxford, 1989.
[149] Dolan et al, "Mental Health Review Tribunals: a survey of Special Hospital Patients' Opinions" (1999) 10(2) *Journal of Forensic Psychiatry*, p24.

serious concern is the need to reverse the burden of proof to avoid a breach of Article 5.

Speedy review

The decision regarding the detention must be taken speedily. Usually, time begins to run when Article 5(4) proceedings are initiated.[150] The word "speedily" has been the subject of many applications, most recently under the English Human Rights Act 1998.[151] A speedy review depends on all the circumstances of each case including access to speedy legal aid and the need to get medical reports in psychiatric detention.[152] In *Baranowski v. Poland,* involving a pre-trial detention and a delay in obtaining bail, it took the domestic court six weeks to obtain evidence from a neurologist, a psychiatrist and a cardiologist and this was held to be a lack of due diligence and a violation of Article 5(4).[153] The procedure for holding a person under Polish law was not based on clear rules. Where domestic law allows for arbitrary or excessive detention, even in the face of compliance with domestic procedures, the deprivation of liberty will not be lawful.

The second of two applicants, in *Keus v. Netherlands and Koendjbiharie v Netherlands,*[154] *Koendjbiharie* had waited for four months for review that included an unexplained adjournment of more than three months and more than a month for the Court of Appeal to draft a simple order. This time scale was held to breach Article 5(4). The Court distinguished between newly detained patients and those needing periodic review of detention on the degree of urgency required in each case. Less urgency applies to the latter situation, but a four months delay in this case was held to be unreasonable in relation to review of continuing detention.[155]

Article 5(4) was violated in *Van der Leer v. The Netherlands,* because the applicant did not have the lawfulness of the detention reviewed speedily by the court and they

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[150] *Van der Leer v. Netherlands* (1990) 12 EHRR 567.
[151] *R v. MHRT & Sec of State for Health ex parte KB,MK, JR ,GM, LB, PD, & TB.*[2002] EWHC 639. *R v MHRT; Torfaen Co. Council & Gwent HA (ex parte Hal)l* (1999) 3 All ER 132.
[152] *Sanchez-Reisse v. Switzerland* (1987) 9 EHRR 71 para 55.
[153] Application no. 28358/95 28th March 2000.
[154] (1990) A/185-C, (1990) A/185B.
[155] *Ibid,* para 24.

regarded the relevant period of five months as too long.[156] The Court said that the initial failure to inform the applicant of the detention order put a special responsibility on the authorities to proceed expeditiously. In *Musial v. Poland,* the applicant complained that the length of time for a speedy judicial decision was breached and the Court considered that a lapse of one year, eight months and eight days was incompatible with Article 5(4) unless there were exceptional grounds to justify it.[157] The delay between the clinical examination and preparation of a medical report is capable of running counter to the principle underlying Article 5; namely the protection of individuals against arbitrariness as regards any measure depriving them of their liberty. Such difficulties do not reduce the obligation on national authorities to provide a prompt review of detention.

A review of the applicant's detention at intervals of 15 months and two years was held by the Court in *Herczegfalvy v. Austria* not to be reasonable.[158] In *E v. Norway,* the review and judgment was given just one day under eight weeks and the Court held this did not conform to speedy access.[159] Harris comments that a period of eight weeks from the filing of the summons to the judgment appears difficult to reconcile with the notion of "speedily" except that the application had been filed in the vacation.[160] The long delay in giving judgment could not be justified. Where there is evidence of a change in the mental state of a detained person, a hearing within a shorter period may be required.[161] Warbrick says the more complicated the decisions under Article 5(4) the harder it is to satisfy the requirement of speed, which puts a burden on the state to show the time actually taken was necessary.[162] Where the state cannot explain the delay or can only do so by reason of the organisation of its judicial system, the Court has shown that it is likely to find a violation.[163]

Thorold says that the "standard set requires a high degree of administrative urgency which other than in assessment tribunal hearings, the United Kingdom tribunals

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[156] (1990) 12 EHRR 567 para 28.
[157] (2001) 31 EHRR 29.
[158] (1993) 15 EHRR 437 para 77.
[159] (1994) 17 EHRR 30 para 66.
[160] *Op. cit.,* 1 p156.
[161] *M v. FRG* No 10272/83,38 DR 104 94 (1984).
[162] *Op. cit.,* 1 at p156.
[163] *Koendjbiharie v. Netherlands* A 185 B paras 28-30 (1990).

system frequently fails to achieve."[164] He believes that rules are in part responsible, in that the "responsible authority" is allowed three weeks to forward its reports on the patient and a further three weeks for the restricted patients and the Home Office opinion. A further 14 days notice of the hearing is required and the Tribunal will have seven days to communicate its decision. He believes it was impossible to meet the requirements set in *E v Norway,* even though specific difficulties arose in that case. Tighter time limits will have to be set to avoid breaches of Article 5(4) and, to some extent, his warnings have been realised in the decision on this issue under the Human Rights Act 1998.[165]

This decision involved the examination of administrative procedures by the court in *R v. MHRT & Sec of State for Health ex parte KB & others,* an English case, that established a breach of Article 5(4) because of unreasonable delay in holding tribunal hearings with a view to discharge, involving a number of people.[166] In each case, the tribunal hearings had been repeatedly adjourned. The complaint concerned the delay between making the applications and the dates of the hearings. This resulted in unjustified detention and uncertainty for the patient. Hearings for patients were frequently cancelled, resulting in anxiety and loss of trust in the system and waste of resources where arrangements had been made to free up staff to attend. The Court addressed the issue of "speedily," assuming reasonable availability of resources and a reasonably efficient administrative system. It would depend on the nature and importance of the subject matter of the case, the complexity of the issues, the preparation required beforehand and the evidence to be considered. Other factors, such as the sudden increase in other applications, or, a holiday period, or "the fact that a patient's case is perceived to be unmeritorious" do not deprive him of this right to a speedy hearing.[167] Domestic law confirms the time period as seven days in the case of section 2 detentions. No such time applies to the section 3 applications, which are the most common. The Court examined in detail the workload of the tribunals and the

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[164] *Op. cit.,* 115 p626.
[165] *R v. MHRT & Sec of State for Health ex parte KB ,MK, JR ,GM, LB, PD, & TB.*[2002] EWHC 639. *R v MHRT; Torfaen Co. Council & Gwent HA (ex parte Hall)* (1999) 3 All ER 132.
[166] *R v. MHRT & Sec of State for Health ex parte KB,MK, JR ,GM, LB, PD, & TB.*[2002] EWHC 639. There were variations in the legal status of the individuals with one on a section 2 Assessment Order necessitating a hearing within seven days but had to wait for four weeks. The remainder were waiting between nine weeks and 27 weeks.
[167] *Ibid.*

unexpected increases each year caused by changes to community care. This should have been taken into account by the State. The Court held that it was the responsibility of the State to ensure speedy hearings and they are obliged to have sufficient resources, including tribunals or courts to ensure speed. Having held all applicants suffered a breach of their rights under Article 5(4), Burnton J. went on to hold central government, not the actual tribunals, responsible for the delays.[168]

The requirement of speed applies to the appellate procedures, as well as to the initial review, unless there are exceptional grounds to explain the delay.[169] The decision in *Reid v. United Kingdom,* reinforces this view as applying to the Scottish four-tier review system.[170] The Court held Article 5(4) was breached by a delay of three years between the application to the Sheriff and the final decision in the House of Lords.

Irish law and speedy review

Mental Treatment Act 1945

The Irish government sought to rely on habeas corpus as a means of speedy review for people detained under the 1945 Act in *Croke v. Ireland.*[171] Two cases were relied on, *Gallagher v. Central Mental Hospital, Minister for Justice and the AG* [172]and *In re Shane Donnelly* [173] as evidence of the speed with which a review of detention under Article 40.4 can occur. The requirement of speed would appear to have been satisfied in both these cases, though the detention had been pursuant to the Trial of Lunatics Act 1883, not the Mental Treatment Act 1945. It may be successfully argued that the requirement of speed is satisfied by a habeas corpus inquiry. The High Court stated in *Croke v. Smith, O'Connor, Eastern Health Board & AG,* that habeas corpus "is undoubtedly a speedy and efficacious remedy."[174] The Constitution is unambiguous that the High Court judge to whom the application is made must

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[168] *Ibid,* para 113.
[169] *Rutten v. The Netherlands Application no.* 32605/96 24 July 2001.
[170] *Hutchinson Reid v. United Kingdom* (2003) 37 EHRR 9.
[171] Application no 33267/96 21st December 2000.
[172] [1996] 3 IR 1.
[173] (1995) Unreported, referenced in Admissibility Decision in *Croke v Ireland* 33267/96 21st December 2000.
[174] [1995] IEHC 6 31st July 1995 p18.

proceed to make the inquiry immediately, but this does not prevent adjournments being made. It was clear from the study on habeas corpus in Ireland that, as soon as the Court received a request, the matter was immediately addressed and set in motion. It was difficult to estimate the time of the final outcome in each case, as the information was missing from files, in many cases dates of completion were not recorded and, it was not possible to assess the time element with any accuracy. Judicial review procedures would not be able to satisfy the speed requirement.[175]

Mental Health Act 2001

The automatic review of the initial decision to detain will take place within 21 days of making the detention order.[176] There will be a right to review of each extension to a detention order, after three months, six months, one year and annually thereafter. The time scales are dependent on what Thorold refers to as a "high degree of administrative urgency" and it is impossible to predict its success.[177] The statutory time scales will provide for a speedy review as long as the necessary resources are provided to avoid a breach of Article 5(4). The English case, *R v. MHRT & Sec of State for Health ex parte KB & others,* dealt with this issue rather forcefully.[178]

Legal Aid

The Court affirmed the right to legal aid for adults with mental disorder in *Meygeri v. Germany.*[179] In addition, the initiative to obtain legal representation should not rest with the individual.[180] The necessity of having to meet particular criteria before being able to commence legal proceedings was addressed in *Winterwerp* where the Government claimed that those with substantial grounds for taking the case could have access to legal representation. The Court held that,

> having substantial and well founded grounds for denying the lawfulness of the detention cannot be a pre-condition for access to the proceedings contemplated

[175] *Sheehan v. Reilly* [1993] 2 IR 81 p89.
[176] Mental Health Act 2001, section 18(2).
[177] *Op. cit.,* 115.
[178] *R v. MHRT & Sec of State for Health ex parte KB ,MK, JR ,GM, LB, PD, & TB.*[2002] EWHC 639.
[179] (1993) 15 EHRR 584.
[180] *Winterwerp v. Netherlands* (1979) 2 EHRR 387.

> by 5(4) since this is precisely the issue the domestic courts should decide. ... Article 5(4) does not require that persons committed to care under the head of "unsound mind" should themselves take the initiative in obtaining legal representation before having recourse to a court.[181]

The failure to provide legal aid in judicial separation proceedings in *Airey v. Ireland* constituted a violation of Article 6.1.[182] The need for legal aid in situations involving the liberty of the individual is established following *Airey.* Thorold says that the need for legal aid in Article 5(4) proceedings in a mental health system "where the issue involves liberty and the applicant is presumed mentally disordered could reasonably be considered *a fortiori.*"[183] The applicant in *Meygeri v. Germany* complained that he had no lawyer at the review of his detention, despite having asked for one, and the Court held,

> ... where a person is confined in a psychiatric institution on the ground of the commission of acts which constituted criminal offences for which he could not be held responsible on account of mental illness, he should– unless there are special circumstances-receive legal assistance in subsequent proceedings relating to his detention. The importance of what is at stake for him-personal liberty-taken together with the very nature of the affliction- diminished mental capacity –compels this conclusion.[184]

Thorold interprets this statement as imposing a positive duty to ensure the patient is legally represented and not simply the duty to introduce a legal aid scheme.[185] The Court in *Winterwerp* recognised the right of access to court and to be heard in person or "where necessary, through some form of representation failing which, he will not have been afforded 'the fundamental guarantees of procedure applied in matters of deprivation of liberty.'"[186] In *Meygeri v. Germany* the Court seemed to place an obligation on the judicial body to ensure the patient is represented.[187]

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[181] *Ibid,* para 66.
[182](1980) 2 EHRR 305 para 26.
[183]*Op. cit.,* 115 p627.
[184] (1992) 15 EHRR 584 para 23.
[185] *Op. cit.,* 115.
[186] (1979) 2 EHRR para 60.
[187] (1992) 15 EHRR 584.

Irish law and legal aid

Mental Treatment Act 1945

Habeas corpus is the review system associated with the 1945 Act and provision is made for legal aid through the non-statutory Attorney General's Scheme.[188] The purpose of the scheme is to provide legal representation for persons who need it, but cannot afford it. The applicant must satisfy the court that he is unable to retain legal representation without the benefit of the Scheme.[189] It is not an alternative to costs and a person wishing to avail of it must do so at the commencement of the proceedings.

Mental Health Act 2001

The 2001 Act provides a right to legal representation for all tribunal hearings and where there is an appeal to the Circuit Court.[190] The Mental Health Commission will assign a legal representative to represent the patient unless he proposes to engage his own. This legal representation will be assigned for the tribunal hearing, but where other legal issues of concern arise, the patient will have to apply for legal aid under the Civil Legal Aid Act 1995. This system is seriously under-funded so that emergency family law issues get priority, leaving other issues on long waiting lists.

Information rights

The right to information regarding the detention is essential to the other rights provided within Article 5(4). These informational rights can be considered autonomously or can be subsumed in Article 5(4) in that a breach of Article 5(2) can mean a breach of Article 5(4) and vice versa.[191] In *X v United Kingdom,* the Court held that a person cannot make use of a right of review "unless he is promptly and adequately informed of the facts and legal authority relied on to deprive him of his

[188] www.irlgov.ie/attorney
[189] The right to legal representation will be available to all patients in relation to tribunal hearings in the 2001 Act.
[190] Mental Health Act 2001, section 17(1)(b).
[191] 4 EHRR 188 para 66.

liberty."[192]The improvement in information rights followed the decision in *X* in which the Court pointed out the need for the applicant to be appraised of the reasons for his recall to hospital. While the majority did not rule on this issue, the dissenting judgment of Evrigensis J. emphasised the importance of information,

> the right of an individual deprived of his liberty to be informed promptly of the reasons for his being taken into custody constitutes a safeguard of personal liberty whose importance in any system which is democratic and founded on the rule of law cannot be underestimated. Quite apart from enabling the person detained to make proper preparations for bringing legal proceedings in accordance with para 5.4 it is the embodiment of a kind of legitimate confidence in the relations between the individual and the public powers.[193]

He believed the right to information was so important that it should be considered autonomously under Article 5(2), not subsumed under Article 5(4).

Irish law and information

Mental Treatment Act 1945

The right to information about the limited safeguards and access to habeas corpus is not provided in the legislation. The provision of information is at the discretion of the Minister for Health and Children.[194] The impact of this deficiency is believed to have contributed to the low rate of applications for habeas corpus from patients detained under the 1945 Act. The failure to provide information is a clear breach of Article 5(4).

Mental Health Act 2001

The 2001 Act provides for the right to information about review of detention at the point of making the detention order or extension of the order.[195] The information also confirms the right to legal representation. However, there is no requirement to give the reasons for the detention, only information about the formal legal situation. This is

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[192] *Ibid.*
[193] (1981) 4 EHRR 188-dissenting judgment of Evrigensis J.
[194] Mental Treatment Act 1945, section 267.
[195] Mental Health Act 2001, sections 16 & 64(6)(b)(vii).

in breach of Article 5(2).[196] The 2001 Act includes a section that requires measures regarding information rights to be specified as a condition of registration of mental health centres.[197] This is one of the positive features of the 2001 Act.

De facto detention

The English Mental Health Act 1983 allows incapable patients to be admitted as informal patients and then prevented from leaving on the basis of their best interests. They are admitted and treated under the common law on grounds of necessity based on their best interests. Gostin refers to such patients as "confined in fact but not under the force of law."[198] The reason such patients are of concern to Article 5(4) is that if their hospital admission meets the criteria for deprivation of liberty under Article 5(1), they are entitled to the safeguards of Article 5(4). These issues were raised in *R v. Bournewood Community and Mental Health Trust ex parte L,* an English case, concerning an autistic man who had been admitted to a psychiatric unit informally and was later prevented from leaving or seeing his family.[199] The applicant in *L* sought judicial review of the decision to detain him and an order of habeas corpus and an action for false imprisonment. Because there was no legal formality in the admission, he was deprived of any challenge before a tribunal. Fennell questions how the common law detention can "accord with a procedure prescribed by law" if, as the Court says, "disregard of domestic law entails breach of the Convention." [200] Lord Steyn stated,

> The common law principle of necessity is a useful concept but it contains none of the safeguards of the 1983 Act. It places effective and unqualified control in the hands of the hospital psychiatrists ... Neither habeas corpus or judicial review are sufficient safeguards against misjudgements and professional lapses in the case of compliant incapacitated patients'.[201]

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[196] *Van der Leer v. Netherlands* (1990) 12 EHRR 567.
[197] *Ibid,* section 64(6)(b)(vii).
[198] Gostin, "Human Rights of Persons with Mental Disabilities The European Convention of Human Rights", (2000) 23(2) *Int.J.L.Psych.* p135.
[199] (1998) 3 All ER 289.
[200] *Op. cit.,* 20 p353.
[201] (1998) 3 All ER 289 p309.

He also said that the law "would be defective if it failed to provide adequate protective remedies to a vulnerable group of incapacitated mental patients."[202] Fennell refers to *The Good Practice Guidelines,* drafted after the case and not binding[203] which state,

> if the patient lacks capacity ,... it is particularly important that both clinical and social care requirements are considered and that account is taken of the patient's ascertainable wishes and feelings and the views of immediate relatives or carers on what would be in their best interests. It is good practice for the clinical team to arrange for such patients to be visited periodically by the hospital managers or by an independent advocate if no-one from outside the hospital would otherwise take an interest in their care.[204]

The jurisdiction of tribunals extends only to the detained, so if there is detention under the common law powers of necessity, it would appear to infringe not only Article 5(1), but also 5(4). The *de facto* detention of compliant incapacitated patients, highlighted in *Bournewood*, remains to be comprehensively addressed. The 1983 Act Code of Practice was amended in 1999 to acknowledge the compliant incapacitated patient by providing for limited safeguards with regard to information and consent to treatment.

This case was subsequently brought before the Strasbourg Court, in *HL v. United Kingdom,* which held that the applicant was detained and the requirements of Article 5(4) were not satisfied.[205] The Government had asserted that an action in judicial review (combined with a writ of habeas corpus) allowed an assessment of the essential conditions bearing on the lawfulness of his detention.[206] The Court held that Article 5(4) was breached as the applicant did not have a procedure available to him which satisfied the requirement of independent review of detention.[207] The decision in *Storck v. Germany* confirms that there is no diminution in the positive obligations on the state with regard to the detention of patients in private facilities.[208]

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[202] *Ibid.*
[203] *Op. cit.,* 20.
[204] NHS Circular HSC, 1998/122.
[205] (2005) 40 EHRR 32 5th October 2004 para 126. Because of the finding of a breach of Article 5(4), the Court held that it was not necessary to examine the applicant's additional submissions.,
[206] *Ibid,* para 124.
[207] *Ibid,* para 142.
[208] Application no 61603/00 16th June 2005.

Irish law and *de facto* detention

Mental Treatment Act 1945

Where voluntary admission under the 1945 Act results in the level of control necessary for deprivation of liberty, such patients are *de facto* detained and are subject to the requirements of Article 5(4) following the decision in *HL* and *Storck*.[209] Even though the 1945 Act expressly provides that when voluntary patients are not capable of being voluntary they must be detained or discharged, this provision is largely ignored. Compliant incapacitated patients are admitted to locked wards where their freedom and contacts are severely curtailed and in which the level of control is high enough to meet the criteria for deprivation of liberty. Where this is the case and there are no safeguards in place for these patients, the lack of formality in admission and the lack of access to review is in breach of Article 5(4) of the Convention.

Mental Health Act 2001

The situation under the 2001 Act is similar in this regard to the 1945 Act in that patients can be admitted voluntarily, but those who are compliant and incapacitated will have no safeguards. The fact that the word "voluntarily" is used may mean that greater care will have to be taken to ensure that such patients are truly voluntary and may result in an increase in the number of compulsory admissions. Where such patients meet the standard laid down in *HL* for deprivation of liberty, this Act is also in breach of Article 5(4) for failure to provide adequate safeguards.[210]

Discharge and delay

The problem of delayed discharge following a tribunal hearing arose in *Johnson v. United Kingdom*.[211] The Tribunal ruled that there was no mental illness, but because the applicant would be unable to live without the support of rehabilitation, he was granted a conditional discharge. The condition involved a requirement of residency in

[209] *HL v. United Kingdom* (2005) 40 EHRR 32.
[210] (2005) 40 EHRR 32.
[211] (1999) 27 EHRR 296.

a supervised hostel. Since there was no hostel accommodation available, he was sent to a less secure hospital and his conditional discharge was deferred. The applicant complained that the delay of four years for his release was a violation of Article 5(1). On the issue of admissibility, the Commission stated,

> It could, in principle, have been justified in deciding that a phased discharge was called for even if this entailed some period of deferment of the applicant's release. ... such a release cannot be indefinitely deferred ... The margin of appreciation afforded to the national authorities, allowing deferral of the discharge for a person who has been found to have recovered from mental illness, must be correspondingly limited and must be subject to strict procedural safeguards to ensure the discharge of such a person at the earliest opportunity.[212]

The Court held that domestic lawfulness was not adequate. There must be compliance with the Convention and conformity with Article 5(1) and the *Winterwerp* criteria. The Court stated, "... it does not automatically follow from a finding by the expert authority that when the mental disorder which justified a patient's confinement no longer persists that the latter must be immediately and unconditionally released into the community."[213] The Court believed such a requirement would be far too rigid an approach to the *Winterwerp* criteria. The Court cited *Luberti v. Italy* for the proposition that the responsible authority is entitled to exercise a similar measure of discretion in deciding on the right circumstances and interests at stake on the appropriateness of discharge.[214] Following the reasoning in *Luberti*, the Court stated,

> The authority should be able to retain some measure of supervision over the progress of the person once he is released into the community and to that end make his discharge subject to conditions. ... It is, however, of paramount importance that appropriate safeguards are in place so as to ensure that any deferral of discharge is consonant with the purpose of Article 5(1) and with the aim of the restriction in sub-paragraph (e) and, in particular, that discharge is not unreasonably delayed.[215]

The Court held that the failure of a mechanism by which a restricted patient could challenge a deferment that unreasonably delayed his discharge or a tribunal that could

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[212] Application no. 22520/93 May 18th 1995.
[213] *Johnson v. United Kingdom* (1997) 27 EHRR 296 para 61.
[214] (1984) 6 EHRR 440.
[215] (1997) 27 EHRR 296 para 63.

review its initial decision violated Article 5(1) and 5(4).[216] The Tribunal finding in *Johnson* implies that the patient is potentially eligible for discharge and this depends on adequate resources from the State. If properly resourced, then it is probable that a patient could be discharged when deemed well enough. Where this is not the case, patients will remain longer in hospital at further cost. The principle of the least restrictive alternative cannot be applied when resources are inadequate. The individual is kept as an inpatient in the face of being well enough for discharge which is probably, depending on the length of time, in breach of Article 5 and the *Winterwerp* principles.

State obligations in this regard were addressed in the English courts in *R v. Secretary of State for the Home Department and Secretary of State for Health, exp. IH,* [217] an English case, where the Court of Appeal held that, although *Winterwerp* required that patients who no longer had a mental disorder were entitled to discharge, that may be subject to conditions, the Convention does not bestow a right to discharge. The decision to discharge is subject to the availability of appropriate resources in the community, along with considerations of public safety and there is no duty on the State to ensure that appropriate community based facilities exist.[218] However, the postponement of discharge without any tribunal hearing for an unreasonably long period was a breach of Article 5(4), unless the postponement was reasonable and based on relevant considerations. Where the difficulty in meeting the conditions continues, it is open to the tribunal to adjourn in order to investigate the feasibility of options it proposed and, to ensure no inappropriate and impossible conditions are imposed. Where all efforts to meet conditions have failed and discharge deferred, the tribunal can, and should, monitor the situation and consider further deferral, amending or varying conditions, order conditional discharge with no specific conditions or continuing detention. The situation may not be resolved if the conditions cannot be met and the patient condemned to remain in hospital, despite not meeting the *Winterwerp* criteria. This case exposes the difficulties where resources are constrained, thereby counteracting the effect of the Convention.

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[216] *Johnson v. United Kingdom* (1997) 27 EHRR 296 para 66.
[217] [2002] EWCA Civ 646.
[218] *Ibid,* para 86-87.

Irish law and discharge and delay

Mental Treatment Act 1945

The 1945 Act provides for discharge on recovery of the patient with a notice requirement to that effect to any relatives as appropriate.[219] Other provisions permit discharge, following application by a relative or friend and, following a direction by the President of the High Court for a report from the Inspector of Mental Hospitals. Where there is concern regarding the propriety of the detention and following an application for two independent medical examinations, the Inspector can investigate.[220] The 1945 Act provides for two forms of temporary discharge, absence on leave which can extend to 48 hours and absence on trial which can extend to 90 days, following which a patient can be re-admitted or discharged.[221] The Department of Health *Guidelines on Good Practice and Quality Assurance in Mental Health Services* advise that well planned discharge policies and procedures should be in place and, where necessary, packages of care should be available.[222] Where community facilities are not available, the patient may be kept in hospital for longer than is necessary, in breach of the *Winterwerp* requirements.

Mental Health Act 2001

The 2001 Act provides that the patient must be discharged where he is no longer suffering from a mental disorder and in reaching this decision, the Act provides,

> **Section 28-**
> (1) Where the consultant psychiatrist responsible for the care and treatment of a patient becomes of opinion that the patient is no longer suffering from a mental disorder, he or she shall by order in a form specified by the Commission revoke the relevant admission order or renewal order, as the case may be, and discharge the patient.

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[219] Mental Treatment Act 1945, section 218.
[220] *Ibid,* sections 220, 222, 240, 241.
[221] *Ibid,* sections 203 & 204.
[222] Department of Health and Children, *Guidelines on Good Practice and Quality Assurarnce in Mental Health Services,* Government Publications, Dublin, 1998.

(2) In deciding whether and when to discharge a patient under this section, the consultant psychiatrist responsible for his or her care and treatment shall have regard to the need to ensure:
(a) that the patient is not inappropriately discharged, and
(b) that the patient is detained pursuant to an admission or a renewal order only for so long as is reasonably necessary for his or her proper care and treatment.

Whether "inappropriate discharge" might embrace permissible delay due to lack of appropriate facilities remains to be seen. Delayed discharge is not expressly permitted in the 2001 Act and this will necessitate the State providing adequate resources to ensure that services are available as soon as the patient is ready to be discharged, a lofty ideal in today's resource starved services. The meaning of "proper care" is also a difficult one if the patient no longer has a mental disorder and where the appropriateness of discharge is in issue. This means that the consultant psychiatrist has a far greater degree of discretion at his disposal than the tribunal. The ambiguity in the scope of this discretion needs to be addressed. The tribunal does not have any express discretion to postpone discharge pending a service plan being in place, but *Johnson v. United Kingdom* confirmed that immediate discharge is not a right in relation to restricted patients.[223] This case is not a decision of the Strasbourg Court and may not have such persuasive authority. It may not be practical in all circumstances to have immediate discharge, provided the delay is reasonable and justifiable. The provision permitting extension of the time limit for a decision by the tribunal does not expressly provide for delayed discharge, but the use of such provision would, in effect, postpone discharge.[224] The margin of appreciation afforded to national authorities may not apply where there is no express provision for delayed discharge in the 2001 Act.

There is a requirement to notify the discharge to the Mental Health Commission and, where appropriate, the housing authority and relevant health board.[225] This in itself is not an obligation to provide services. Some restricted patients have languished in hospitals for years as is evident from the Report of the Inspector of Mental Hospitals 2003, where particular attention is paid to such patients in the Central Mental

[223] (1997) 27 EHRR 296.
[224] Mental Health Act 2001, section 18(4).
[225] *Ibid,* section 28(4).

Hospital.[226] Some may be waiting for a less secure hospital place, but there is no power to force the provision of an appropriate facility.

Conclusion

This chapter endeavoured to examine Ireland's compliance with Article 5(4) and the results indicate that there are serious failures to comply with the Convention under the 1945 Act. Most significant are the exclusion of wards of court from the minimal safeguards in the Act and the reliance on habeas corpus and judicial review as a means of satisfying Article 5(4) requirements.[227] While habeas corpus is not regarded as adequate in providing the required substantive review of initial and continuing detention, it is likely to satisfy the requirement of speed under Article 5(4) and in emergencies. The actual use of habeas corpus in Ireland was examined in a study that confirmed a low rate of applications from patients in local psychiatric hospitals when compared with patients in the high security hospital and with prisoners. The results revealed a widespread failure to inform patients about this right and there was some evidence that even staff were not aware of habeas corpus. Access to habeas corpus as the only form of independent review under the 1945 Act is dependent on having information about the procedure and, without information, this right to have recourse to the courts cannot be availed of by patients, particularly those in the local psychiatric hospitals. The findings in this study, if taken together with the fact that there is no system of independent review under the 1945 Act, creates a bleak picture regarding rights to review of detention.

The alternative remedy is judicial review. It is clear that the approach of the Irish courts to this provision is restrictive and would not meet the requirement of substantive review. In addition, it would not satisfy the requirement of speed under Article 5(4). The 1945 Act does not provide any right to information necessary to enable a challenge to the legality of the detention in breach of Article 5(4) requirements.

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[226] *Op. cit.*, 98.
[227] *X v. United Kingdom* (1981) 4 EHRR 181.

Both statutes may well breach Article 5(4) where compliant incapacitated patients are deprived of their liberty based on the decision in *HL v. United Kingdom* and have no access to review.[228] The 2001 Act will largely satisfy the requirements of Article 5(4) with regard to review of detention by putting in place an independent review mechanism. Again, the exclusion of wards of court will breach Article 5(4). There are concerns regarding aspects of the tribunal system, such as the discretion regarding the compliance with procedures in the detention order. The restriction of the tribunal with regard to discharge may have an unforeseen impact on the patient and it is predictable that the rigidity of this approach will cause difficulties when resources do not match patients' needs. The time scales are sufficiently limited and will need to be resourced adequately to be fulfilled. Legal representation will also be provided before the tribunal and on appeal to the Circuit Court. However, the burden of proof is placed on the patient in the appeal and this is clearly in breach of the Convention in light of the decision in *Reid v. United Kingdom.*[229] The right to information enabling a challenge to the legality of detention is provided in the 2001 Act, thereby complying with Article 5(4). However, this right to information does not entitle the patient to information concerning the reasons for his detention and, to this extent, will breach Article 5(2).

The failure of the 1945 Act to comply with Article 5(4) is clearly outlined in this chapter and highlights the need for the urgent introduction of the 2001 Act. The 2001 Act provides for a review of its operation in 2007 so that the deficiencies in this Act with regard to Article 5(4) can be addressed.[230]

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[228] (2005) 40 EHRR 32.
[229] (2003) 37 EHRR 9.
[230] Mental Health Act 2001, section 75.

Chapter 3

ARTICLE 8 AND THE RIGHT TO RESPECT FOR PRIVATE AND FAMILY LIFE, HOME AND CORRESPONDENCEUNDER IRISH LAW

Introduction

This chapter considers the nature of the right to respect for private life, family life, home and correspondence under Article 8 and the enforcement of these rights in Irish law. The main focus for consideration is the right to respect for private life, particularly the right of self-determination in relation to consent to treatment for mental disorder. The safeguards for consent to treatment in both the 1945 Act and the 2001 Act are examined in order to assess the adequacy of Irish law having regard to Article 8 requirements. Incapacitated voluntary patients' rights to self-determination are considered in light of the adequacy of common law powers to treat without consent, particularly following the decisions in *HL v. United Kingdom* and *Storck v. Germany.*[1] Related to the right of self-determination is seclusion, which involves a significant interference with Article 8 rights and advance directives, which are at the opposite end of the spectrum in support of such rights. These issues are the subject of law reform in many jurisdictions in an effort to uphold rights to dignity, autonomy and self-determination. Other aspects of the right to respect for private life, such as the right to confidentiality and proxy decision-makers, as well as the right to respect for family life, home and correspondence, are considered.

Article 8 provides:

> 1. Everyone has the right to respect for his private and family life, his home and his correspondence.
> 2. 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.

[1] (2005) 40 EHRR 32, Application no. 61603/00 16th June 2005.

The object of Article 8 is to protect the individual against arbitrary interference by public authorities.[2] The basis for the Article is the protection of this private sphere from interference, except where it is lawful and justified as necessary by reference to paragraph 2. Such interference would be considered necessary where it corresponds to a pressing social need, is proportionate to the legitimate aim pursued and if the reasons presented by the national government are logical and sufficient. The obligation in Article 8 refers to the right "to respect for," not the *right to,* private and family life, home and correspondence.

Harris refers to the dual focus on the state with regard to aspects of Article 8 - on the one hand the need to control state interference in "central matters" of inter-personal relationships "where the principal concern of the right-holder is to keep the state out".[3] The other role is to protect the individual's right to physical and psychological integrity, the right to mental stability and privacy rights that include self-determination in relation to medical treatment and confidentiality. There is often a tension between the need to balance these competing requirements, particularly for people with mental disabilities where autonomy rights sometimes clash with welfare rights.

Private life

The right to respect for private life under Article 8 includes a person's physical and psychological integrity. It is primarily intended to ensure development, without outside interference, of the personality of each individual in his relations with other human beings.[4] The right can embrace aspects of an individual's physical and social identity.[5] Article 8 also protects the right to establish and develop relationships with other human beings and the outside world.[6] The ability to conduct one's life in a manner of one's own choosing may also include the opportunity to pursue activities perceived to be physically or morally harmful, or of a dangerous nature for the

[2] *Glaser v. United Kingdom* (2001) 33 EHRR 1 para 63.
[3] Harris, O'Boyle & Warbrick, *Law of the European Convention on Human Rights, Butterworths,* London, 1995, p353.
[4] *X and Y v. Netherlands*, (1985) 8 EHRR 235 para 22.
[5] *Mikulić v. Croatia*, Application no. 53176/99, para 53.
[6] *Bensaid v. United Kingdom* (2001) 33 EHRR 205 para 47.

individual concerned.[7] In *Bensaid v. United Kingdom*, involving the deportation of a person with schizophrenia, the Court stated,

> Private life is a broad term not susceptible to exhaustive definition. The Court has already held that elements such as gender identification, name and sexual orientation and sexual life are important elements of the personal sphere protected by Article 8. Mental health must be regarded as a crucial part of private life associated with the aspect of moral integrity.[8]

The right to dignity as an aspect of private life is regarded as fundamental under the Convention.[9] This dignity right in Article 8 has been interpreted as including the preservation of mental stability.[10] The Court's case law does not exclude treatment which does not reach the level of severity to breach Article 3, but which may breach Article 8 in its private-life aspect where there are sufficiently adverse effects on physical and moral integrity.[11] This does not mean that every act or measure which adversely affects moral or physical integrity will interfere with the right to respect for private life guaranteed by Article 8.[12] The Court, in *Bensaid v. United Kingdom,* held that there was not enough evidence that the applicant's moral integrity would be substantially affected to engage Article 8. Even if the deportation did affect the applicant's private life, this interference complied with Article 8(2) as being in accordance with the law to protect the economic well-being of the country, the prevention of disorder and crime, as well as being "necessary in a democratic society" for those aims.

State obligations regarding the moral and physical integrity of the person were held, in *Ranninen v. Finland,* to extend to situations of deprivation of liberty which can include seclusion of a patient.[13] The English Court of Appeal has applied *Ranninen* in holding that the practice of seclusion could engage Article 8 and that the Mental Health Act Code of Practice ought to be followed, unless there was a good reason to the contrary, in order to give the necessary degree of predictability to meet the

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[7] *Pretty v. United Kingdom* (2002) 35 EHRR 1 para 62.
[8] *Bensaid v. United Kingdom* (2001) 33 EHRR 205 para 47, *Dudgeon v United Kingdom* 4 EHRR 149 para 52.
[9] *Pretty v. United Kingdom* (2002) 35 EHRR 1 para 63.
[10] *Bensaid v. United Kingdom* (2001) 33 EHRR 205 para 49.
[11] *Ibid.*
[12] *Ibid,* para 46.
[13] *Ibid,* para 63.

requirements of Article 8(2).[14] In *X v. Austria,* the Commission stated that "compulsory medical intervention, even if it is of minor importance, must be considered as an interference with [the right to respect for private life]."[15]

The scope of the state's positive obligation under Article 8 to ensure the right to physical and moral integrity of citizens extends to a duty to supervise and control private psychiatric institutions. The applicant, in *Storck v. Germany,* had been admitted to a private psychiatric clinic, initially aged 15 years, for a seven month period between 1974-1975. She was readmitted again, from July 1977-April 1979, and placed in a locked ward without any judicial order as the clinic had no authority to admit detained patients. She was medically treated against her will and the Court stated that "even a minor interference with the physical integrity of an individual must be regarded as an interference with the right of respect for private life if it is carried out against the individual's will."[16] This may indicate the requirement of resistance, but in an earlier decision, *HL v. United Kingdom,* the Court stated,

> The right to liberty in a democratic society is too important for a person to lose the benefits of Convention protection simply because they have given themselves up to detention, especially when they are not capable of consenting to, or disagreeing with, the proposed action.[17]

The Court strongly supported different treatment of a compliant incapacitated patient compared to a capable consenting patient in relation to deprivation of liberty under Article 5. Fennell argues that the same principle must apply to interferences with physical integrity and states that, "[I]t is too important to be lost simply because a person has given themselves up to the intervention, especially if they lack capacity to consent."[18] Where there is complete control over imposing treatment, such as strong medication or ECT, Fennell submits that this would effectively lean towards a

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[14] *Munjaz* v. *Mersey Care National Health Service Trust & Others* [2003] EWCA Civ 1036 and *S* v. *Airedale National Health Service Trust & others* Court of Appeal (Civil Division): Lord Woolf MR, Hale and Latham L.J. [2003] EWCA Civ 1036.
[15] (1980) DR 154 para 156.
[16] Application no. 61603/00 para 143.
[17] (2005) 40 EHRR 32 para 90.
[18] Fennell P., "The Mental Capacity Act 2005, the Mental Health Act 1983, and the Common Law". (2005) *Journal of Mental Health Law* pp163-168.

deprivation of liberty necessitating appropriate safeguards.[19] The Court held that her right to personal integrity under Article 8 had been infringed as there was a lack of state supervision of the actions of private institutions.

Article 8 is a qualified right which may be interfered with provided that the interference is justified as being in accordance with the law, for a legitimate aim and necessary in a democratic society.[20] Compulsory treatment will be justified if it is in accordance with domestic law which must be predictable, having regard to the legitimate aim of the treatment, in order to give the person adequate protection against arbitrary interference.[21] It must pursue a legitimate aim such as the protection of health, the prevention of crime or the protection of the rights of others. The requirement that the interference is necessary in a democratic society means that it fulfils a pressing social need and is proportionate to the legitimate aim pursued. The requirement of proportionality is satisfied where the means used to achieve the aim are not excessive. The state is permitted a margin of appreciation where a range of discretion is available to states to make a decision as to which interests fall to be protected under health, or under the rights or freedoms of others.

Private life and the right to self-determination

The very essence of the Convention is respect for human dignity and human freedom. In *Pretty* v. *United Kingdom* and *Glass* v. *United Kingdom,* the Court held that Article 8 addresses quality of life issues and includes the right to self-determination in regard to medical treatment.[22] In *Pretty v. United Kingdom* the applicant argued that, while the right to self-determination ran like a thread through the Convention as a whole, it was Article 8 in which that right was most explicitly recognised and guaranteed. The Court stated that, although no previous case had established any right to self-determination as such as being contained in Article 8, it considered that the notion of

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[19] Bellhouse et al, "Capacity–based mental health legislation and its impact on clinical practice 1) admission to hospital," (2003) *Journal of Mental Health Law* pp9-24 and Bellhouse et al, "Capacity–based mental health legislation and its impact on clinical practice 2) treatment in hospital," (2003) *Journal of Mental Health Law* pp24-38 for examination of capacity assessments applied to (1) admission and (2) treatment.
[20] *Munjaz* v. *Mersey Care National Health Service Trust &Others*[2003] EWCA Civ 1036.
[21] *Malone v. United Kingdom* (1985) 7 EHRR 14 par 68.
[22] (2002) 35 EHRR 1 para 65 (2004) 39 EHRR 15.

personal autonomy is an important principle underlying the interpretation of its guarantees.[23] The right to autonomy is expressed as a fundamental human right and is recognised by Article 8.

> ... the personal autonomy protected by Article 8 means that in principle it is for the competent patient, and not his doctor, to decide what treatment *should or should not* be given in order to achieve what *the patient* believes conduces to his dignity and in order to avoid what *the patient* would find distressing.[24]

Refusal to accept a particular treatment might inevitably lead to death, but the imposition of medical treatment, without the consent of a mentally competent adult patient, would interfere with a person's physical integrity in a manner capable of engaging the rights protected under Article 8(1) of the Convention.[25] Where consent is normally required, as in medical treatment, action without consent will not be an interference if the state can convincingly show that it was necessary and the individual was not in a position to give informed consent. This arose in *Herczegfalvy v. Austria,* where the Court gave,

> Decisive weight ... to the lack of specific information capable of disproving the government's opinion that the hospital authorities were entitled to regard the applicants' psychiatric illness as rendering him entirely incapable of taking decisions for himself.[26]

The Court had earlier decided that the treatment of the applicant was in accordance with psychiatric principles generally accepted at the time.[27] Harris refers to the danger that any "irrational" unwillingness to consent will be classed as a failure to consent at all, thereby undermining the individual's right to exercise his rights as he sees fit.[28] This may seem contrary to efforts to enable decision-making wherever possible.

There is strong rhetoric concerning the right to autonomy and self-determination which is upheld across many jurisdictions, including the United States, Canada, Australia and England, and its importance is highlighted worldwide in judicial

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[23] *Ibid,* para 61.
[24] *Burke v. GMC & DRC and OS* (2004) EWHC 1879 para 131.
[25] *Ibid,* para 63.
[26] *Herczgefalvy v. Austria* (1992) 15 EHRR 437 para 83
[27] See chapter 4 for full discussion of this case.
[28] *Op. cit.,* 3 p 338.

statements.[29] The legality of any intervention to treat an individual rests on the existence of consent, or where the individual is incapable of consenting, some other lawful authority. Any interference with this right which impacts on both private and family life in Article 8(1) must, according to *Herczgefalvy v. Austria*, "be convincingly shown to be necessary," must be justifiable as being in accordance with the law, pursue a legitimate aim and be proportionate to the achievement of that aim. [30]

The Court in *R (on the application of N) v. M,* an English case, said that what was convincingly shown to be medically necessary would depend on a number of factors: the certainty of mental disorder and its seriousness, the risks to others, the potential alleviation of the condition by the treatment and the extent of alleviation, and the severity of the adverse consequences for the patient.[31] Where treatment is administered against the will of the patient, the phrase "in accordance with the law" in Article 8(2) means that: the "best interests test" must be satisfied, that the treatment must be in accordance with a responsible and competent body of professional opinion and no less invasive treatment achieving the same results is available.

Under the common law, the doctrine of necessity provides the legal basis for the treatment and care of voluntary patients who are compliant but incapacitated.[32] In English law, when a person lacks capacity, for whatever reason, to take decisions about medical treatment, it is necessary for other persons with appropriate qualifications to take that decision for him.[33] The principle of necessity applies and the requirements of the principle are that there must be a necessity to act when it is not practicable to communicate with the assisted person and that the action taken must be what a reasonable person would in all circumstances take, acting in the best interests of the assisted person.[34] Best interests have been subjected to a double test: the *Bolam* "not negligent" test, together with a separate duty to act in an incapacitated

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[29] *Schloendorff v. Society of New York Hospitals* [1914] 211 NY 125,. *Malette v. Shulman* 67 DLR (4th) 321 at 336, *Department of Health v JWB & SMB* (1992) 66 ALJR 300 at 317, *Re T* [1993] Fam 95 p102.
[30] (1992) 15 EHRR 437 para 82.
[31] [2002] EWCA Civ 1789 para 19.
[32] *Re F* [1990] 2 AC 1, *R v. Bournewood ex parte L* [1998] 3 ALL ER 289.
[33] *Re F (Mental Patient: Sterilisation)* [1990] 2 A.C. 1 para 55.
[34] *Ibid*, para 75.

person's best interests.[35] In *Re A (Male Sterilisation),* Butler-Sloss P. said that best interests encompasses "medical, emotional and all other welfare issues."[36] An evaluation of best interests would involve a balance-sheet approach whereby the actual and potential benefits would be balanced against actual and potential dis-benefits along with the gains and losses from each option proposed by the doctor. In cases requiring court involvement, these would be presented as options to the judge who would make the final decision.[37]

Irish law and the right to self-determination

Constitutional law

Rights to privacy, autonomy and bodily integrity are recognised as unenumerated rights under the Irish Constitution.[38] In *Ryan v. Attorney General* the Supreme Court held that the right to bodily integrity existed as an unspecified right in the Constitution in Article 40.3.[39] Eventually, this was broadened into a more general right not to have one's health endangered by the actions of the State.[40] One of the unspecified rights of the person under the Constitution is the right to be treated with dignity, which is progressively diminished by increasingly invasive medicine.[41] The right to refuse medical treatment is recognised as part of the right to privacy and bodily integrity contained in Article 40.3.1. In *In re a Ward(Withdrawal of Medical Treatment),* the right to autonomy in the context of medical treatment, as a related right to privacy, was given strong support.[42] In that case, the Irish courts addressed, for the first time, issues around incapacity and consent and said that the constitutional rights of every person included the right to privacy, autonomy and self determination.[43] These rights were held to apply to people without capacity to consent equally with those who could consent. The Supreme Court held that to rule otherwise would "differentiate between

[35] *Bolam v. Friern Hospital Management Committee* [1957] 2 All ER 118.
[36] [2000] 1 FLR 549.
[37] *Ibid,* para 560.
[38] *Ryan v. Attorney General* [1965] IR 294. *Kennedy & Arnold v. Ireland* [1987] IR 587.
[39] [1965] 1 IR 294.
[40] *State (C) v Frawley* [1976] IR 365.
[41] *In re a Ward(Withdrawal of Medical Treatment)*[1995] 2 ILRM 401.
[42] [1995] 2 ILRM 401 and Hogan & Whyte, *JMKelly The Irish Constitution* (2003) para 7.3.130.
[43] *In re a Ward (Withdrawal of Medical Treatment)* [1995] 2 ILRM 401 p404.

the well and the infirm."[44] The position regarding the right to consent to treatment was outlined by Denham J.,

> Medical treatment may not be given to an adult person of full capacity without his or her consent. ...The consent which is given by an adult of full capacity is a matter of choice. It is not necessarily a decision based on medical considerations. Thus, medical treatment may be refused for other than medical reasons, or reasons most citizens would regard as rational, but the person of full age and capacity may make the decisions for their own reasons. ... The requirement of consent to medical treatment is an aspect of a person's right to bodily integrity under Article 40.3 of the Constitution....[45]

The Court held that mental incapacity did not result in the diminution of personal rights under the Constitution, including, the right to life, to bodily integrity, to privacy, and the right to refuse medical care or treatment.[46] The requirements of the common good, public order or morality in the particular case did not require restriction of the ward's rights.[47] The Court stated that these rights are administered in a different way, in this case by the Court acting as proxy decision-maker.[48] Denham J. stated,

> If the ward were of full capacity ... she would be required to consent before the current medical treatment were to be given to her. She is unable to do so. The issue then is whether anyone else can make the decision for her.[49]

The test applied in the case was whether it was in the best interests of the ward that her life should be prolonged by continuance of the particular medical treatment she was receiving. This test is consistent with that used by the wardship jurisdiction being essentially paternalistic and probably incompatible with the value of autonomy. This aspect was counteracted somewhat by the Court's reliance on its substituted judgment for the ward's wishes, as far as these were ascertainable. While the Court acknowledged the wishes of her family in supporting the withdrawal of treatment, the Court had the power to make the final decision in the case of a ward of court.[50] The

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[44] *Ibid,* p431.
[45] *Ibid,* p454.
[46] [1995] 2 ILRM 401 p 404.
[47] *In re a Ward of Court (Withdrawal of Medical Treatment)* [1995] 2 ILRM 401 at p428, [1996] 2 IR 79.
[48] *Ibid.*
[49] *Ibid,* p456.
[50] *Ibid,* p454.

Supreme Court reaffirmed the commitment to autonomy and self-determination in *North Western Health Board v. HW & CW,* acknowledging that a competent adult can refuse treatment for reasons that include non-medical reasons that may be regarded by others as irrational.[51] The *parens patriae* jurisdiction of the High Court was used instead of the Constitution in directing treatment, in *JM v. St. Vincent's Hospital,* for a patient who was incapable of consenting. The President of the High Court held that the refusal of treatment prior to incapacity was not a "clear final decision," thereby justifying the intervention by the High Court.[52]

Common law

Arising from principles of autonomy and self-determination and in compliance with Article 8, the common law in Ireland provides that the consent given by an adult of full capacity is a matter of choice. The decision may not be based wholly on medical considerations. Treatment can be refused for other than medical reasons, even those that most citizens would not regard as rational.[53] Adults who are competent are entitled to make decisions without any consultation with others. The voluntary refusal of medical treatment by an adult of full capacity who has been informed of all the issues is determinative. The rare exceptions applying to this position are in relation to contagious diseases and to emergency treatment.

The duty of disclosure regarding the risks or side-effects of treatment is similar to the duty of care in diagnosis and treatment and is an essential component of decision-making. Irish law is somewhat unclear on the requirements for informed consent. The standard required appears to be the *Bolam* standard with the proviso that if the court is not happy with this standard it can set a higher standard.[54] The *Bolam* standard requires that actions taken are in accordance with a practice accepted at the time by a responsible body of medical opinion skilled in the particular form of treatment in

[51] *North Western Health Board v HW & CW* Unreported Supreme Court, 8th November 2001.
[52] [2003] 1 IR 321.
[53] *In re a Ward(Withdrawal of Medical Treatment)* [1996] 2 IR 79 p156. An irrational decision has been interpreted in English law as "a decision which is so outrageous in its defiance of logic or accepted moral standards that no sensible person who had applied his mind to the question to be decided could have arrived at it." *Re MB* [1997] 2FLR 426.
[54] *Bolam v. Friern Hospital Management Committee* [1957] 2 All ER 118.

question.[55] In *Walsh v. Family Planning Services*, involving informed consent to elective treatment, the Supreme Court applied the test laid down in *Dunne v. National Maternity Hospital,* which provides that the doctor is negligent where he is "guilty of such failure as no medical practitioner of equal specialist or general status and skill would be guilty of if acting with ordinary care."[56] While this aspect is similar to *Bolam,* the Supreme Court did not adopt the *Bolam* test entirely, as it added a further requirement that the doctor would not be protected by a general and approved practice if this practice had inherent defects that would be obvious to anyone giving it due consideration. The disclosure of risks of treatment was considered to be a matter for professional judgment except where the disclosure of a 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.[57] However, in *Geoghegan v. Harris,* the High Court changed the focus away from the medical standard to the needs of the reasonable patient to have information on the material risk of severe pain resulting from particular treatment, regardless of statistical frequency.[58] This decision has not been appealed, so it is likely that the uncertainty of *Walsh* will remain authority for the time being despite some commentators taking for granted that informed consent is part of Irish law.[59]

Where someone does not have capacity to decide and the treatment involves an emergency, or is medically necessary, doctors carrying out the treatment will be justified by the common law doctrine of necessity based on what is regarded as the "best interests" of the person according to the standard of a responsible body of professional opinion, the *Bolam* standard, or in Ireland, the *Dunne* standard.[60] The Supreme Court, in *In re a Ward (Withdrawal of Medical Treatment),* weighed a number of factors in the balance in arriving at a decision on best interests.[61] The Court took account not only of medical best interests, but a very broad range of factors, including the ward's life history, the views of family and carers and spiritual aspects

[55] *Ibid.*
[56] [1989] IR 91 p136.
[57] [1992] 1 IR 496, [1989] IR 91.
[58] *Geoghegan v. Harris* [2000] 3 IR 536.
[59] Byrne & Binchy, *Annual Review of Irish Law,* Round Hall Press, Dublin, 1997.
[60] *Bolam v. Friern Hospital Management Committee* [1957] 2 All ER 118 *Dunne v. National Maternity Hospital* [1989] IR 91.
[61] [2000] 3 WLR 1288.

of her life.[62] The common law is different in England and requires a two-stage step, whereby the doctor proposes a number of options for treatment in the patient's best interests in accordance with a responsible body of medical opinion. The judge then makes the decision as to which of the proposed treatments is in the patient's best interests.[63] The common law in England reflects a more exacting requirement in decisions on best interests.

Incapacity legislation

An adult who is of unsound mind and incapable of managing himself or his affairs may be made a ward of court and all rights to self-determination are lost.[64] The President of the High Court will then make all serious medical treatment decisions for the individual whose welfare is the paramount consideration.[65] The "Committee of the Person" (the person to whom the ward's affairs are committed) will take minor decisions, including minor medical decisions of an everyday nature.[66] The High Court has exclusive jurisdiction to grant or withhold consent to the treatment of a ward of court, subject to the principle that, in an emergency, a doctor is entitled to take urgent action to preserve life and health. This system does not support the right to self-determination or autonomy, is disproportionate to the aims of the protective jurisdiction and is likely to breach Article 8 in its private life aspects.[67] In *JM v. Board of Management of St. Vincent's Hospital,* the Court used its *parens patriae* jurisdiction to give consent to life-saving medical treatment on behalf of a patient in a coma where prior refusal on religious grounds was deemed unclear.[68] In this case, the patient had refused the proposed treatment prior to becoming incapable, so there were uncertainties regarding management as it did not fit the profile of the incapacitated person needing emergency treatment. The gap in Irish law for this kind of situation means that the system of wardship is the only option for proxy decision-making. The

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[62] *In re a Ward of Court(Withdrawal of Medical Treatment)* [1995] 2 ILRM 401 pp463-465.
[63] *Re S (Sterilisation)*[2000] 2 FLR 389.
[64] Lunacy Regulation (Ireland) Act 1871 and in the Courts (Supplemental Provisions) Act 1961. The procedure is set out in Order 67 of The Rules of the Superior Courts 1986. See chapter 6 for full discussion of wardship.
[65] *JM v. St.Vincent's Hospital* [2003] 1 IR 321. Lunacy Regulation (Ireland) Act 1871 (1871 Act) and in the Courts (Supplemental Provisions) Act 1961 (1961 Act). The procedure is set out in Order 67 of The Rules of the Superior Courts 1986 (1986 Rules).
[66] *In re an Application by the Midland Health Board* [1988] ILRM 251. See p138 this chapter.
[67] See chapter 6 for full account of the wardship system.
[68] [2003] 1 IR 321.

High Court will, in these circumstances, rely on the opinion of doctors to provide evidence of the patient's incapacity and proceedings will have to be instigated in order to ensure the intervention is lawful. The Law Reform Commission is examining the introduction of a comprehensive framework dealing with proxy decision-making system for incapacitated adults.[69]

Advance Directives

The right to self-determination can be expressed in an advance directive under the common law where a mentally capable person makes a decision regarding future treatment in anticipation of incapacity. In the English case, *Re C (Adult: Refusal of Medical Treatment),* the Court of Appeal accepted that where the individual had capacity to make an advance directive at the time it was made, that directive remains binding and effective even where there is subsequent loss of capacity.[70] There is no Irish decision on the issue, but the Supreme Court, in *In re a Ward (Withdrawal of Medical Treatment),* indicated that the wishes of a person were relevant to a court decision permitting withdrawal of treatment.[71] Similarly, in *JM v. St Vincent's Hospital* the President of the High Court seemed to adopt a form of substituted judgment test in stating that he did not regard the patient's pre-coma decision as having been a final one and considered that it was based primarily on her wish to please her husband who wanted her to have the treatment.[72] The Power of Attorney Act 1997, which provides for an enduring power of attorney, does not include medical treatment decisions to be made by the attorney on the onset of incapacity.[73] Even if such powers were extended to cover health care decisions, this would not provide a solution for adults who never had capacity to execute such a power, or did not execute a power when they had the capacity to do so. The Law Reform Commission includes these powers in their recommendation on capacity legislation and proposes to introduce assisted and substitute decision–making regimes.[74] The English Mental

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[69] Law Reform Commission, *The Law and the Elderly* (LRC CP 23-2003), and *Vulnerable Adults and the Law* (LRC CP 37 2005).
[70] [1994] 1 All ER 819. See also *Re T (Adult Refusal of Treatment)* [1993] Fam 95, *Re AK (Medical Treatment: Consent)* [2001] 1 FLR 129, *HE v. A Hospital NHS Trust* [2003] 2 FLR 408.
[71] [1995] 2 IR 79.
[72] [2003] 1 IR 321.
[73] See chapter 6 for discussion of enduring power of attorney.
[74] Law Reform Commission, *Consultation Paper on Vulnerable Adults and the Law* (LRC CP 37-2005).

Capacity Act 2005 provides for recognition of advance decisions to refuse treatment which have specific formalities attached, including an express statement in writing that the decision is to apply "even if life is at risk."[75] The position in English law is that an advance directive refusing specific psychiatric treatment may be overridden if the patient is subject to detention under mental health legislation and treatment can be imposed using the powers of such legislation.

Mental health legislation

Mental Treatment Act 1945

The Mental Treatment Act 1945 contains no express provision for personal or proxy consent to treatment, nor is there any judicial decision on the matter. One of the assumptions about the legal basis for compulsory treatment of detained patients is that compulsory admission incorporates a right to compulsorily treat the patient. This assumption has never been challenged in the Irish courts. Jacob, writing in the 1970s about the assumption that compulsory admission impliedly authorised compulsory treatment under the English Mental Health Act 1959, argued that the assumption of legality of treating a detained patient without consent, and differently from voluntary patients, is invalid.[76] He argued that there was no express power in the 1959 Act to treat detained patients compulsorily, because the Act is relevant to admission and discharge only. These arguments apply equally to the 1945 Act, which has no express provision granting authority to the hospital staff to impose treatment. One of the problems is that the language used in the 1945 Act is of a paternal character and the Act was primarily intended to provide for the "prevention and treatment" of mental disorders. To this extent, the presumption is understandable, even if unacceptable.[77] The legislation was passed at a time when such assumptions were made in the 1940s and 1950s and issues of autonomy were not considered. The presumption of lack of capacity for detained patients is strengthened by the failure to differentiate between those patients who have capacity and those who do not, as there is no capacity assessment and treatment is imposed on the basis of the legal status of the patient.

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[75] Mental Capacity Act 2005, sections 24-26.
[76] Jacob J., "The Right of the Mental Patient to his Psychosis", (1976) 39 *Mod. L. Rev.* 17.
[77] *In re Philip Clarke* [1950] IR 235.

The wording in the 1945 Act leading to treatment may provide some clues as to the assumption that treatment can be given based on detention status. The "person of unsound mind" is a category where the recommendation from the certifying doctor is for "admission, care and treatment," thereby linking the compulsory admission and treatment.[78] The word "treatment" is not defined in the 1945 Act and the presumption again is that all forms of treatment can be administered without consent. There is no statutory definition of "unsound mind," but based on various statutory references, in my opinion, it means mental illness and an inability to care for oneself and one's property, as in wardship, and is therefore closely related to being incapacitated.[79]

There are no safeguards provided in the legislation where treatment is given to a resisting patient. In *SC v. Smith & Others,* the Supreme Court warned that in the exercise of powers under the 1945 Act, the clinical director is required to act in accordance with the principles of constitutional justice and to be conscious not only of the power and discretion in the Act, but also of the constitutional rights of the person.[80] Such rights include the right to bodily integrity. In contrast to treatment, the 1945 Act provides safeguards around the use of "bodily restraint" and provides that it can only be used "if necessary for the purpose of medical or surgical treatment or to prevent the person injuring himself, or others".[81] However, the legislators did not extend this necessity requirement to other forms of treatment, such as electro-convulsive therapy, which was used frequently at that time.

There are two categories in temporary detention, one comprising those persons admitted for mental illness and the other comprising people admitted for addiction. The criteria for admission of the first category include being "unfit on account of his mental state for treatment as a voluntary patient."[82] The presumed inability to consent to necessary hospital treatment is the basis for both compulsory admission and

[78] Mental Treatment Act 1945, section 163(2)(b).
[79] Mental Treatment Act 1945, as amended by Mental Treatment Act 1961, section 12. The PUM admission procedure is used instead to ensure Garda involvement in the admission and transportation of the patient.
[80] [1998] 1 IR 101.
[81] Mental Treatment Act 1945, sections 263 and 264.
[82] *Ibid*, section 184(4)(a)(iii).

treatment without consent.[83] The second category of persons under temporary admission are addicts and the reference to unfitness for voluntary admission is replicated here.[84] The definition of addict refers to a person "incapable of managing himself or his affairs or of ordinary proper conduct."[85] Many addicts have fluctuating capacity and may well be capable of consenting to treatment, but the presumption that applies to other categories regarding consent is applied to this group, even though they are treated separately in the Act. The treatment for all detained patients should be confined to the management and treatment of the addiction or mental illness, in order to comply with the principle of proportionality. If another condition arises, like a physical illness, consent will be required in that instance. The practice then is to have someone to consent on the person's behalf where he is deemed incapable, even though this has no legal basis. The common law will provide the legal basis for any urgent treatment.[86]

A second assumption about the legal basis for treatment without consent for mental disorder is that treatment can be given to all detained patients on the basis of the common law doctrine of necessity based on the best interests of the patient. The use of the common law would seem to fit better with Jacob's conclusions about the absence of express legislative provisions around consent. Since neither of these assumptions has been litigated in Ireland, the legal basis for compulsory treatment of such patients remains uncertain.

People admitted as voluntary patients should be able to give legally effective consent to treatment as there is nothing in the Act or common law to suggest otherwise. The reality is that those admitted voluntarily who have capacity and want to refuse treatment may consent in order to avoid being detained. The 1945 Act provides that a voluntary patient "who becomes mentally incapable of expressing himself as willing or not willing to remain" should be detained or discharged.[87] Patients are not dealt with as the 1945 Act requires, but given treatment on the basis of necessity and best

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[83] Casey & Craven, *Psychiatry and the Law,* Oaktree Press, Dublin, 1999, p504.
[84] Mental Treatment Act 1945, section 184(4)(a)(ii).
[85] *Ibid,* section 3(a).
[86] *In re F* [1990] 2 AC 1.
[87] Mental Treatment Act 1945, section 195.

interests.[88] The deficiencies and lack of safeguards, outlined above, demonstrate the urgent need to implement the provisions of the 2001 Act regarding consent to treatment in order to comply with Article 8.

Mental Health Act 2001

The Mental Health Act 2001 contains principles that go some way to supporting the right to self-determination and set the tone for its interpretation. The 2001 Act requires that, in a decision concerning care and treatment, the best interests of the person is the principal consideration with due regard to the interests of others.[89] As far as possible, the person should be notified about the decision to give treatment and be given the right to make representation and his views should be considered in the decision.[90] Any decision under the 2001 Act is required to respect the right of the person to dignity, bodily integrity, privacy and autonomy.[91] These principles incorporate the constitutional rights to dignity and autonomy and apply to voluntary and detained patients. Separate sections in the Act on both admission and treatment provide clear demarcation on the requirements applying to each area, thus ensuring that no assumptions should be made arising from detention.[92]

Bearing in mind the principles outlined, treatment can be given without consent to an individual detained under the 2001 Act.[93] Safeguards apply only to those who are formally detained and not to voluntary patients who are compliant, but incapacitated, and are, in reality, *de facto* detained. The sole statutory test for competency to consent requires that the patient understand the nature, purpose, and likely effects of

[88] Many of these issues were highlighted in *HL v United Kingdom* (2005) 40 EHRR 32.
[89] Mental Health Act 2001, section 4(1).
[90] *Ibid,* section 4(2).
[91] *Ibid*, section 4(3).
[92] *Ibid*, section 8 and Part 4 of the Mental Health Act 2001.
[93] Department of Health and Children, *Report of the Inspector of Mental Hospitals for year ending 2003,* Government Publications, Dublin, 2004. Total of 23,234 admissions in 2003, meeting the 10% annual figure for compulsory admissions..

treatment.[94] The word "patient" means a person detained under the Act and does not include voluntary patients.[95] The Act defines informed consent as,

> **Section 56.-**
> In this part "consent", in relation to a patient, means consent obtained freely without threats or inducements, where-
> (a) the consultant psychiatrist responsible for the care and treatment of the patient is satisfied that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment; and
> (b) the consultant psychiatrist has given the patient adequate information, in a form and language the patient can understand, on the nature, purpose and likely effects of the proposed treatment. [96]

This standard is in line with the common law position and is close to the reasonable patient standard in informed consent as the focus is on the patient's needs and it places responsibility on the doctor regarding communication of information.[97] It would seem that there is an onus to ensure that this communication is not solely a paper exercise as the consultant has to be satisfied regarding the patient's "capacity to understand," suggesting an intellectual capacity to understand, rather than actual understanding. The capacity of the patient will need to be addressed in this regard and, where it is apparent that the patient is lacking in capacity to understand, the second opinion safeguard is involved. The English Mental Health Act Commission examined this issue and advised all second opinion doctors to require "both a capacity and adequate understanding of the treatment and its consequences."[98] In these circumstances two factors are required, one to ensure capacity and the second is to avoid negligence.[99]

Capacity in English law is issue specific and will depend on the type of decision to be made and is commensurate with the gravity of the decision. In *Re C (Adult :Refusal of Medical Treatment),* [100] modified by *Re MB (Medical Treatment),* the Court of Appeal

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[94] Mental Health Act 2001, section 56. At time of writing, (Feb. 2006) this legislation is not yet in force and the 1945 Act continues to apply. This provides no protection against enforced treatment falling back on the common law doctrine of necessity, best interests and the professional standard.
[95] Mental Health Act 2001, section 2(1). Section 69 provides for the inclusion of voluntary patients in the definition of patient.
[96] Mental Health Act 2001, section 56(b).
[97] *Geoghegan v Harris* unreported High Court 21st June 2000.
[98] Jones R., *Mental Health Act Manual* (9th ed.), Thomson, London, 2004, p 298..
[99] It is interesting to note that capacity comes from the law of battery, a factor that is often overlooked.
[100] [1994] 1 AII ER 419, [1997] 2 FLR 426.

held that there are three stages to the decision: to take in and retain treatment information in relation to a particular decision, to believe it and to weigh that information, balancing risks and needs. Thorpe J., in *Re C,* stated,

> Although his general capacity is impaired by schizophrenia, it has not been established that he does not sufficiently understand the nature, purpose and effects of the treatment he refuses ... he has understood and retained the information that in his own way he believes it, and that in the same fashion he has arrived at a clear choice.[101]

In *In re MB (Medical Treatment)* the decision in *Re C* was slightly modified to provide that a person lacks capacity where he is unable to comprehend and retain the information which is material to the decision, especially as to the likely consequences of having or not having the treatment in question, and the patient is unable to use the information and weigh it in the balance as part of the process of arriving at a decision.[102]

In the 2001 Act, different requirements apply in relation to psychosurgery, electro-convulsive therapy (ECT) and medicine. In each case, consent must be in writing and there is no express provision in the Act for the withdrawal of consent. The provision of a second opinion is obtained by the patient's consultant psychiatrist in a form specified by the Commission and "following referral of the matter to him or her."[103] There is no requirement that the opinion is independent of the service and, on this basis, it is likely to be someone nearby, particularly in rural areas with limited access to other psychiatrists. Unlike the English Mental Health Act 1983, the second opinion request does not go to the Commission, but remains with the patient's psychiatrist. A consultant will be unlikely to choose a second opinion which may be challenging and may contravene his own opinion. The Commission does not have an express function in the 2001 Act to provide a panel of independent psychiatrists for second opinion medical examinations for consent to treatment, only for a tribunal hearing.[104] It may be possible to derive such a duty from the 2001 Act, which contains a general section stating that the Commission "shall undertake or arrange to have undertaken such

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[101] [1994] 1 All ER 819.
[102] [1997] 2 FLR 426 p437.
[103] Mental Health Act 2001, sections 59 (1)(b) (ii), 60(b) (ii) and 61(b).
[104] *Ibid,* section 33.

activities as it deems appropriate to foster and promote ... high standards and good practice in the delivery of mental health services."[105] The Act then lists specific Commission functions and states that this list is "without prejudice" to this general provision, implying a basis for other activities which could include second opinion panels in consent to treatment.[106] The Commission will have to prepare a code of practice for the 2001 Act and will have to address this issue. These omissions are significant in relation to the imposition of treatment against the wishes of a mentally competent adult.

Another issue that arises in relation to the second opinion procedure is that there is no requirement that reasons are given for the decision reached. This contrasts with the decision in the English case, *R (on the application of Wooder) v. Feggetter and the MHAC,* which held that the question of fairness requires a second opinion doctor to give reasons in writing for a decision that permits overriding the self-determination of a mentally competent patient.[107] There is no right of appeal, other than judicial review, against the second opinion. Additional requirements apply in relation to psychosurgery in that the Mental Health Commission and tribunal must be notified of such proposal, but there is no requirement to have a second opinion for the tribunal.

All of the 2001 Act safeguards for consent to treatment are broadly modelled on the English Mental Health Act 1983, but the provisions of the 1983 Act are more stringent in requiring an addition to the independent second opinion. The doctor must consult two others concerned with the patient's treatment one of whom must be a nurse and the other neither a doctor or nurse.[108] These people must confirm that the patient is capable of understanding the nature, purpose and likely effects of the treatment and has consented to it. The doctor must, in addition, confirm that the treatment would be likely to alleviate or prevent a deterioration in the patient's condition.[109] The 2001 Act does not require a second opinion to affirm the patient's knowledge about the treatment or to affirm that the patient has consented.

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[105] *Ibid*, section 33(2).
[106] *Ibid,* section 33(3).
[107] [2002] EWCA Civ 554.
[108] Mental Health Act 1983, sections 57(2)(a)and section 57(3).
[109] *Ibid*, section 57(2)(b).

In regard to the treatment for psycho-surgery, the Act provides,

Section 58.-

(1) Psycho-surgery shall not be performed on a patient unless-

(a) the patient gives his or her consent in writing to the psycho-surgery, and

(b) the psycho-surgery is authorised by a tribunal.

(2) Where it is proposed to perform psycho-surgery on a patient and the consent of the patient has been obtained, the consultant psychiatrist responsible for the care and treatment of the patient shall notify in writing the Commission of the proposal and Commission shall refer the matter to a tribunal.

(3) Where such a proposal is referred to a tribunal under this section, the tribunal shall review the proposal and shall either-

(a) If it is satisfied that if it in the best interests of the health of the patient concerned, authorise the performance of the psycho-surgery, or

(b) If it is not so satisfied, refuse to authorise it.[110]

The tribunal can refuse to permit such treatment as not being in the patient's best interests, even though the patient has consented to it. There is no requirement of access to an independent second opinion in this regard. In comparison with the English 1983 Act, the safeguards are limited, omitting any requirement that the tribunal or a second opinion psychiatrist affirms that the patient's consent is real and is based on adequate information. An appeal can be made to the Circuit Court against the decision of the tribunal and no treatment can commence until either the appeal period ends or the decision of the court is announced.[111] The tribunal will not be in a position to authorise such treatment for patients who lack capacity. Instead, where such intervention is necessary, it will have to be referred to the High Court for a declaration as to its lawfulness.

In regard to the treatment for ECT, the Act provides,

Section 59.-

(1)(b) where the patient is unable or unwilling to give such consent-

(i)the programme of therapy is approved (in a form specified by the Commission) by the consultant psychiatrist responsible for the care and treatment of the patient, and

[110] Mental Health Act 2001, section 58(3).
[111] *Ibid*, section 58(4).

(ii)the programme of therapy is also authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him by the first-mentioned psychiatrist.[112]

The provisions are again broadly similar to section 58 of the 1983 Act without the provision that the patient's consent is affirmed by the second opinion and the two other persons.[113] There is no requirement that the second opinion is independent, is Commission approved or that any reasons must be given for the decision. These same provisions apply to the administration of medicine, but the second opinion will only apply after the three month period has elapsed.[114]

Section 60.-
Where medicine has been administered to a patient for the purposes of ameliorating his or her mental disorder for a continuous period of 3 months, the administration of that medicine shall not be continued unless either-

(a) the patient gives his or her consent in writing to the continued administration of that medicine, or

(b) where the patient is unable or unwilling to give such consent-

(i) the continued administration of that medicine is approved (in a form specified by the Commission) by the consultant psychiatrist responsible for the care and treatment of the patient, and

(ii) the continued administration of that medicine is also authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him by the first-mentioned psychiatrist.

The failure to get the patient's consent or to provide a second opinion prior to the three month "stabilising period' is difficult to justify, particularly in the case of a mentally competent patient refusing the treatment. The effect of the section means that patients, whether mentally competent or not, can be forcibly treated against their wishes for a three month period which is not subject to any review mechanism until afterwards. In *Petition of WM,* the Court of Session in Scotland dealt with the question as to whether the scope of the consent provision in the Mental Health (Scotland) Act 1984, providing for a three month period before the safeguards applied, was broader than necessary in a democratic society, incorporated apparently arbitrary limits and lacked appropriate procedural safeguards. The Court held that the

[112] *Ibid,* section 59(1).
[113] Mental Health Act 1983, section 58(3)(b).
[114] See Chapter 4 p177 *et seq.* for further discussion.

three month period during which consent was not required did not violate Article 8 and though there was a clearly defined departure from the principle of personal autonomy, the requirement of proportionality was not breached.[115] This was not a Strasbourg Court decision so it would have limited persuasive authority in Ireland.

The imposition of treatment constitutes an interference with private life under Article 8(1) and can only be justified under Article 8(2) if it is convincingly shown to be necessary and the terms of the law are sufficiently precise to enable the individual to foresee its consequences for him. It is arguable that Irish law, in relation to the imposition of ECT and medicine, is not precise enough in that there is no certainty that the second opinion is independent or that those providing second opinions will be approved by the Commission. The result is that the patient cannot rely on this provision to provide any degree of independence. The requirement of foreseeability should apply whether the patient is competent or not. There appears to be unquestioned acceptance in these jurisdictions of the three month stabilising period and, even if this is medically justifiable, there should be some review of the plan at the outset and during the period, due to the severe effects of some medications for mental disorder.

The 2001 Act does not differentiate between those detained adults who have capacity for self-determination and those who do not in relation to the above treatments. Where the patient is either unable or unwilling to consent to treatment, the outcome is the same. Those who are unwilling to consent may have capacity for self-determination but that capacity will be overridden by the provisions of the Act. This interference will need to be justified as necessary and must be proportionate to its aim in order to comply with the requirements of Article 8(2). In this regard also, there is a question as to the proportionality of the decision to forcibly treat people who are compulsorily admitted and whose capacity has not been assessed.[116]
The Act provides for treatment not requiring consent,

Section 57.-

[115] [2002] MHLR 367. Also Jones, *op. cit.*, 97 p303.
[116] *R (Wilkinson) v. Broadmoor Hospital* [2001] EWCA Civ 1545.

> (1) The consent of a patient shall be required for treatment except where, in the opinion of the consultant psychiatrist responsible for the care and treatment of the patient, the treatment is necessary to safeguard the life of the patient, to restore his or her health, to alleviate his or her condition, or to relieve his or her suffering and by reason of his or her mental disorder the patient concerned is incapable of giving such consent.
> (2) This section shall not apply to the treatment specified in section 58, 59, or 60.

This section provides for urgent medical treatment in four specific circumstances ranging from life-saving, to restoration of health, alleviation of the illness and relief of suffering where the patient is unable to consent due to incapacity. This is clear acknowledgement of the difference in the capacity of patients and complies with the Constitution and the common law on the right of the capable adult to refuse medical treatment. The section does not apply to psycho-surgery, ECT and medicine for mental disorder. There is no provision for a second opinion procedure. Treatment is defined in the Act 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."[117] It is a broad definition that potentially embraces all possible treatments, particularly under the "other remedies" clause.

The section is somewhat similar to sections 62 and 63 of the English Mental Health Act 1983 where a number of unsuccessful challenges have sought to establish a breach of Article 8(1).[118] The imposition of compulsory medical treatment without the consent of the patient is an interference with the respect for private life under Article 8(1), but it will not be a breach if justification is found in Article 8(2) and if the treatment is necessary and proportionate.[119] In *Storck v. Germany,* the applicant had resisted both her continued stay at the clinic and her medical treatment. As a result, it had to be administered by force and constituted an interference with her right to respect for private life, which could not be justified due to the illegality of the detention.[120]

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[117] Mental Health Act 2001, section 2(1).
[118] *B v. Croydon Health Authority* [1995] 1 All ER 683, *Petition of WM*, Outer House, Court of Session [2002] MHLR 367.
[119] *R (Wilkinson) v. Broadmoor Hospital* [2001] EWCA Civ 1545.
[120] *Storck v. Germany* Application no .61603/00 16th June 2005 para 144.

Medical examinations for compulsory admission, tribunal hearings and discharge can be carried out without the patient's consent and without any assessment of capacity to consent to such examinations.[121] The Act provides no guidance on the issue of capacity in any of these circumstances, but if the examination does not involve any physical contact, the need for consent may not arise.

The right of self-determination arises in relation to seclusion and restraint. The 2001 Act provides that seclusion applies to voluntary patients and children and cannot be used unless it is necessary for the purposes of treatment, or to prevent the patient from injuring himself or others and it must comply with the Commission rules.[122] The Act has no express reference to capacity or to rights of appeal regarding continuity of this management technique. In *Munjaz* v. *Mersey Care National Health Service Trust & Others,* an English case, the Court of Appeal held that seclusion is capable of being medical treatment for the purposes of section 63 of the 1983 Act and there is a power to seclude both detained and informal patients under common law principles, where it is reasonably necessary and proportionate to protect others from harm.[123] The Court of Appeal required that the guidance in the Code of Practice would be followed in this regard as a means of securing the justification for interfering with the right to respect for private life. The law must have the necessary degree of predictability and transparency to comply with Article 8(2). The decision of the Court in *Raininen v Finland,* held that the notion of physical and moral integrity of the person extends to situations of deprivation of liberty which can include seclusion of a patient.[124] The issue then is the justification for these management techniques in the 2001 Act and need for guidance in the proposed code of practice from the Mental Health Commission.

In the context of medical treatment, a voluntary patient means a person who is capable of consenting and a voluntary patient is defined in the 2001 Act as "a person

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[121] Mental Health Act 2001, section 10(3) for admission, section 56, 58, 59 & 60 for consent to treatment, and section 49(6)(g) for tribunal hearing.
[122] *Ibid,* section 69. Commission rules refer to the Code of Practice being drafted by the Commission under section 33(3)(e). See chapter 9 for full discussion of children and treatment.
[123] [2003] EWCA Civ 1036.
[124] (1997) 26 EHRR 563, [2003] EWCA Civ 1036 para 63.

receiving care and treatment in an approved centre who is not the subject of an admission or a renewal order."[125] Voluntary admission in the Act provides,

> **Section.-29.-**
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> 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.

Voluntary patients will be subject to common law principles in relation to their treatment. Individuals admitted voluntarily fall into two categories: those who have capacity and consent to admission and those who do not have capacity, but are not objecting to the admission. The compliant incapacitated group are treated on the basis of the common law principles and are referred to as *de facto* detained. Such patients should theoretically be able to leave hospital and refuse treatment, but these choices are not open to them, nor do they have the safeguards available to detained patients such as the second opinion procedure. In *R v. Bournewood Community and Mental Health NHS Trust, ex parte L,* an English case, one of the judges, Lord Steyn, spoke about relying on the doctrine of necessity to justify the deprivation of liberty of compliant incapacitated patients,

> The common law principle of necessity is a useful concept, but it has none of the safeguards of the 1983 Act. It places effective and unqualified control in the hands of the hospital psychiatrist and other health professionals. It is, of course true that such professionals owe a duty of care to patients and they will almost invariably act in what they consider to be the best interest of the patient.[126]

The decision in *HL v. United Kingdom* and the more recent decision in *Storck v. Germany* are directly relevant to the 2001 Act.[127] The question is whether, in order to be voluntary, one has to be capable and consenting, or if it is possible to be incapable and non-objecting. Both decisions would suggest that section 29 should be interpreted so that the person can only be admitted if they are capable and consenting. If compliant incapacitated patients are admitted and the level of control outlined by the

[125] Mental Health Act 2001, section (2)(1).
[126] [1998] 3 AII ER 289 pp 308, 309.
[127] (2005)40 EHRR 32, Application no.61603/00 16th June 2005.

Court in *HL* and *Storck* is applied to them, this may well result in a deprivation of liberty for the purpose of the Convention. Fennell argues that, when a compliant incapacitated person is admitted as a voluntary patient and strong treatment like neuroleptics or ECT is used without consent, then the level of control involved in giving this treatment may tip the balance in favour of a deprivation of liberty.[128] Where a person is incapable and deprived of liberty and is given treatment, the question is whether it is in accordance with a procedure prescribed by law and justified by reference to the requirements of Article 8(2). Under the 2001 Act, patients who are detained can be compulsorily treated when they are unable or unwilling to consent, provided the safeguard of a second opinion is obtained in the case of ECT or medicine after three months. The compliant incapacitated voluntary patient has no safeguards and is not entitled to any representative to act on his behalf. The Convention on Human Rights and Biomedicine provides that treatment of such patients must be for their direct benefit and should be authorised by a representative or a body provided by law.[129] In addition, Recommendation (2004) 10 urges member states to provide appropriate safeguards for compliant incapacitated patients.[130]

The 2001 Act prohibits research on people who are detained on the assumption that they are unable to consent.[131] This is an example of the status approach to capacity and fails to take account of the fact that many people in this category have capacity to consent. The fact that a person has been detained under mental health legislation does not automatically rebut the presumption of capacity. The assumption is that those who have voluntary status are capable of consenting to being involved in clinical trials, but this fails to take account of the compliant incapacitated patient. The decisions in *HL* and *Storck* apply to patients whose circumstances meet the requirements to establish a deprivation of liberty. The assumption that all detained patients are incapable of consenting and all voluntary patient are capable is invalid. The core issue in this assumption is the failure to take account of capacity as the only legitimate way of ensuring who is able to consent to the procedure.

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[128] *Op. cit.*, 18.
[129] Convention on Human Rights and Biomedicine 1997 Article 6(1) & (3).
[130] Council of Europe, Committee of Ministers, *Recommendation (2004) 10. on the protection of the human rights and dignity of persons with mental disorder*, Article 26.
[131] Mental Health Act 2001, section 70.

The Control of Clinical Trials Acts 1987-1990 require that ethical approval for the clinical trial is given by the Minister for Health and Children. These Acts provided some minimum protection for those without capacity to consent: that information is given to the participant concerning the trial, the right to withdraw consent at any time, and that for an incapacitated person a written and signed consent is given on their behalf by someone who is independent of the person in charge of the trial.[132] The standard of safeguards in this legislation does not meet human rights standards with regard to independence of the proxy decision-maker. The EU Clinical Trials Directive has been transposed into Irish law through Ministerial Regulations providing for greatly improved safeguards for all participants in clinical trials.[133] Those who do not have capacity to consent, including children, must have a representative, who may be a family member, to act and give informed consent on their behalf. The Convention on Human Rights and Biomedicine 1997 requires that, unless there is a direct benefit for the person who is unable to consent, they should not be involved in research, other than in exceptional circumstances.[134] This problem has been recognised also in Recommendation (2004) 10 which advocates the application of "appropriate provisions" to protect those who are compliant, but without capacity to consent.[135]

Confidentiality of medical information

This right to respect for private life in Article 8 embraces a right to confidentiality whereby medical information receives a high level of protection. Restrictions on the right of access to personal files must be in accordance with Article 8(2). Duties of confidentiality are not absolute and are liable to be overridden where there is a stronger interest in disclosure. A margin of appreciation is left to states in reaching a balance between the various private and public interests, the extent of which depends on the seriousness of the interference and the nature of the information at stake. The Court has affirmed the importance of this right,

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[132] Control of Clinical Trials Act 1987, section 9(7)(b).
[133] Directive 2001/20/EC and European Communities (Clinical Trials on Medicinal Products for Human Use) Regs. 2004.
[134] Convention on Human Rights and Biomedicine 1997, Articles 6,and 17. Ireland has not yet ratified this Convention due to difficulties around the right to life in Article 40.3.3 of the Constitution and the provision in the Convention on research on embryos in Article 18.
[135] *Op. cit.,* 130. See also Article 7 on protection of vulnerable persons.

> The protection of personal data, not least medical data, is of fundamental importance to a person's enjoyment of his or her right to respect for private life and family life ... Respecting the confidentiality of health data ... is crucial not only to respect the sense of privacy of a patient but also to preserve his or her confidence in the medical profession and in the health services in general. Disclosure must be justified by an overriding requirement in the public interest.[136]

The right to privacy in medical records was held to be part of the right to respect for privacy in *MS v. Sweden*, but, on the facts, the Court was satisfied that disclosure to the State social services body was necessary and in accordance with law to protect the financial well-being of the State.[137] A woman's health records dealing with her HIV status were held to be covered by Article 8(1) and the right to respect for private life, but limited disclosure was justified for the criminal court.[138]

The Convention on Human Rights and Biomedicine provides that everyone has the right to respect for private life in relation to information regarding his or her health. Recommendation (2004) 10 refers to the importance of confidentiality and clear record keeping.[139] It would seem that there are few clear guidelines at present on the limitation of disclosure of such information to a "need to know basis" to ensure that the principle of proportionality in the Convention is satisfied.[140]

Irish law and confidentiality of medical information

The Irish Constitution provides for protection of the right to privacy as an aspect of personal rights under Article 40.3.1, though there is no specific reference to medical confidentiality.[141] The right to privacy is not absolute and is balanced against other factors.

> The nature of the right to privacy must be such as to ensure the dignity and freedom of an individual in the type of society envisaged by the Constitution, namely, a sovereign, independent and democratic society.[142]

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[136] *Gaskin v. United Kingdom* (1990) 12 EHRR 36.
[137] (1997) 28 EHRR 313.
[138] *Z v. Finland* (1997) 25 EHRR 371.
[139] *Op. cit.*, 130, Articles 3(1) & (2).
[140] *X v. Y* [1988] 2 All ER 648, *W v. Egdell* [990] 1 All ER 835.
[141] Madden D., *Medicine, Ethics and the Law,* Butterworths, Dublin, 2002.
[142] *Kennedy & Arnold v. Ireland* [1987] IR 587.

The right to privacy in the context of health care decisions on behalf of an incapacitated person has been affirmed by the Supreme Court in *In re a Ward of Court (Withdrawal of Medical Treatment).*[143] There is no specific statutory provision governing the duty of confidence in the doctor patient relationship. The duty is governed by professional codes of practice as well as the common law duty of confidence. English law has persuasive authority in Ireland so it is likely that developments in the English common law would have an impact in Ireland. The Data Protection (Amendment) Act 2003 and the Freedom of Information Act 1997 supplement the right to confidentiality by protecting personal information and providing safeguards for disclosure. The Irish Medical Council and An Bord Altranais, the Nursing Board, have ethical guidelines that refer to the requirements for confidentiality in professional relationships.[144] The employment contract of staff in hospitals should require that patient information is kept confidential and disclosure of information can lead to an action by the patient for breach of contract.[145]

There is no absolute right to confidentiality between doctor and patient and the Irish Medical Council outlines the exceptions to this right based on the balance that has to be struck between the right to confidentiality and the interests of the patient, of other people and the public.[146] In the absence of consent, the Council recognises that confidentiality may be breached in situations where it is ordered by a judge or tribunal, it is necessary in the interests of the patient, or to protect the welfare of society, or is necessary to safeguard the welfare of another person or patient.[147] The Council emphasises the importance of informed consent to the sharing of information with third parties, before which the doctor must explain the nature and context of the report, the implications of the examination for this purpose and have patient consent. The significance, rather than the detail of the findings, should be conveyed to any third party under confidential cover.

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[143] *In re a Ward of Court (Withdrawal of MedicalTreatment)* [1995] 2 ILRM 401.
[144] Irish Medical Council, *Guide to Ethical Conduct and Behaviour* Dublin, 2004. An Bord Altranais, *The Code of Professional Conduct for Each Nurse and Midwife,* Dublin, 2000.
[145] *X v. Y* [1988] 2 AII ER 648.
[146] Irish Medical Council, *Guide to Ethical Conduct and Behaviour,* Dublin, 2004.
[147] *Ibid*, para 16.3.

Mental health legislation

There is no reference to the protection of medical information in the 1945 Act and the disclosure of such information is governed by the general right to privacy in the Constitution, the common law right of confidentiality and the ethical guidelines. Any sharing of information with outside agencies by the psychiatrist is governed by the Medical Council which advocates for prior informed consent. The principles in the 2001 Act provide that, in making any decision under the Act regarding the admission, care and treatment of the person, regard must be had to the right to privacy.[148] Where the patient is unable to consent to disclosure to family or others, there is no provision in the legislation for proxy decision-making. In other contexts, the disclosure of "written statements" as evidence before a mental health review tribunal is permitted with the consent of the patient or his legal representative.[149] No guidance is given where a patient refuses to permit disclosure. The tribunal hearings will be in private, thus safeguarding this aspect of the right to privacy for the patient.[150] In relation to the tribunal hearings, the second opinion will be required to report to the tribunal and will not be in breach of confidentiality where information is disclosed on the basis of protecting the interests of society.[151] This would accord with the Medical Council exceptions and be justified by reference to Article 8(2) as satisfying the legitimate aim of protecting the interests of others.

The applicant for a detention order will usually be in a position to have access to information regarding the patient in this context and there are no clear guidelines on the safeguarding and limitation of information to a "need to know" basis. In this regard, the right to respect for private life of the patient and the right to respect for family life for the carer may come into conflict where the carer believes he needs information in order to act in the best interests of the patient and this is contrary to the wishes of the patient. Any information given without consent will have to withstand the necessity test, have a legitimate aim and be proportionate to the achievement of that aim in order to comply with Article 8(2).

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[148] Mental Health Act 2001, section 4(3).
[149] *Ibid,* section 49(6)(b) & (d).
[150] *Ibid,* section 49(9).
[151] [1990] 2 WLR 471.

Family life

The right to respect for family life overlaps with private life and some aspects of these rights are dealt with in other Articles such as the right to marry and found a family under Article 12 which deals with intimate issues that could also be addressed under Article 8.[152] The state is required to act in order to facilitate normal family life. The recognition of family is a question of fact depending on the existence of close personal ties.[153] The right also extends to the right to make decisions in relation to medical treatment on behalf of incapacitated minors.[154] People who become mentally disordered may need to be moved away from family or the family may need protection from them. The state is required to make efforts to maintain ties and to try to reunite parents with children who have been in care.[155] The Court, in *K & T v. Finland,* held that there must be extraordinarily compelling reasons before a baby can be physically removed from the care of its mentally ill mother against her will and immediately after birth as a consequence of a procedure in which neither she nor her partner had been involved.[156] The reasons for the removal of the baby were not justified under Article 8(2) as the situation did not constitute an emergency and a less intrusive measure should have been found. There may have been "necessity" to take some precautionary measures to protect the child, but the interference in the applicant's family life cannot be regarded as having been necessary in a democratic society.

Family life involves some authority of parents over their children and, in *Neilsen v Denmark* the Court said that it was normally for the parent to decide where the child should live and to take various decisions for him including medical treatment.[157] The right to have contact must always be balanced against the welfare and best interests of the child. The Court has held that the restrictions on child visits to someone in a high security hospital who had committed murder, manslaughter and sexual offences were

[152] See chapter 8 for full discussion of this issue.
[153] *Z & E v. Austria* (1986) 49 DR 67, and *K & T v. Finland* (2003) 36 EHRR 18 para 150.
[154] *Neilsen v. Denmark* (1999) 11 EHRR 175, Application no. 6825/74 18th May 1976. *Glass v. United Kingdom* (2004) 39 EHRR 15.
[155] *Erikson v. Sweden* A 156 para 71 (1989), *K & T v. Finland* 12th July 2001.
[156] *K & T v. Finland* Application no. 25702/94 12th July 2001.
[157] (1989) 11 EHRR 175 para 61.

not unlawful and did not breach Article 8 of the Convention unless the child was one of a permitted category.[158] The relationship between an aunt or uncle and a nephew or niece did not automatically constitute family life within the meaning of Article 8 but was dependent on the facts of the individual case. The directions regarding child visits were not disproportionate to the aim of the protection of children.

Restrictions on the right of cohabitation arose in *Re Jennifer Connor,* a Northern Ireland Court of Appeal case.[159] It concerned a woman with a cognitive impairment as a result of long-term alcohol abuse who had been receiving psychiatric treatment for many years. She was made the subject of a guardianship order in May 2002 following injuries she sustained while living in the community with her cohabitee, later her husband in November 2002. The order placed restrictions on the amount of time she spent with her husband and at the time of the hearing permitted four nights together. Mrs Connor challenged the proportionality of the restrictions under Article 8(1) and Article 12 of the Convention.[160] She argued that the Trust had to demonstrate the necessity of the restrictions on living with her husband and to undertake an explicit analysis of her situation "through the prism of the European Convention."[161] This was rejected by the first instance judge, stating that,

> While that 'right' [under Article 8(1)] may not be specifically mentioned in reports, it is clear that the trust were actively considering the relationship between the applicant and her husband and the question of overnight stays. In those circumstances the Trust were dealing with the substance of the issue in the context of where and with whom the applicant should reside.[162]

This approach was rejected by the Court of Appeal, holding,

> There is no evidence that the trust ever recognised, much less addressed, the interference with the applicant's article 8 rights. In none of the documents generated by the trust's consideration of her case can any reference to article 8 be found. [The Trust's barrister] claims that what the trust officers were embarked upon in considering Mrs. Connor's case was 'in essence' an article 8 exercise. We cannot accept that argument. The consideration of whether an interference with a convention right can be justified involves quite a different approach from an assessment at large of what is best for the person affected.

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[158] *R v. Secretary of State for Health ex p ML* [2001] 1 FLR 406.
[159] [2004] NICA 45 (14th December 2004).
[160] See Chapter 8 p 267 *et seq.* for further discussion on the right to marry.
[161] *Ibid,* at para 19.
[162] *Ibid*, at para 20

> The trusts consideration of Mrs Connor's case clearly partakes of the latter of these.[163]

The Court went on to say that the Trust should have considered Mrs Connor's request to live permanently with her husband from an Article 8 perspective, being an interference with such rights. Such interferences would have to be justified as being the least restrictive possible to secure her welfare. The Trust was required to review Mrs. Connor's request in light of Article 8 and the guidance from the Court of Appeal.

The issue of family and proxy decision-making arose in *Glass v. United Kingdom* where the mother of a minor with severe mental and physical disabilities acted as her son's legal proxy.[164] As a parent, she had authority to act on his behalf and to consent to treatment for him. The Court held that the decision to impose treatment in defiance of the mother's objections gave rise to an interference with the son's right to respect for his private life and, in particular, his right to physical integrity.[165] The failure to obtain court authorization for the treatment resulted in a breach of Article 8(2) as there was no emergency to justify the intervention.[166] The independent right to family life of the mother, even in the extreme circumstances where her child's life was in danger of being ended by a particular treatment, was not addressed. Instead, the Court limited its attention to the mother's right towards her child as a vehicle for his right as a vulnerable incapacitated child to self-determination.[167]

Irish law and the right to respect for family life

Constitutional law

Article 41 of the Irish Constitution outlines the obligation to safeguard the family based on marriage and gives protection to legislative and other policies that positively discriminate in favour of the marital family.[168] The Constitution deals with the

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[163] *Ibid,* para 29.
[164] (2004) 39 EHRR 15.
[165] *X and Y v. Netherlands,* 26 March 1985, A - 91, para 22; *Pretty v. the United Kingdom* (2002) 35 EHRR 1 paras 61 and 63.
[166] *Ibid,* para 10.
[167] *Glass v. United Kingdom* (2004) 39 EHRR 15. Application no. 61827/00 9th March 2003 p72.
[168] *Nicolau v. An Bord Uchtala* [1966] IR 567.

protection of the family from external forces.[169] This privileged legal position does not apply to non-marital families or to individuals in families, but rather to the family as a unit.[170] Recommendations for reform confirm that the Constitution should guarantee all individuals a right to respect for their family life regardless of the legal formalities.[171]

Mental health legislation

The voluntary admission of children under both 1945 and 2001 Acts involves parents and neither statute provides guidance on the child's rights in these circumstances.[172] Children are compliant incapacitated patients and there are no safeguards for treating them as individuals apart from parental authority which is not subject to any supervision. Reliance on the decision in *Nielsen v. Denmark* would mean that this situation is as it should be, the proper exercise of parental rights.[173] The decision in *Storck v. Germany,* where the applicant was 15 years old on her first admission, confirms the state obligation to provide effective review and supervision of such admissions to ensure Articles 5 and 8 are not violated and applies to children as to vulnerable adults.[174] The 2001 Act defines children as those up to 18 years and the treatment of the older competent child against his will may well raise proportionality issues under Article 8(2), taking into account the decision in *Storck.* Conflicts may arise between private and family life in relation to confidential information when the patient does not want to share information to which the family feel entitled. The information should be limited to what is necessary for the particular task in order to comply with Article 8(2).

Home

The interests protected by Article 8 are the peaceful enjoyment of the home and the right to occupy one's home, including protection against unwarranted intrusion by

[169] *L v. L* [1992] 2 IR 77 p108.
[170] *Murray v. Ireland* [1985] IR 523.
[171] *Report of the Constitution Review Group* (*Pr* l2632, 1996) p323.
[172] Mental Treatment Act 1945, section 191(2). See chapter 9 for full discussion on children.
[173] (1989) 11EHRR 175.
[174] Application no.61603/00 16th June 2005.

public officials and private parties.[175] There is no right to a home. Interference with the right to respect for home and private life may arise in relation to compulsory care in the community. However, to date, no breach of the Convention has been established in this regard.[176] In *L v. Sweden,* the Commission held that a decision to grant leave from detention with the imposition of treatment as a condition of leave constituted an interference with Article 8 and the right to respect for privacy unless it could be justified under Article 8(2).[177] The interference was held lawful as necessary for the protection of health under Article 8(2) on the basis that the applicant would stop taking medication if left to her own devices. The Commission held that the restriction was necessary in a democratic society.

Out-patient treatment in the community has been held by the Commission, in *W v. Sweden,* not to amount to detention for the purpose of Article 5.[178] The applicant was required to take medication and to have hospital treatment every two weeks. On the basis of these decisions, it would seem that conditional release does not *per se* amount to detention, nor does it breach Article 8 where there is justification under Article 8(2). The principle of proportionality applies to the conditions of the release providing for the least restrictive alternative and ensuring there are safeguards against abuse.

Irish law and the right to respect for home

Constitutional law

The right to the inviolability of the "dwelling" is enshrined in Article 40.5 of the Irish Constitution and generally refers to the place where people live.[179] The right is not absolute and forced entry can take place under statute and common law.[180]

Mental health legislation

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[175] *Guerra and Others v. Italy* 19 February 1998 *Reports of Judgments and Decisions* 1998-I para 57. *Arondelle v. United Kingdom* Application no 7889/77.
[176] *L v. Sweden* Application no. 10801/84 61 DR 62 (1988), *W v. Sweden* [1988] 59 DR 158.
[177] Application no. 10801/84 61 DR 62 (1988).
[178] [1988] 59 DR 158.
[179] *DPP v. McMahon* {1965] I IR 142.
[180] Criminal Law Act 1997, section 6(1).

The 1945 Act provides that, where the Gardaí have reasonable grounds for believing a person of unsound mind is in a house, they have the right to enter and place the person under care and control for the safety of the person and in the public interest.[181]

Under the 2001 Act, the Gardaí must have reasonable grounds for believing the person has a mental disorder and there is a "serious likelihood of the person causing immediate and serious harm to himself or others."[182] In order to comply with Article 8(2) the interference in the dwelling will have to be justified as necessary and proportionate.[183] The interpretation of words like "immediate and serious" harm are crucial to establish justification for the interference. This is particularly important in the case of Garda entry to the home which can be carried out without a warrant. Other informal intrusions on the home should be subject to a code of practice in order to comply with this right to respect for the home.

The 1945 Act provides for two forms of community control: absence on leave which can extend to 48 hours, and absence on trial, which can extend to 90 days following which a patient can be re-admitted or discharged.[184] The 2001 Act provides that a patient may be given conditional or unconditional leave only for the unexpired period of the detention order and the safeguards applying to detention will apply as if the person were hospitalised.[185] Neither Act gives details as to what interventions can take place during this time and how invasive of private, family or home life they might be. Interventions under community treatment orders have been found to be justified under Article 8(2).[186] The intrusion by staff into the homes of patients in community residential facilities and the lack of privacy in such places might well engage Article 8 and the right to respect for private life and the home. Clearly, such interferences would have to stand the "necessity" test in Article 8(2), pursue a legitimate aim and be proportionate to that aim.

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[181] Mental Treatment Act 1945, section 165 and amended by Mental Treatment Act 1961, section 9.
[182] Mental Health Act 2001, section 12(1)(b).
[183] *McLeod v. United Kingdom* (1999) 27 EHRR 493.
[184] Mental Treatment Act 1945, sections 203 & 204.
[185] Mental Health Act 2001, section 26. The Criminal Law (Insanity) Bill 2002 proposes Review Boards to deal with those coming within the narrow provisions of the Bill. The Boards will have power to discharge people conditionally or unconditionally and with supervision as appropriate.
[186] *L v. Sweden* Application no. 10801/84 61 DR 62 (1988).

Correspondence

The right to respect for correspondence includes letters and also protects telephone conversations.[187] It is likely that the protection extends to other forms of communication, such as email.[188] The right guaranteed is to "uncensored communication with others."[189] This right to confidentiality, particularly in a doctor patient relationship, is as much an aspect of private life as it is of correspondence. The issue of correspondence is important in the every day life of patients in psychiatric care.[190] The Court is mindful of the need to ensure confidentiality in the correspondence of detained persons, recognising that such communication is vitally important.

The control of correspondence in a psychiatric hospital arose in *Herzegefalvy v. Austria* where the applicant was deprived of writing materials and unstamped letters and his letters were filtered through his guardian, who decided whether or not they would be sent to the addressees.[191] Apart from those being sent to government authorities, the remainder were returned to him. The Government conceded that this was an interference with his correspondence, but argued that it was justified as the essential purpose had been to protect his health. The Court stated,

> Any interference constituted a breach of Article 8 unless it was in accordance with law, pursued a legitimate aim or aims under paragraph 2 and was moreover 'necessary in a democratic society' for achieving those aims. The impugned measure should have some basis in national law; it also refers to the quality of the law in question requiring that it should be accessible to the person concerned who must moreover be able to foresee its consequences for him and be compatible with the rule of law. [192]

The Court emphasised that there must be a measure of protection in national law against arbitrary interferences with the rights safeguarded by paragraph 8(1) in order to achieve compatibility with the rule of law. Where discretion is vested in a public authority, the authority must clearly indicate the scope of the discretion, to prevent too

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[187] *Klass v. Germany* (1979) 2 EHRR 214.
[188] *Op. cit.*, 83 p807.
[189] *Op. cit.*, 3 p320.
[190] *R v. Ashworth ex parte N* [2001] EWHC Admin 339.
[191] *Herzegefalvy v. Austria* (1992) 15 EHRR 437.
[192] *Ibid*, para 88.

much latitude, "although the degree of precision required will depend on the particular subject matter."[193] The Court referred to vaguely worded provisions that did not specify the scope of conditions of exercise of the discretionary power in this case,

> ... such specifications appear all the more necessary in the field of detention in psychiatric institutions in that the persons concerned are frequently at the mercy of the medical authorities, so their correspondence is the only contact with the outside world ... in the absence of any detail at all as to the kind of restriction permitted or their purpose, duration and extent or the arrangements for their review, the above provisions do not offer the minimum degree of protection against arbitrariness required by the rule of law in a democratic society.[194]

The Court held that the system was not in accordance with the law and was not justifiable having regard to Article 8(2).

Irish law and the right to respect for correspondence

Constitutional law

The right to communicate was declared by the High Court to be included in Article 40.3 of the Constitution as the exercise of a basic human faculty that "inheres in the citizen by virtue of his human personality."[195] The Irish courts have declared that like all other constitutional rights, this right is not absolute.

Mental health legislation

The 1945 Act provides for the right to send an unopened letter to the Minister for Health, the Inspector of Mental Hospitals, the President of the High Court, the local health board and, where relevant, the Ward of Court office.[196] The Act provides that notices of such rights are at the discretion of the Inspector and Minister for Health, as provided in the Act, "if the Minister so directs ... and if the Inspector of Mental

[193] *Ibid*, para 89.
[194] *Ibid*, para 91.
[195] *Attorney General v. Paperlink* [1984] ILRM 373.
[196] Mental Treatment Act 1945, section 266.

Hospitals indicates the positions where they are to be posted."[197] There is a presumption that, outside of this specific protection, correspondence can be restricted and there are no guidelines on the extent of the restriction. The Mental Treatment Regulations 1961, which provide that a person in charge may examine correspondence to and from patients where he "thinks fit," appear extreme in their discretion, the scope of which is unclear and too vague to constitute a justifiable interference.[198] It is not clear if the restrictions are carried out for the "protection of health or morals," for the "rights or freedoms of others" and whether these intrusions are proportionate to the aim of the restriction or are foreseeable. The arbitrariness of such a system would appear to risk breaching Article 8(2).

The 2001 Act does not refer to the right to correspondence, although the principles section refers to the right to respect for the privacy of the individual, thereby embracing this provision.[199] The right to respect for correspondence needs specific protection to prevent arbitrariness as there may be an unacceptable level of discretion otherwise. The Mental Health Commission will have the task of introducing a code of practice which should give guidance on the right to correspondence and the criteria on which restrictions may be based.

Conclusion

This chapter considered Article 8 rights, in particular the right of self-determination and the authority to treat persons for mental disorder. The 1945 Act does not contain any safeguards for the imposition of medical treatment and there is an assumption that detention includes the right to treatment, despite the fact that there is no express power in the Act to do so. Arguments in favour of this position are vague and would not satisfy Article 8(2) and the requirement of lawfulness, foreseeability of effect and precision. The recent *Storck* decision is clear that even a minor interference with the physical integrity of an individual must be regarded as an interference with private life in Article 8 when carried out against the will of the person.[200] The provision of some safeguards for the imposition of seclusion and restraint is in contrast to the

[197] *Ibid*, section 267.
[198] Mental Treatment Regulations 1961, Article 7.
[199] Mental Health Act 2001, section 4.
[200] Application no. 61603/00 16th June 2005.

imposition of treatment, but is reflective of the era when there was much greater reliance on such measures. The requirement of proportionality in Article 8 may well be breached in relation to treatment under the 1945 Act particularly in relation to addicts. Voluntary patients under the 1945 Act, who are incapacitated, are not legally recognized and the absence of safeguards for consent to treatment for these patients is likely to engage Article 8. The overall impression of the 1945 Act is one where the scope of the Act is unclear in relation to treatment and to the level of discretion permitted in many sections affecting patients' rights and so is in breach of the requirement of lawfulness under the Convention by not providing adequate safeguards against interference.

In contrast, the 2001 Act has clear dividing lines between detention and treatment. There are safeguards for consent to treatment for detained patients, but some are open to question, such as the second opinion for consent to treatment which could not be regarded as independent. The patient would not be able to rely on having a Mental Health Commission approved second opinion psychiatrist, in contrast with the second opinion for the tribunal hearing, and this could well infringe the requirement of foreseeability of effect of the second opinion system. The second opinion doctor will not have to give reasons for the decision in contrast to the situation with an English decision on the matter.[201] The question of proportionality arises in relation to the three months rule for medicine where no consent or second opinion is required until after this period, despite the section being flagged as requiring consent or a second opinion. The justification for this rule may be that it is necessary for the protection of health, but modifications could provide safeguards at the beginning of the imposition of medicine and throughout this period. There are no treatment safeguards for the voluntary incapacitated patient and so the decisions in *HL* and *Storck* arguably apply to some of these patients where they are deemed to be deprived of their liberty. Overall, the 2001 Act presents weaknesses in the safeguards for consent to treatment, has no safeguards for voluntary incapacitated patients and does not meet the requirement of lawfulness in Article 8(2).

[201] *R v. Feggetter & MHAC, ex parte JW* [2002] EWCA 554.

In the context of participation in clinical trials, the 2001 Act prohibits detained patients from involvement using the status test as an indicator of capacity and disregarding the notion of benefit.[202] The safeguards in relation to clinical trials have improved and would appear to meet rights standards in relation to proxy decision-making for incapacitated patients.[203] There are no provisions for advance directives, but the Law Reform Commission has made proposals which would lead to a comprehensive system of proxy decision-making, as well as advance directives for health care and the extension of the enduring power of attorney to cover health care decisions.[204] These proposals are influenced by developments in English and Scottish law.[205] They emphasise the need to respect the right to private life by providing safeguards for the right to self-determination in advance directives.

The right of confidentiality in medical treatment is protected by a number of statutes, but there are concerns that information is shared too readily. This situation is unlikely to change without a code of practice. The Irish Medical Council provides limited guidance that does not include people who cannot give informed consent.

The protection of the right to respect for private life may present difficulties in balancing competing interests. The problem arises also with older children and raises concerns about the necessity and justification for imposing treatment on a competent older child under Article 8(2).[206]

The right to respect for the home extends to residential centres where people with mental disorders live, although these places are not often perceived as someone's home. Interferences in these homes with intrusive visits by health personnel need to be justified under Article 8(2). The right to respect for correspondence is not referred to specifically in the 2001 Act, though the principles section, which provides for the right to respect for privacy and autonomy, may support this right. Moreover, interferences with the right must be justifiable by reference to Article 8(2).

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[202] Mental Health Act 2001, section 70.
[203] Clinical Trials Legislation 1987-1991, Directive 2001/20/EC and European Communities (Clinical Trials on Medicinal Products for Human Use) Regs. 2004.
[204] *Op. cit.*, 69 chapter 7.
[205] Mental Capacity Act 2005 and Adults with Incapacity Act 2000.
[206] See chapter 9 for further discussion.

Chapter 4

ARTICLE 3 AND THE PREVENTION OF TORTURE, INHUMAN AND DEGRADING TREATMENT UNDER IRISH MENTAL HEALTH LAW

Introduction

This chapter considers the impact of Article 3 on the rights of mentally disordered people and the provisions in Irish law to prevent torture, inhuman and degrading treatment. There are two mechanisms for the enforcement of rights under Article 3, one is an application before the Strasbourg Court and the second is through the Committee for the Prevention of Torture, the CPT. This Committee was set up under the Convention for the Prevention of Torture, Inhuman or Degrading Treatment and Punishment and has a direct influence on medical care, defining what is inhuman or degrading in two key areas: detention in psychiatric care, and the adequacy of care for prisoners with mental disorder.[1] Key questions under Article 3 and Irish law will be addressed throughout this chapter: whether the conditions in which mentally disordered people are detained could reach the minimum level of severity to come within the scope of Article 3, whether medical treatment could amount to inhuman and degrading treatment, whether the side effects of treatment could be severe enough to engage Article 3; and whether the failure to treat an individual could amount to a breach of Article 3.

Article 3 provides:

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

Article 1 of the Convention requires states to secure to everyone within their jurisdiction the rights and freedoms contained in the Convention. This obligation, taken together with Article 3, requires states to take measures designed to ensure that individuals within their jurisdiction are not subjected to torture or inhuman or degrading treatment or punishment, including such ill-treatment administered by

[1] Council of Europe, CPT Standards on Health Care Services in Prisons, Extract from the 3rd General Report [CPT/Inf (93) 12]

private individuals.[2] The state has a positive obligation to take all reasonable measures to protect children, the mentally disordered, the detained and other vulnerable individuals from the risk of a breach of Article 3. The obligation is engaged when the state knows or ought to know that there is a "real and immediate risk" of a breach which has a high threshold. The more vulnerable the individual, the lower the threshold of risk which engages the positive obligation and the greater the preventative measures required.[3] According to Convention case law, children and other vulnerable individuals are entitled to effective deterrence against breaches of personal integrity.[4] The Court, in *Z v. United Kingdom,* held that this includes protection against child abuse and the state is required to take reasonable steps to prevent ill-treatment of which the authorities had, or ought to have had, knowledge.[5] In relation to psychiatric illness, this could mean state failure to recognise the risks to children of failing to provide treatment for a parent.

Obligations arising from Article 3 are imposed on states to carry out investigations and to ensure that those within their jurisdictions are not subject to treatment prohibited by Article 3. The main purpose of Article 3 is to protect "a person's dignity and physical integrity."[6] It is a non-derogable Article that creates state obligations and, unlike other Articles, it does not have any limiting qualification. Harris states, "This can be understood to mean that ill-treatment within the terms of Article 3 is never permitted, even for the highest reasons of public interest."[7] Freedom from torture is a fundamental human right and "holds a special place ... and many international legal sources express support for such a right."[8] Article 3 "prohibits in absolute terms torture or inhuman or degrading treatment or punishment, irrespective of the circumstances and the victim's behaviour."[9] The preventative nature of Article 3 guarantees against ill-treatment and also encourages state compliance.

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[2] *A v. United Kingdom* (1999) 27 EHRR 611 para 22.
[3] *Keenan v. United Kingdom* (1998) 33 EHRR 913 paras 102, 110, and *Herczegfalvy v Austria* (1992) 15 EHRR 437.
[4] *X and Y v. Netherlands* 26 March 1985, Series A no. 91, para 21–27.
[5] (2002) 34 EHRR 3 para 73.
[6] *Tyrer v. United Kingdom* (1978) 2 EHRR 1. para 33.
[7] Harris, O'Boyle & Warbrick, *Law of the European Convention on Human Rights*, Butterworths, London, 1995, p55.
[8] UN Convention Against Torture 1984 and the European Convention for the Prevention of Torture, and Inhuman or Degrading Treatment.
[9] *Labita v. Italy* Application no. 26772/95, para 119.

The Committee for the Prevention of Torture

The European Convention for the Prevention of Torture and Inhuman and Degrading Treatment or Punishment 1987 (Prevention of Torture Convention) was introduced as a supplement to Article 3, as a preventative measure to monitor the practical implementation of the human rights standards. The Convention provides a remedy for an individual or state victim when Article 3 has been breached, *ex post facto* and the Prevention of Torture Convention provides a preventative system. An independent Committee was established under the Prevention of Torture Convention, known as the Committee for the Prevention of Torture (CPT). This committee visits various public places of detention in the Contracting States and reports on its findings.[10] It examines the treatment of individuals "with a view to strengthening, if necessary, the protection of such persons from torture and from "inhuman or degrading treatment or punishment." Its findings may be used by the Court to assist in a judgment.[11] The CPT "works outside the conventional human rights framework which is public, visible and binding on governments."[12] It operates outside public scrutiny, uses "moral persuasion" and depends on cooperation in response to its systematic monitoring of places of detention. It is interesting to note that the requirements in the Prevention of Torture Convention and in Article 3 are different. The CPT has a lower threshold because it can criticise states about conditions in places of detention that it visits that might not give rise to a finding of a breach under Article 3. It provides national reports, indicating findings and making consequential recommendations for reform of the protection of detained persons.

The objective of this Convention is preventative in nature and the CPT has a range of standards, including those applying to prisons and psychiatric hospitals.[13] These standards relate, *inter alia,* to conditions of detention, seclusion and restraint,

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[10] The committee has a number of independent experts nominated by the contracting states but acting in an individual capacity and the basis of involvement with Contracting States in co-operation. Allegations of consistent abuse can result in ad hoc visits and a more assertive approach in the face of non-co-operation.

[11] Harding T., "The Application of the European Convention of Human Rights to the Field of Psychiatry" (1989) 12 *Int J. of L. & Psych.* pp245-262.

[12] Gostin "Human Rights of Persons with Mental Disabilities The European Convention of Human Rights" (2000) 23(2) *Int. J.of L. & Psych.* P145.

[13] Council of Europe, CPT Standards on Involuntary placement in Psychiatric Establishments Extract from the 8th General Report [CPT/Inf (98) 12].

treatment plans, consent to treatment along with information and safeguards for patients.[14] The Committee is of the view that people who are institutionalised are particularly vulnerable to abuse, so it is part of its mandate to ensure standards are met. The CPT may visit any hospital or institution which has a custodial character, such as geriatric hospitals or residences for those with intellectual disabilities.

Minimum level of severity

The Strasbourg Court recognises three distinct categories of "ill-treatment" under Article 3: torture, inhuman treatment and degrading treatment. These are separated on the basis of the degree of suffering experienced by the individual and were clearly demonstrated in the decision of the Court in *Ireland v. United Kingdom.*[15] Ill-treatment must reach a minimum level of severity if it is to fall within Article 3. The assessment of this minimum level is relative and depends on all the circumstances of the case, the context and duration of the treatment, its physical and mental effects on a person whose age, gender and state of health will be factors.[16] The requirement of a minimum level of severity for the action to fall within the parameters of Article 3, regardless of the type of action involved, has the intention of eliminating a range of complaints apart from those that reach a level of severity in terms of suffering and degradation. The Court has stated that, in cases where the level of severity is not sufficient to engage Article 3, "there might be circumstances in which Article 8 could be regarded as affording a protection in relation to conditions during detention which do not attain the level of severity required by Article 3."[17]

The lower threshold of severity applies to inhuman and degrading treatment. The Court has held that treatment will be inhuman only "if it reaches a level of gravity involving considerable mental or physical suffering, and degrading if the person has undergone humiliation or debasement involving a minimum level of severity" and where it impacts adversely on his personality in a manner incompatible with Article 3.[18]

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[14] *Ibid,* paras 40-48.
[15] (1980) 2 EHRR 25.. This was the first time an inter-state application was brought before the Courts.
[16] *Ibid.*
[17] *Raninen v. Finland* [1997] 26 EHRR 563 para 63.
[18] (1980) 2 EHRR 25 para 162.

> Such treatment arouses in the victims feelings of fear, anguish or inferiority, capable of humiliating and debasing them and possibly breaking moral resistance occasioning physical injury and psychiatric damage.[19]

The Court has acknowledged the inevitable element of suffering or humiliation connected with a legitimate deprivation of liberty, but Article 3 obliges the state to ensure that a person is detained under conditions which are compatible with respect for human dignity. Further, the state is obliged to ensure that the individual is not subject to distress or hardship exceeding that expected in detention and that the person's health and well-being are adequately secured.[20] The person must also be provided with the necessary medical care and treatment.[21] The cumulative effect of conditions must be considered in addition to the specific allegations by an applicant.[22] More recently, the Court has ruled on breaches of Article 3 and found both conditions and treatment have amounted to torture, inhuman and degrading treatment.[23] The Court found a violation of Article 3 in *Nevmerzhitsky v. Ukraine,* where the applicant's health deteriorated significantly and the conditions had such an effect on his health and well-being that they amounted to degrading treatment.[24] Prior to detention, the applicant had no skin disease and had normal health but contracted allergic dermatitis in custody which later proved to be microbic eczema and scabies. He received his first medical examination after 6 weeks of detention. It was recommended that he receive specialist treatment which was not done and for 6 months, after his hunger-strike, he received no medical intervention. The Court held this was not "adequate and reasonable medical attention, given the hunger strike and the diseases from which the applicant was suffering."[25] The Court held Article 3 was violated with regard to lack of adequate medical treatment and assistance that amounted to degrading treatment. This decision has implications for the area of mental health care where the adequacy of medical treatment is in question, though the impact is much more difficult to establish compared to identifiable physical symptoms.

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[19] *Ibid,* para 167. Techniques employed included hoodwinking, wallstanding, food and sleep deprivation and sensory disorientation.
[20] *Kudła v. Poland* Application no. 30210/96, para 92.
[21] *Aerts v. Belgium* (2000) 29 EHRR para 64..
[22] *Dougoz v. Greece*, Application no. 40907/98, para 46.
[23] *Nevmerzhitsky v. Ukraine* Application 54825/00 5th April 2005.
[24] Application 54825/00 para 87.
[25] *Ibid*, para 105.

The highest threshold applies to complaints of torture and evidence is rarely severe enough to satisfy Article 3. Torture is defined as deliberate and intentional inhuman treatment causing very serious and cruel suffering.[26] In *Selmouni v. France,* the Court acknowledged that the standard is not static and, in recognition of present-day circumstances, that actions which were not in the past regarded as torture may be recognised as such in the future.[27] This indicates that the notion of torture is set to expand to include previously excluded forms of ill-treatment. The Court held that the physical and mental violence that caused severe pain and suffering and was serious and cruel was more properly categorised as torture. Gostin comments that torture is "unlikely to apply to mental health cases unless there is some anti-therapeutic, or unethical motive, such as political oppression."[28]

However, neither the Commission nor the Court has ever found that conditions in a psychiatric hospital were so severe as to breach Article 3 on torture grounds. The closest has been in *Nevmerzhitsky v. Ukraine,* where the applicant alleged he had been force-fed five times a week while on hunger-strike by other detainees, not by trained staff. He was frequently handcuffed to a chair or a heating facility and forced to swallow a rubber tube that was connected to a special nutritional mixture. Justification by the government for the feeding was medical necessity and the Court reiterated that a measure which is of therapeutic necessity from the point of view of established principles of medicine cannot, in principle, be regarded as inhuman and degrading. The same can be said about force-feeding that is aimed at saving the life of a particular detainee who consciously refuses to take food when medical necessity is convincingly shown to exist[29] The applicant claimed that there had been no medical necessity to force-feed him, as there had been no medical examination, tests or other documents that sufficiently proved that necessity. He alleged that the force-feeding had been aimed at his humiliation and punishment, as its purpose had been to make him stop the hunger strike and to subject him to severe physical suffering. The failure of the government to establish life-threatening circumstances meant medical necessity was not proven and the feeding was, therefore, arbitrary. The Court held that the means used to force-feed amounted to torture, where it was resisted, and there was no

[26] *Ireland v. United Kingdom* (1980) 2 EHRR 25 para 167.
[27] (2000) 29 EHRR 403.
[28] *Op. cit.,*11 p141.
[29] *Herczegfalvy v. Austria* (1993) 15 EHRR 437 para 83

medical justification. Therefore, this constituted "treatment of such a severe character warranting characterisation of torture."[30]

Conditions of detention

Positive obligations apply in relation to conditions of detention and Article 3 applies to all categories of detention, including psychiatric detention. It applies to patients in hospitals who complain that their conditions are dirty or lacking in security or that they have been abused by staff or other patients. There is no specific basis in the Convention for questioning the conditions of detention or treatment, but these could be raised under Articles 3, 5 or 8. There have been many unsuccessful challenges to state practice using Article 3 involving psychiatric detention, including challenges to conditions of detention and medical treatment.[31] In *B v. United Kingdom,* the applicant complained of grossly overcrowded conditions, poor sanitary facilities and the constant threat of violence.[32] The Commission declared the complaint admissible and stated that, even if hospital staff do their best with the conditions, this would not exclude the possibility that the physical conditions of detention could in themselves give rise to a question under Article 3. In keeping with the deference shown in later cases, the Commission ruled against the applicant due to the absence of a single incident which was so grave as to warrant a finding of inhuman and degrading treatment.

In *Pretty v. United Kingdom,* the Court stated that physical and mental suffering may be covered by Article 3 where the illness is exacerbated by the conditions of detention, expulsion or other measures for which the authorities are responsible.[33] In considering whether treatment is "degrading" within the meaning of Article 3, one of the factors which the Court will take into account is the question as to whether its object was to humiliate and debase the person concerned, although the absence of any such purpose cannot conclusively rule out a finding of violation of Article 3.[34]

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[30] Application 54825/00 para 98.
[31] Among the failed Article 3 cases are the Vagrancy cases (1979) 1 EHRR 373, *Winterwerp v. Netherlands* (1979) 2 EHRR 387, *Bozano v .France* (1987) 9 EHRR 297, *Aerts v. Belguim,* (2000) 29 EHRR 50, *Herzgefalvy v. Austria* (1993) 15 EHRR 437.
[32] Application no 6870/75 32 DR 5 (1981) Comm Rep p 29-30.
[33] (2002) 35 EHRR 1 para 52.
[34] *Price v. United Kingdom*(2002) 35 EHRR 1. Application no. 33394/96 10th July 2001 para 24.

The Court has found evidence of inhuman and degrading treatment and a breach of Article 3 involving a mentally disordered person in the prison system. In *Keenan v. United Kingdom,* a prisoner was suffering from a severe mental disorder, with a history disclosing episodes of disturbed behaviour, including suicidal tendencies, particularly following his removal from the hospital wing to a normal prison location.[35] The Commission stated that it could not be certain that his symptoms and suicide resulted from the conditions of his detention imposed by the authorities. The Court decided that this difficulty was not determinative of the issue as to whether the obligations of the State were fulfilled under Article 3, as there are circumstances where proof of the actual effect on the person may not be a major factor.[36] In respect of a person deprived of his liberty, the Court said that recourse to physical force by staff where this is not strictly necessary in light of the detainee's own conduct diminishes human dignity and is, in principle, an infringement of the rights set forth in Article 3.[37]

Similarly, treatment of a mentally ill person may be incompatible with the standards imposed by Article 3 in the protection of fundamental human dignity, even though that person may not be able or capable of pointing to any specific ill-effects.[38] Referring to *Herczegfalvy v. Austria* and *Aerts v. Belguim*, the Court said that the assessment of whether the treatment or punishment concerned is incompatible with the standards of Article 3 has, "in the case of mentally ill persons, to take into consideration their vulnerability and their inability, in some cases, to complain coherently or at all about how they are being affected by any particular treatment."[39] The lack of effective monitoring and specialist assessment and treatment were significant defects in the medical care of a mentally ill person known to be a suicide risk. These factors, along with the imposition of punishment and an extended sentence, may "have threatened his physical and moral resistance, and is not compatible with the standard of treatment required in respect of a mentally ill

[35] (2001) 33 EHRR 38.
[36] *Ibid*, para 109.
[37] *Ibid,* para 112.
[38] *Ibid,* para 113.
[39] *Ibid,* para 111. *Herczegfalvy v. Austria* (1993) 15 EHRR 437 and *Aerts v. Belguim*, (2000) 29 EHRR 50.

person."[40] The Court held that these failures in *Keenan* met the severity standard to be regarded as inhuman and degrading treatment and punishment within Article 3.

The finding of a breach of Article 3 involving a physically disabled person is important by analogy for mentally disordered persons. In *Price v. United Kingdom,* the applicant, a thalidomide victim with numerous health problems including defective kidneys, committed contempt of court in the course of civil proceedings and was ordered by a judge to be detained for seven days for non-payment of fines.[41] It appears that, in accordance with English law and practice, the sentencing judge took no steps, before committing the applicant to immediate imprisonment, to ascertain where she would be detained or to ensure that it would be possible to provide facilities adequate to cope with her severe level of disability. There was no evidence in this case of any positive intention to humiliate or debase the applicant. The Court held that, to detain a severely disabled person in conditions where she was dangerously cold, risked developing sores because her bed was too hard or unreachable, and was unable to go to the toilet or keep clean without the greatest of difficulty, constituted degrading treatment contrary to Article 3 of the Convention.[42] The same reasoning should apply, *mutatis mutandis,* to mentally disordered persons who are detained in hospital, strengthened by the additional factor of their vulnerability and their inability to complain about how they are being affected. Conditions which seriously threaten the mental health of the person, like those in *Keenan* should engage Article 3.

One of the important questions is whether inadequate and non-therapeutic conditions could breach Article 3. The Court has never found such a breach in psychiatric detention, only in relation to conditions in prison.[43] Instead, the Court prefers that such conditions would be considered under Article 5, which imposes minimum therapeutic standards.[44] Gostin comments on minimum standards applying to those detained in psychiatric care and he believes that,

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[40] *Ibid*, para 116.
[41] (2002) 34 EHRR 53.
[42] *Ibid,* para 30.
[43] *Price v. United Kingdom* (2002) 34 EHRR 53, *Nevmerzhitsky v. Ukraine* Application 54825/00.
[44] *Aerts v. Belgium* (2000) 29 EHRR 50.

> ... minimally adequate care and treatment should be a necessary precondition to detention on grounds of unsoundness of mind; otherwise it would be difficult to justify detention on those grounds alone. ... if a person is to be deprived of liberty, not as a punishment for a criminal offence, but because of the need for therapy, then the government should have a duty to provide minimally adequate treatment. Minimally adequate standards of treatment would help to assure that a person's mental health does not deteriorate, but can actually improve.[45]

Conditions of detention were raised in *Dhoest v. Belguim,*'[46] where the applicant was detained in a high security hospital and alleged a breach of Article 3. He was strapped to a bed, tranquillisers were put in his soup and coffee and he spent 14 years in extreme isolation, with no social contact. Part of his complaint was that he had not received treatment, other than drugs. The Commission held it did not violate Article 3 because he was considered to be partly responsible for his own behaviour. There seemed to be little consideration of the extremely harsh conditions for someone who was mentally ill and in isolation. The decision in this case leads Fennell to conclude that "standards and conditions will have to fall very low for the therapeutic purpose to be destroyed."[47] He also maintains that where detention is based solely on 5(1)(e) alone, complaints about conditions in the place of detention are better brought under Article 5 than Article 3.

The proportionality doctrine was raised in *Aerts v. Belguim,* where the Court held that there must be some connection between the ground of detention relied on and the place and the conditions of detention.[48] The applicant was held for seven months in unsuitable conditions in the psychiatric wing of a prison, despite the psychiatrist's reporting that he urgently needed transfer to a better equipped centre for his mental health.[49] The applicant had not received any regular medical or psychiatric attention and he alleged that the conditions of detention had caused a deterioration of his mental

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[45] *Op. cit.,* 11 p144.
[46] (1987) 12 EHRR 97. He alleged there was a breach of Article 5(1)(e) because he was detained as a person of unsound mind and was entitled to appropriate treatment in order to ensure that he was not detained longer than absolutely necessary.
[47] Fennell P., "The Third Way in Mental Health Policy: Negative Rights, Positive Rights, and the Convention", (1999) 26(1) *Journal of Law and Society* pp47-70.
[48] (2000) 29 EHRR 50. See chapter 1 for full discussion of this issue.
[49] *Ibid.*

health. His allegations regarding the conditions were supported by a CPT visit to the place of detention.[50]

Aerts alleged violations of Articles 3, 5 and 6 and the Court held that Article 5(1) had been violated in that the necessary relationship of proportionality between the grounds of detention relied on and the place and conditions of detention did not exist. The psychiatric wing could not be regarded as an institution appropriate for the detention of persons of unsound mind. Detention on the grounds of unsoundness of mind had to be in a hospital, clinic or similar institution. The Court held the conditions were not so severe as to bring them within the scope of Article 3 and there was not enough evidence to establish inhuman and degrading treatment. The Court held that, where the sole basis of detention is unsoundness of mind, an anti-therapeutic environment may contravene Article 5(1) even if it is not severe enough to amount to inhuman and degrading treatment as to breach Article 3. The first sign of this attitude had arisen in *Ashingdane v. United Kingdom,* where the Court held that the detention of a person is "lawful" under Article 5(1)(e) only if effected in an appropriate institution.[51]

Seclusion

Seclusion and restraint in mental health is not in itself a breach of Article 3, as it may be justified to prevent injury to the person or to others. The Commission distinguished between complete sensory deprivation, coupled with total social isolation, which could destroy the personality and was unjustifiable and removal from association for various reasons, including protective reasons, which would not amount to inhuman and degrading treatment.[52] It will depend on the conditions, duration, purpose and the effects on the person concerned.[53] However, the conditions involving seclusion could breach Article 3 where it is a sufficiently disproportionate response. According to Gostin, "where a particular act of restraint is disproportionate or arbitrary and even if

[50] The CPT considered that the standard of care given to the patients placed in the psychiatric wing at the prison fell below the minimum acceptable from an ethical and humanitarian point of view and that prolonging their detention for lengthy periods carried an undeniable risk of a deterioration of their mental health. Although the CPT had severely criticised these conditions, it had not asserted that the physical conditions of detention or the lack of medical attention constituted inhuman or degrading treatment of the inmates.

[51] *Ashingdane v. United Kingdom* (1984) 6 EHRR 69 Para 44.

[52] *Dhoest v. Belgium* (1987) 12 EHRR 97 para 117.

[53] *A v. United Kingdom* Application no. 6840/74.

restraint is generally necessary it may breach Article 3".[54] Its use will have to satisfy the test of "medical necessity" required by the Court in *Herczegfalvy v. Austria* in order to avoid breaching the Convention.[55] The use of restraint against voluntary patients can be carried out under the common law and, though the precise nature is not clear and even allowing for the "medical necessity" test, there is scope for using restraint on such patients.[56] Many of the cases concern prisoners. In all cases regard must be had to all the surrounding circumstances of the case, including the particular conditions and their severity, the duration and purpose and how the person was affected.

The issue of seclusion and restraint arose in *A v. United Kingdom* in the context of the conditions of the place of seclusion.[57] The case was an important indication of the Commission's willingness to look at such issues. A friendly settlement was reached and included the introduction of new guidelines providing for improved standards on seclusion. In this way, Article 3 provided the opportunity to have standards raised for all those in detention, not just the applicant. This was the closest the Court came to a finding of a breach of Article 3 arising from mental hospital conditions. Gostin comments that this case "implicitly recognises that certain forms of seclusion, even if ordered by medical authority, could be inhumane."[58]

One of the leading English cases on seclusion, *R v. Mersey Care NHS Trust Ashworth Hospital Authority & others Ex p Munjaz,* addressed the use of seclusion where the hospital had departed from the provisions of the Code of Practice.[59] The Code requires that seclusion should be used as a last resort and for the shortest possible time; that it should not be used as a punishment or threat, as part of a treatment programme, or because of shortage of staff, or where there was any risk of self-harm; that a decision to seclude should be taken by a doctor or nurse in charge; and that the continued need for seclusion should be reviewed every two hours by two nurses and every four hours by a doctor.

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[54] *Op. cit.,* 12 p149.
[55] (1992) 15 EHRR 437.
[56] Bartlett & Sandland, *Mental Health Law Policy and Practice,* OUP, Oxford, 2003, p395.
[57] Application no. 6840/74 July 1980.
[58] *Op. cit.,*11 p 143.
[59] [2003] EWCA Civ 1036. See also *R (S) v. Airedale NHS Trust and others* [2002] EWHC 1521.

The Court of Appeal in *Munjaz* found several legal bases in English law for seclusion. The power to seclude detained patients arises by necessary implication from the statutory power to detain. Seclusion is also capable of being "medical treatment" within the meaning of the Mental Health Act 1983 and, therefore, might also be authorised medical treatment under the Act and under the common law doctrine of necessity. Informal patients can be secluded under the common law where this is reasonably necessary and proportionate to protect others from the immediate risk of significant harm and, where a patient lacked capacity, to provide whatever treatment or care was necessary in the patient's own best interests.[60]

Adherence to the Code satisfied the State's obligation to avoid a contravention of Article 3 and met the requirements of legality where rights protected by Articles 5 or 8 were interfered with. The Court of Appeal in *Munjaz,* held that hospitals should observe the Code unless they had a good reason for departing from it in relation to an individual patient or a group of patients sharing particular well-defined characteristics, and they were not free to depart from it as a matter of policy, or on an arbitrary basis. [61] The hospital must show that the use of seclusion is necessary and the reasons must be given.[62] The seclusion of detained patients involves a "real and immediate risk" of inhuman or degrading treatment.[63] Therefore, the State has a positive obligation to provide practical and effective protection for detained patients from the use or unnecessary prolongation of seclusion, by establishing and enforcing a national procedure that ensures the frequent medical review of seclusion.

Seclusion, not amounting to inhuman or degrading treatment within Article 3, may nevertheless breach Article 8.[64] The power to seclude compulsorily detained patients should, as with the power to detain, be defined as a power to seclude only when necessary (as in the case of voluntary patients). Since seclusion constitutes a further interference with a detained patient's residual liberty, Article 5 requires that seclusion must be regulated by a procedure "prescribed by law." The courts should, therefore, not only look at the quality of the decision-making, but should also consider the

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[60] *Op. cit.,* 47 p395.
[61] *R (on the application of Munjaz) v. Mersey Care NHS Trust* [2003] EWCA Civ 1036 paras 45, 60 and 72-76.
[62] *R (Wooder) v. Feggetter* [2003] QB 219.
[63] *X v. United Kingdom* (1981) 4 EHRR 188.
[64] *Raninen v. Finland* (1997) 26 EHRR 563. See chapter 3 for further discussion of seclusion.

factual basis of the decision and decide whether continued seclusion is justified. A lack of resources is not justification for a failure to review seclusion in accordance with the Code.[65]

Irish law and Article 3

The CPT and Ireland

The CPT has visited the Central Mental Hospital (CMH) and has made recommendations for change.[66] The report of the CPT concentrated on conditions and on the activities of the people detained and commented on the inadequate facilities in the old buildings, making suggestions for immediate improvement. The lack of protection of the rights of mentally disordered prisoners was highlighted and the CPT wanted a government commitment that this would be resolved.[67] It also stated that every competent patient, whether voluntary or involuntary, should be given the opportunity to refuse treatment or any other medical intervention.[68] Another issue raised by the CPT was the lack of independent review of detention under the current legal system. Patients sent by the courts or transferred from the prison are not included in the review system proposed in the 2001 Act, though it is envisaged that the proposed Criminal Law (Insanity) Bill 2002 will provide a form of independent review of those sent to the CMH by the courts.

In 2002, the CPT also visited a psychiatric hospital and residential centres for people with intellectual disabilities, focusing on the needs of the incapacitated who are in closed spaces and are *de facto* detained. They examined living conditions and safeguards around admission and review of continuing admission. The CPT expressed concern about the lack of "a clear legal or administrative framework for the involuntary admission to establishments for mentally disabled persons," as such admissions are regarded as voluntary.[69] They found such people are admitted usually

[65] *R (on the application of Munjaz) v. Mersey Care NHS Trust* [2003] EWCA Civ 1036.
[66] Council of Europe, CPT *Report to 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,* 20-28 May 2002 para 85.
[67] *Ibid,* para 88.
[68] *Ibid,* para 88.
[69] *Ibid,* para 94.

by a decision of a doctor, or referral from elsewhere. The CPT expressed concern that there were no avenues of appeal against such placements. Nor was there evidence of any decision-making process and plan for each individual or formal review by an independent authority as to the need for placement or supervision. The CPT 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 for people placed in them.[70] The Law Reform Commission is proposing changes for vulnerable adults and decision-making, but it is not clear that this will resolve the problems raised in the CPT reports. The numbers of people with a learning disability, who are living in large psychiatric hospitals, remains a major source of concern, all of whom would have voluntary status, regardless of capacity.[71] The decision of the Strasbourg Court in *HL v. United Kingdom and Storck v. Germany* applies in these circumstances in relation to state obligations to ensure the rights of such individuals are protected with appropriate procedures and safeguards.[72]

Constitutional law

State responsibility involves positive obligations to take measures to protect vulnerable persons from abuse. The *parens patriae* prerogative of the State provides the Courts with jurisdiction, as does the Constitution, to ensure protection for adults themselves or their property and for children who are at risk in order to have their welfare safeguarded.[73] Article 40.3.1 of the Constitution provides for recognition of the right to bodily integrity in *Ryan v. Attorney General* [74] and this right was broadened into a more general right not to have one's health endangered by the actions of the State.[75] Failure to meet this obligation could be a breach of constitutional rights and a violation of Article 3. However, there is no case where a prisoner was released because of the conditions of detention.

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[70] *Ibid,* para 94.
[71] Department of Health and Children, *Report of the Inspector of Mental Hospitals for year ending 2003,* Government Publications, Dublin, 2004.
[72] (2005) 40 EHRR 32 and Application no. 61603/00 16th June 2005. See chapters 1 & 2 for discussion of these cases.
[73] Lunacy Ireland Act 1871 and Child Care Act 1991, Bunreacht na hEireann, Article 34.
[74] [1965] IR 294.
[75] *The State (C) v. Frawley* [1976] IR 365.

The High Court addressed the issue of endangerment of health in *The State (C) v. Frawley,* as well as the conditions necessary to infringe the mentally disordered prisoner's rights and so taint his detention with illegality to deprive it of the character of detention in accordance with the law, thereby necessitating his release.[76] The applicant sought an order of habeas corpus on the basis that the conditions of detention rendered his detention illegal. He was suffering from a severe sociopathic disorder, which caused him to seriously endanger his life by self-injuring and swallowing metal objects, and had to be handcuffed frequently and kept in solitary confinement. The prison authorities subjected him to an extremely rigid regime of restraint on the basis of his safety. One of his complaints was that he was not receiving the appropriate therapy that was shown to be highly specialised and not available in Ireland. The High Court did not believe that the State had an obligation to provide such a specialised regime of treatment for the applicant and the few others known to have this rare condition. The High Court accepted that the State had "a duty to protect the health of persons held in custody as well as is reasonably possible in all the circumstances."[77] Nor could the State without justification or necessity expose that person's health to danger. The application of restraints on an individual in his own interests was regarded as constitutional.[78] The High Court held that the conditions of detention did not amount to torture, inhuman or degrading treatment and refused an order for release. In view of the decision of the Strasbourg Court in *Nevmerzhitsky v. Ukraine,* the Irish courts may well have to make a different decision faced with similar facts in future.[79]

In *The State (Richardson) v. The Governor of Mountjoy Prison,* the High Court discussed the right not to have one's health endangered in relation to the deplorable sanitary conditions in the prison which the prisoner alleged were a threat to her health.[80] The Court held that the State had failed in its duty to provide her with appropriate facilities for maintaining proper standards of hygiene. Other prisoners have sought release, unsuccessfully, through habeas corpus on the grounds, *inter alia,*

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[76] *Ibid.*
[77] *Ibid,* at p152.
[78] *Ibid.*
[79] Application no. 54825/00 5th April 2005.
[80] [1980] ILRM 82.

that they were beaten up in custody, that body searches and close supervision amounted to a breach of constitutional rights relating to human dignity, bodily integrity and constituted inhuman and degrading treatment.[81]

Mental Treatment Act 1945

A hospital inspection system is provided for in the 1945 Act, whereby at least one inspection is carried out annually and a report is compiled for the government with a view to being debated before the Houses of the Oireachtas.[82] These reports receive scant attention from either the government or opposition parties. The reports highlight the seriously inadequate physical conditions in facilities, ranging from patients having to slop-out to unsafe observation areas and overcrowding, as well as poor attention to the health needs of patients.[83] The 2001 report stated,

> ... psychiatric patients enjoy poorer health and have higher mortality rates than the general population. There are several factors contributing to this. The onus is on those responsible for the physical health of patients resident, particularly long-term, in psychiatric hospitals or community residences, is all the more pressing because of this consideration ... It is disquieting to the Inspectorate to have to record that physical health examination of in-patients, as documented in case note material, is often infrequent, desultory and superficial in nature. It is self-evident that some psychiatric patients may not complain of subjective distress.[84]

The 2003 report commented on the contrast in conditions between private and public hospital accommodation as being a cause for concern reflecting the social divide in society.[85] All recent reports refer to the lack of activities for patients particularly at weekends. The conditions of detention in psychiatric care, along with the isolation and lack of appropriate programmes, including, for children, the loss of education, could be severe enough to engage Article 3, when it involves a severe negative impact on the mental health of the individual.

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[81] *The State (Harrington) v. Garvey* High Court unreported 14th December 1976.
[82] Mental Treatment Act 1945, sections 247 and 248.
[83] Department of Health and Children, *Report of the Inspector of Mental Hospitals for year ending 2000,* Government Publications, Dublin 2001. See also reports for the years, 2001, 2002, 2003.
[84] Department of Health and Children, *Report of the Inspector of Mental Hospitals for year ending 2001,* Government Publications, Dublin, 2002.
[85] *Op. cit.,* 71 p5.

Seclusion

The practice of seclusion and restraint is not subject to any formal safeguards or access to review of the practice other than the entries in the Seclusion Register and subsequent inspection by the Inspector of Mental Hospitals.[86] The 1945 Act refers only to restraint and provides that restraint must "be necessary for the purposes of medical or surgical treatment or to prevent the person of unsound mind injuring himself or other persons."[87] Seclusion was included in later regulations requiring that each case of seclusion and restraint must be recorded and signed by the doctor who ordered it.[88] Further regulations require that the patient must be visited every 15 minutes by a nurse.[89] Guidelines on the practice of seclusion and restraint are outlined in a Department of Health & Children document, *Guidelines on Good Practice and Quality Assurance in Mental Health Services* 1998. Some of the guidelines have a basis in the 1945 Act and in statutory instruments, while others are examples of good practice. In addition to the statutory requirements of recording and observation, the Guidelines require: a clear written seclusion policy incorporating procedures to be followed, that staff are fully informed of the need for a separate nursing seclusion care plan for the patient and information on events leading up to the seclusion, including the actual behaviour, the patient's response and reasons for seclusion. Seclusion is required to be reviewed by the consultant psychiatrist on a six hourly basis in contrast with the English Code of Practice requiring four hourly review. Presumably, these guidelines could be used by the courts in assessing if the correct standard of practice had been followed.[90] There is a summary of these guidelines appended to the annual reports of the Inspector of Mental Hospitals.

Mental Health Act 2001

The 2001 Act proposes a rigorous inspection system to ensure that minimum standards are met in all mental health centres and adherence to the standards will be a

[86] *Ibid,* Appendix 1 confirms 3,585 incidents of seclusion involving 652 patients. See chapter 3 for discussion of seclusion.
[87] Mental Treatment Act 1945, section 263.
[88] Mental Treatment Regulations (SI No. 261of 1961), Article 24.
[89] *Ibid,* Article 6(1).
[90] *R (on the application of Munjaz) v. Mersey Care NHS Trust* [2003] EWCA Civ 1036.

condition for registration of the centres.[91] The Inspector has a primary role in reporting on the conditions of hospitals.[92] The poor conditions in many of the remaining hospitals and the urgent need for upgrading of some of the older psychiatric units attached to general hospitals are regarded as a priority.[93] The 2001 Act provides for an individual care plan with the individual being consulted as far as possible.[94] The 2001 Act provides for seclusion as follows,

> **Section 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.
>
> (4) In this section "patient" includes-
>
> (a) a child in respect of whom an order under section 25 is in force, and
>
> (b) a voluntary patient.

The Mental Health Commission are obliged to draft rules for seclusion and restraint that will add some detail to the provisions of the section.[95] It is likely that such rules will be included in a code of practice being drawn up under the Act. The decision of the English Court in *Munjaz* is significant persuasive authority on the application of the English Code to seclusion.[96] The question of necessity applies to the use of seclusion, but this may not be adequate, as such necessity would have to be convincingly shown to exist. The Strasbourg Court's statements on positive obligations regarding children and vulnerable adults necessitates safeguards in the application of seclusion, particularly where children are being secluded while detained in unsuitable conditions, like an adult ward, which may exacerbate the illness and increase the need for seclusion as a result.[97] The lack of formal safeguards, of independent monitoring and review of seclusion, or an independent second opinion

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[91] Mental Health Act 2001, section 64.
[92] Mental Treatment Act 1945, section 237 as amended by Mental Treatment Act 1961, s 33.
[93] *Op. cit.,* 71. See also reports for years ending, 2002, 2001, 2000, 1999.
[94] Mental Health Act 2001, section 66(2)(g).
[95] Mental Health Act 2001, section 69(2).
[96] *R (on the application of Munjaz) v. Mersey Care NHS Trust* [2003] EWCA Civ 1036.
[97] *Z v. United Kingdom* (2002) 34 EHRR 3, *A v United Kingdom* 27 EHRR 611.

before it commences, are also causes of concern having regard to the English decision in *Munjaz*.[98] The Court's statements on positive obligations regarding children and vulnerable adults require the provision of safeguards in the application of seclusion.

Because the basis of psychiatric admission is therapeutic, it is important that the conditions of detention meet a standard that does not impact negatively on the health of the patient. The indications from the CPT visits and from the Inspector's reports are that there are areas of concern regarding conditions. Rectification of such problems involves providing an appropriate environment in relation to physical conditions and a therapeutic milieu. Minimally adequate conditions relating to the treatment of mentally ill prisoners need to be addressed based on the decision in *Aerts*. This has become a critical issue following research indicating that the rate of severe mental illness among remand prisoners is 38 times higher than the general community, compared with sentenced prisoners whose rate is 13 times higher.[99] The findings indicate that mentally-ill people are being placed in prison for often minor offences. The leading researcher stated that "prison is a toxic place for people with serious mental illnesses."

Medical treatment

The Convention case law provides that medical treatment could, in theory, be inhuman and degrading, but not if it is therapeutically necessary.[100] The vulnerability of mentally disordered people requires that the Court is satisfied that treatment is convincingly shown to be necessary. A wide range of interventions and extreme forms of treatment can be imposed in some cases and demonstrated to be therapeutically necessary. The Court has shown a great deal of deference to hospital authorities in consideration as to whether medical treatment and the side-effects can be regarded as inhuman and degrading and has never found a breach of Article 3 on these grounds. In *Herczgefalvy v. Austria,* medical justification was permitted to trump an objective consideration of the conditions of confinement.[101] The applicant

[98] *R (Wooder) v. Feggetter* [2003] QB 219.
[99] Kennedy H., "Mental Illness in Irish Prisoners" report in Irish Times 6th December 2005. The research has not been formally published yet.
[100] *Herczegfalvy v. Austria* (1993) 15 EHRR 437.
[101] *Ibid.*

complained that the medical treatment he was receiving amounted to degrading treatment. He was suffering from paranoia and deemed not responsible for his acts. He was restrained because of the danger posed by him if left free. Following a diagnosis of mental illness, he was forcibly administered food and neuroleptics, isolated and attached with handcuffs to his security bed for several weeks. The Commission held that there had been a violation of Article 3 on the basis that the treatment went beyond what was necessary to serve its purpose, including a week when he was unconscious and handcuffed to his bed. The Court confirmed that psychiatric patients remain under the protection of Article 3, and recognised the vulnerability of patients who may not be able to protect themselves in such circumstances and stated,

> ... 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 ...[102]

While the Court considered that prolonged periods in the psychiatric wing would carry with them the risk of deterioration in a person's mental health and despite the extreme conditions, the evidence was not sufficient for a finding of breach of Article 3. The Court held that, according to the psychiatric principles accepted at the time, medical necessity justified the treatment in issue,

> While it is for the medical authorities to decide, on the basis of the recognised rules of medical science, on the therapeutic methods to be used, if necessary by force, to preserve the physical and mental health of patients who are entirely incapable of deciding for themselves and for whom they are therefore responsible, such patients nevertheless remain under the protection of Article 3, whose requirements permit of no derogation ... The established principles of medicine are admittedly in principle decisive in such cases; as a general rule, a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading. The Court must nevertheless satisfy itself that medical necessity has been convincingly shown to exist.[103]

Even with patients who are not capable of consenting, Article 3 requires that the treatment of the patient is necessary. There was no convincing evidence for the Court that his mental health had suffered and it was not established that he had suffered

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[102] *Ibid,* para 82.

[103] (1993) 15 EHRR 437 para 82. *Bolitho v. Hackney AHA* [1997] 4 All ER 471 and the requirement that the professional opinion has a logical basis that can stand scrutiny.

treatment classified as inhuman or degrading. The Court held that the imposition of food and drugs when he was on hunger strike did not breach Article 3 because such force could be justified "to preserve the physical and mental health of patients who are entirely incapable of deciding for themselves and for whom ...[the medical authorities] are therefore entirely responsible."[104] His incapacity to make decisions for himself was the deciding factor in accepting the necessity for imposition of the treatment.

The imposition of medical treatment on competent patients under the English Mental Health Act 1983 was raised under Article 3. This arose in *R (on the application of Wilkinson) v. Broadmoor Hospital*, an English case, in which the claimant's doctor and statutory second opinion determined to treat him with anti-psychotic medication despite his refusal. The patient sought judicial review of the decision and got an independent opinion disagreeing as to the nature of the mental disorder, his capacity to consent to the treatment and the benefits of the treatment.[105] He also wanted to cross-examine medical witnesses, which is rare in judicial review proceedings. Where alleged breaches of human rights are fundamental under Articles 2 and 3 or raise questions of necessity and proportionality, the Court's need to investigate and resolve medical issues is more acute.[106] A decision had to be made as to whether the plaintiff was capable of consenting or refusing treatment or whether the forcible administration of such treatment would, *inter alia,* be degrading and so impermissible under Article 3.[107] The Court, referring to the statement in *Herczegfalvy* concerning medical necessity and convincing evidence, stated,

> Where there is an allegation of breach of the claimant's Article 3 rights, it is important to bear in mind that the court cannot permit the forcible administering of medical treatment unless it is shown convincingly to be medically necessary. If the patient obtains independent medical evidence to the effect that the treatment is otherwise unsuitable, it may be clear to a court, even without oral evidence, that the case in favour of treatment has not been convincingly shown.[108]

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[104] *Ibid,* para 82.
[105] [2001] EWCA Civ 1545.
[106] *Ibid,* para 25.
[107] *Ibid,* para 26.
[108] *Ibid,* para 36.

Where medical necessity cannot be convincingly shown to exist, a right to refuse treatment is imposed on the relevant section under the 1983 Act. In *R (N) v. M*, an English case, the Court did not hold that the standard of proof, "convincingly shown to be necessary" was the criminal standard, but said that it is high.[109] One commentator states that the word "convincingly"' does not allow for any doubt as to whether it has been shown that an argument is well founded.[110]

The issue of capacity arose in *Wilkinson* in reference to the increasing importance of the distinction between those who do not have capacity and those who do, but that the therapeutic necessity test applied to those without capacity also.[111] One of the CPT reports was used in support of a modern approach to the issue. It stated,

> Patients should, as a matter of principle, be placed in a position to give their free and informed consent to treatment. The admission of a person to a psychiatric establishment on an involuntary basis should not be construed as authorising treatment without his consent. It follows that every competent patient, whether voluntary or involuntary, should be given the opportunity to refuse treatment or any other medical intervention. Any derogation from this fundamental principle should be based upon law and only relate to strictly defined exceptional circumstances ...[112]

Efforts to create a distinction between the rights of those with capacity and those without could engage Article 14. Hale LJ, in *Wilkinson,* pointed out that most people are able to appreciate that they are being forced to do something against their will even if they are not able to make the decision that it should or should not be done.[113] In determining what is in an incapacitated person's best interests, their wishes and feelings are an important element and, where they are opposed to the plan, the benefits will have to be weighed against the disadvantages, particularly if force is required.[114] Similar statements were made by the Court in *Keenan v. United Kingdom,* "there may be a breach of Article 3 even where the applicant is not able to understand

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[109] [2002] EWCA Civ 1789.
[110] *Op. cit.,* 47 p363.
[111] *R (on the application of Wilkinson) v. Broadmoor Hospital* [2001] EWCA CIV 1545 para 31.
[112] Council of Europe, *Report of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment 2000* para 41. Also in the CPT Report on Ireland 2002 para 88 on their visit to residential care centres for people with intellectual disability where no admission procedures are provided.
[113] [2001] EWCA CIV 1545 para 79. Also Hale B., "Mentally Incapacitated Adults and Decision-Making: The English Perspective," 20(1) *International Journal of Law and Psychiatry* 59.
[114] *Ibid,* para 64.

any ill-effects of his or her treatment."[115] Hale LJ allowed that detained patients with capacity can, in certain circumstances, be treated against their will.[116] Bartlett cautiously concludes that "treatment of doubtful benefit, which is strongly opposed by the patient, and which will, if administered, entail the use of force with possible detrimental effects to the overall health of the patient, be in breach of Article 3 of the Convention."[117]

The obvious question that arises for resolution is what happens to those patients who are incapacitated and refusing treatment when a declaration from the court or some other authorisation is not sought? In these circumstances, how can the treatment be convincingly shown to be medically necessary? This is a deficit in legislation in relation to incapacitated people that must be addressed in order to avoid breaching the requirements of Article 3.

The standard of proof required in Article 3 is that the court should be satisfied that medical necessity has been "convincingly" shown to exist.[118] The Court outlined the factors relevant to such a decision to impose medical treatment as follows: the certainty of a treatable mental disorder, its seriousness, the risk to others, whether the treatment will alleviate the illness and how much alleviation, and the unfavourable and severe side effects of the treatment.[119] If the treatment in question is not in accordance with *Bolam,* it cannot satisfy the test of medical necessity laid down in *Herczgefalvy.* In addition to *Bolam*, the treatment has to be "convincingly" shown to be necessary to satisfy this test.[120] There are particular considerations that doctors must take into account in discharging their duty of care for those who lack capacity to consent. Best interests are no longer limited to medical best interests, but are wider and embrace a range of factors, including the emotional and welfare interests. The doctor proposes a number of appropriate options for treatment in the patient's best interests in accordance with a responsible body of medical opinion. The judge then makes the decision as to which of the proposed treatments is in the patient's best

[115] [1998] 26 EHRR CD 64 para 112.
[116] [2001] EWCA CIV 1545 para 81.
[117] *Op. cit.,* 47 p365.
[118] *Herczgefalvy v. Austria* (1993) 15 EHRR 437 para 82.
[119] *R v. N & M* [2002] EWCA para 19.
[120] *Ibid,* para 29.

interests weighing up the advantages and disadvantages.[121] The court's jurisdiction is to declare the best interests of the patient on the application of a welfare test analogous to that applied in wardship.

Irish law and medical treatment

Mental Treatment Act 1945

The 1945 Act does not provide any guidance on consent to treatment and does not differentiate between patients who do not have capacity to consent and those who do. There is no consideration in the 2001 Act of the issue of capacity either in relation to admission or in relation to consent to treatment. There is no legal framework for treating compliant incapacitated individuals, many of whom are voluntary and have no idea what their legal rights involve and there is no requirement to have an advocate or representative for them. There are no safeguards, other than the common law duty of care applying to patients who are treated while detained. The medical necessity test, outlined in *Herczegfalvy,* requires that a much higher standard than that provided under the 1945 Act is required to avoid a possible breach of Article 3.[122] This test should apply to all patients refusing treatment with or without capacity, according to the decision in *Wilkinson.*[123] The *Guidelines on Good Practice and Quality Assurance in Mental Health Services* specifically exclude consideration of the medical treatment of patients as "this matter must remain the exclusive domain of individual clinicians."[124] This deference is difficult to comprehend along with the omission of any reference to polypharmacy and international best practice standards that would underline the importance of these issues for the individual patient. The 1945 Act does not provide any basis for showing the treatment is medically necessary. These issues are highlighted by the recent decision in *Manweiler v. Burke and Eastern Region Health Authority,* which held that the psychiatrist was negligent, *inter alia,* in failing

[121] *Re S (Sterilisation) [*2000] 2 FLR 389.
[122] (1993) 15 EHRR 437 para 82.
[123] [2001] EWCA CIV 1545 para 31.
[124] Department of Health & Children, *Guidelines on Good Practice and Quality Assurance in Mental Health Services,* Government Publications, Dublin, 1998 p3.

to diagnose the patient and then keeping the patient on anti-psychotic medication which was unnecessary.[125]

Mental Health Act 2001

Invasive medical treatment, which impacts seriously on the person's bodily integrity and which is given without consent, unless convincingly shown to be necessary, is prohibited by Article 3.[126] The 2001 Act would not appear to meet this standard in its consent to treatment provisions.[127] Of particular concern with regard to Article 3 is the lack of independence of the second opinion doctor in consent to treatment, leaving open the question of satisfying the "convincing necessity" test. The notion of treating patients with capacity differently from those without capacity raises issues under Article 14 of the Convention and also under Article 40.1 of the Constitution. The Supreme Court, in *In re a Ward(Withdrawal of Medical Treatment),* was unequivocal in its statements regarding the constitutional rights of an incapacitated person allowing of no differentiation, saying it would be discrimination.[128] The Supreme Court statements add further to the responsibility of the State in providing safeguards for the imposition of treatment and a proper framework for decision-making.[129] This raises again the *Herczegfalvy* test and the comments by Hale LJ in *Wilkinson* that most people are aware of being forced to do something against their will, even if they are unable to make that decision.[130] There are no capacity assessments of compliant incapacitated voluntary patients, which means that treatment will be given to them without consent, thereby raising Article 3 rights in terms of degrading treatment and the right to dignity of the person.

Failure to treat

Medical treatment or the lack of it can breach Article 3 if it constitutes a "lack of proper care" and where it is delayed without good reason. It is difficult to reach the

[125] Unreported High Court, May 6th 2005, Unreported Supreme Court, September 2005.
[126] The provisions outlined in the 2001 Act regarding treatment are dealt with in chapter 3 in the context of self determination.
[127] See chapter 3 for full discussion of consent to treatment provisions.
[128] [1995] 2 ILRM 401.
[129] [1996] 2 IR 79.
[130] [2001] EWCA CIV 1545 para 79.

severity standard required in Article 3. Article 3 not only protects against deliberate interventions that are inhuman and degrading, it also protects against the withdrawal of medical treatment where the consequences are suffering in an inhuman and degrading way. In *D v. United Kingdom,* the Court held that the withdrawal of treatment that would inevitably follow the deportation of the applicant, an AIDS sufferer, would involve a breach of Article 3 as it "would expose him to a real risk of dying under the most distressing circumstances and would thus amount to inhuman treatment."[131] The failure of the authorities to provide effective medical care may breach Article 3 where the patient is severely affected. A prisoner was prevented from having necessary treatment in *Hurtado v. Switzerland* and state obligations were questioned.[132] The Court, relying on earlier decisions, reaffirmed that treatment must be provided in the place of detention, or in another place to which the person must be released temporarily. Where a failure to follow either course of action results in injury to the person, this may be inhuman treatment under Article 3. In *Nevmerzhitsky v. Ukraine,* the failure to provide adequate care and treatment that resulted in damage to the individual's health constituted a violation of Article 3.[133]

The applicant in *Bensaid v. United Kingdom,* complained that his proposed deportation placed him at risk of inhuman and degrading treatment contrary to Article 3.[134] The Court said that, in considering the expulsion of aliens, contracting states must have regard to Article 3, which enshrines one of the fundamental values of democratic societies.[135] The Court considered that the suffering associated with a relapse of his schizophrenia could, in principle, fall within the scope of Article 3. The applicant faced a risk of relapse even if he stayed in the United Kingdom as his illness was long term and required constant management. Removal would arguably increase the risk, as would the differences in available personal support and accessibility of treatment. Even though the applicant's circumstances in Algeria would be less favourable than those enjoyed by him in the United Kingdom, treatment was available. The risk of deterioration following his return was speculative. The Court accepted the seriousness of the applicant's medical condition, but these did not

[131] (1997) 24 EHRR 423, para 53.
[132] (1994) A 280–A Commission Report.
[133] Application 54825/00 5th April 2005.
[134] *Bensaid v. United Kingdom*(2001) 33 EHRR 205, Application no. 44599/98 6th May 2001.
[135] *Ibid,* para 37.

disclose the "exceptional circumstances" of the *D* case, where the applicant was in the final stages of a terminal illness with no prospect of care or support on deportation.[136] Having regard, however, to the high threshold set by Article 3, particularly where the case does not concern the direct responsibility of the contracting state for the infliction of harm, the Court did not find that there was a sufficiently real risk that the applicant's removal in these circumstances would be contrary to the standards of Article 3.[137]

Irish law and failure to treat

There is no absolute right to treatment under Irish law and the doctrine of the separation of powers would militate against the courts directing the provision of services, unless these were provided for in legislation as of right. The doctrine of the separation of powers is fundamental to all the provisions of the Constitution and involves for each of the three constitutional bodies, the judiciary, the executive and the legislature, "not only rights but duties also; not only areas of activity and function, but boundaries to them as well."[138] This doctrine has been invoked a number of times to determine the extent of judicial power sometimes resulting in a negative response in identifying those tasks which are not justiciable.[139] The doctrine has also influenced the manner in which legislation is interpreted by the courts and in two cases, *Sinnott v. Minister for Education* and *TD v Minister for Education* the Supreme Court has clearly indicated that issues of distributive justice fall within the remit of the executive and legislature, not the judiciary.[140]

There is a general obligation under the Health Act 1970 to provide medical services and the Health Services Executives must make available, without charge, a general practitioner, medical and surgical service for persons who are entitled to free medical care.[141] Many people with long term mental disorders have free medical care. Article 40.3.1 of the Constitution, dealing with the right to bodily integrity, raised the issue of

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[136] *D v. United Kingdom* (1997) 24 EHRR 423.
[137] *Ibid,* para 40.
[138] *Crotty v. An Taoiseach* [1987] IR 713. See also Hogan & White, *JM Kelly The Irish Constitution*, Dublin, 2003, Chapter 3.
[139] *L v. L* [1992] IR 116.
[140] [2001] 2 IR 545 and [2001] 4 IR 259.
[141] Health Act 1970, section 58.

negative rights to health with regard to state involvement in the life of the individual. In *Ryan v. Attorney General,* Kenny J. stated,

> I understand the right to bodily integrity to mean that no mutilation of the body or any part of its members may be carried out on any citizen under the authority of the law except for the good of the whole body and that no process which is or may, as a matter of probability, be dangerous or harmful to the life or health of the citizen or any of them may be imposed (in the sense of being made compulsory) by an Act of the Oireachtas.[142]

A constitutional law commentator, Forde, stated that "it was not indicated in what circumstances the Court would order the State to adopt measures necessary to protect health."[143] The difficulty of compelling the State to provide is a recurring one and the Irish courts are reluctant to get involved in what would be regarded as a breach of the separation of powers. In *The State(C) v. Frawley,* regarding conditions of detention in prison, both the High Court and Supreme Court held that the State was not obliged to provide a specialist psychiatric service for a mentally disordered person.[144] The English courts too have been reluctant to get involved in resource issues that they consider properly the domain of the executive.[145]

The negative obligation regarding bodily integrity could be applied to people with mental disorders who are unable to access adequate psychiatric care and suffer continuing relapse or reach the severity of impact to commit suicide. The annual reports of the Inspector of Mental Hospitals refer to the number of deaths of inpatients who commit suicide in psychiatric care. In 2002, there were 13 suicides or suspected suicides, nine in the hospital and four by patients who were on leave, one of whom was on unauthorized leave.[146] In 2003, there were 15 suicides or suspected suicides and seven of these were on leave, including four without permission.[147] The Inspector stated that formal audit procedures should be carried out in each case of suicide or suspected suicide among in-patients. Any out-patients who are known to the hospital

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[142] [1965] IR 294.
[143] Forde M., *Constitutional Law of Ireland,* Firstlaw, Dublin, 2004.
[144] [1976] IR 365.
[145] *R v. Central Birmingham HA. ex parte Walker* (1987) 3 BMLR 32, *R v. Cambridge DHA, ex parte B* [1995] 1 WLR 898. One patient with cancer went to the High Court to try and access treatment but no judgment was pronounced-though she got her treatment immediately. J.Byrne - Irish Times 28th June 2001.
[146] Department of Health and Children, *Report of the Inspector of Mental Hospitals for year ending 2002,* Government Publications, Dublin, 2003, p14-15.
[147] *Op. cit.,* 71 p13.

to have committed suicide should be reported to the Inspector. It would not be difficult to see if a failure to treat these patients played any part in their subsequent suicides and whether it is possible to assess the contribution of inappropriate treatment.

The title of the 1945 Act states its purpose is "to provide for the prevention and treatment of mental disorders and the care of persons suffering therefrom ..." The duty of care in relation to the prevention of a known risk of suicide arose where a proper pre-discharge assessment was not carried out. The family of the patient in *Healy v. North Western Health Board* were successful in establishing negligence against the hospital and health board where the patient was discharged while still depressed and subsequently committed suicide.[148] This case is similar to *D v. United Kingdom,* as *Healy's* vital life-saving treatment was withdrawn from him on discharge, resulting in unnecessary suffering and avoidable death, which arguably could be a breach of Article 3.[149] This application could also apply to other suicides that could be linked with foreseeable service failures.

The *Guidelines on Good Practice and Quality Assurance in Mental Health Services* state that "treatment plans should be discussed with patients, the nature of any treatment fully outlined and the treatment plan, including any medication, recorded in the case notes." The reports of the Inspector of Mental Hospitals frequently refer to the failure to provide treatment plans for in-patients. Where patients are discharged to community services, the question arising in relation to frequent readmission is whether the failure to access out-patient facilities for treatment could be serious enough to engage Article 3. There is a 70% readmission rate to Irish psychiatric in-patient services and this figure represents a serious impact on the lives of the individuals subject to readmission.[150] It is arguable that, even if this lack of community care is not regarded as sufficiently severe to engage Article 3, it would very likely be a breach of Article 8 and the right to respect for private and family life.

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[148] Unreported High Court January 31st 1996.
[149] (1997) 24 EHRR 423.
[150] Health Research Board Report, *Activities of Irish Psychiatric Services 2003,* Dublin, 2004.

The 2001 Act requires that a treatment plan is in place for all who are in mental health centres.[151] These plans help to identify progress and define responsibilities for care so when the treatment is not adequate the plans act as a reference point. The denial of treatment to a severely ill patient could be serious enough to engage Article 3, based on the *D* case. The high readmission rate and the suicide rate in Ireland are factors that need further examination in relation to a failure to treat.[152]

Treatment side effects

Medical treatment with side-effects could involve a breach of Article 3 if the side-effects are sufficiently serious. The admissibility decision of the Commission in *Grare v. France,* concerning the imposition of medication with unpleasant side-effects, arose as an alleged breach of Article 3. The side-effects of the neuroleptic drugs produced tremors, trouble with vision, hypertension, shorter attention span and weight gain. It was accepted that the treatment could produce side-effects, but the Commission held that there was no evidence to indicate that the treatment had reached the level of gravity to engage Article 3.[153] If the medication is therapeutically justified, the possibility of establishing a breach of Article 3 is more remote unless, as Jones suggests, it could be demonstrated that there was an equally effective alternative that produced less serious side-effects.[154] This is echoed in the Council of Europe Recommendation (2004) 10 which provides that treatment which is particularly intrusive should be used only where no less intrusive means of providing appropriate care is available.[155] It suggests that such treatment should be subject to appropriate ethical scrutiny, accord with international standards and safeguards and, where a person is unable to consent, be authorised by a court or competent body and documented in a register. The explanatory memorandum suggests that ECT is an example of such treatment.[156]

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[151] Mental Health Act 2001, section 66(2)(g).
[152] Department of Health & Children, *National Suicide Review Group Annual Report 2004*, Dublin 2004. Report confirmed 444 suicides in 2003.
[153] (1992) 15 EHRR CD 100.
[154] Jones R., *Mental Health Act Manual,* (9th ed.), Thomson, London, 2004, p778.
[155] Council of Europe, Committee of Ministers, *Recommendation (2004) 10* on *the protection of the human rights and dignity of person with mental disorder* Article 28.
[156] Council of Europe, *Explanatory Report on Recommendation (2004) 10 concerning the protection of the human rights and dignity of person with mental disorder* para 206.

Irish law and treatment side effects

The issue of medication has been raised on a number of occasions by the reports of the Inspector of Mental Hospitals. The reports have "urged caution in relation to drug prescribing, the frequent review of the necessity for prescribed medication and of any side effects deriving from it, and avoidance of poly-pharmacy."[157] These reports have highlighted the wide range and diversity of drug prescribing, with junior doctors particularly under pressure to prescribe new products, despite a lack of guidance for appropriate and effective prescribing in certain circumstances.[158] Referring to the sudden deaths, 32 in 2002, including 13 suicides, one death was due to the toxic level of psychotropic drugs present, leading the Inspector to comment, "clinicians should bear in mind that some psychotropic drugs have the capacity to induce fatal cardiac arrythmias and carry out appropriate tests on individuals who they think may be medically compromised before prescribing these drugs, having obtained fully informed consent before doing so."[159] In 2003, the report referred to 19 sudden deaths, including 15 suicides, and stated that, of the sudden deaths, three died from causes that may have been drug related, including one from the gastro-intestinal effects of the newer atypical anti-psychotic drugs and two from sudden cardiac deaths, likely from cardiac arrythmias and possibly related to current medication.[160] Schizophrenia Ireland, a non-governmental organisation, carried out a survey of service users' experience of medication and treatment and found polypharmacy was widespread.[161] A large number of respondents were not given information on the medication and possible side-effects. This raises the question of informed consent for those who were treated and representation for those without capacity. Amnesty International has referred to this issue as a cause for concern in one of their reports.[162]

The 2001 Act provides for an Inspectorate that will have power to attach conditions to the continued approval of a registered centre in order to enforce standards and can

[157] *Op. cit.*, 83.
[158] *Op. cit.*, 84.
[159] *Op. cit.*, 146 pp14-15.
[160] *Op. cit.*, 71 pp13-14.
[161] Schizophrenia Ireland, *A Question of Choice Service Users Experience of Medication and Treatment* (Dublin 2002)
[162] Amnesty International, *Mental Illness The Neglected Quarter,* Dublin, 2003.

refuse to register the mental health centre as suitable for the admission of patients.[163] One of the principal functions of the Inspector is to write a report on "the quality of care and treatment given to persons in receipt of mental health services."[164] The issues of medication and side-effects are not specifically referred to, but would be an important quality of care issue that service users frequently raise. The evidence for concern about these issues is available, even to a limited extent. These inspections are not confined to in-patient services and include almost all mental health services, so they have a broad remit that includes out-patient treatment clinics.[165]

Conclusion

The conditions in psychiatric hospitals have been more closely examined in recent years, particularly with the visits from the CPT, which have highlighted many serious inadequacies in services for mentally disordered persons in high security hospitals and in residential care services for people with intellectual disabilities. The statutory reports of the Inspector of Mental Hospitals have continuously highlighted poor physical conditions in psychiatric hospitals, some of which would be regarded as degrading, particularly the requirement to slop-out in the CMH. The Irish courts have resisted placing an obligation on the executive to provide specialist services for mentally disordered prisoners.[166]

The standard in relation to the imposition of treatment on patients does not seem to meet the requirements of the *Herczegfalvy* necessity test. The decision in *Nevmerzhitsky v. Ukraine* will need to be considered in relation to inadeqeuate treatment, as will the need to establish medical necessity in order to avoid violation of Article 3.[167] The evidence for the imposition of treatment, particularly when the second opinion doctor is not required to be independent or approved by the Mental Health Commission, is of concern. In contrast, the second opinion for the tribunal hearing is independent and provided by the Commission. The Guidelines, provided in

[163] Mental Health Act 2001, section 64.
[164] *Ibid,* section 51(1)(b)(ii).
[165] Mental health services are defined in the Act as those carried on under the direction of a consultant psychiatrist and this may mean that those few independently provided services may not be subject to inspection.
[166] *The State C v. Frawley* [1976] IR 365.
[167] Application 54825/00 5th April 2005.

lieu of a code of practice, specifically exclude any direction on medical treatment, believing that to be the remit solely of the medical profession. This gives full discretion to the profession, while failing to alert doctors to international best practice and the dangers of polypharmacy, leaving a significant gap in standard setting. Service users regard polypharmacy as a significant issue, which along with inadequate information about the interaction of different medicines, needs to be addressed, particularly from the informed consent perspective. This issue needs to be addressed by the new Inspectorate as a specific issue, as its impact goes beyond conditions of treatment and includes the reported higher morbidity rates for people in psychiatric care.[168] The safeguards around the use of seclusion would appear to be lax and, while minimal procedural requirements exist, the initiation of seclusion does not require a second opinion, or the application of the "convincing necessity" standard, even where children are concerned.

The failure to provide treatment services and supports for patients in the community, arguably leading to a breach of Article 3, might arise where there is frequent readmission to hospital and in the context of suicide, where treatment has been denied, or the patient has been discharged prematurely. The inhuman and degrading treatment associated with having to be hospitalised due to poor service provision could, in some cases, be severe enough to engage Article 3. The inadequacy of community provision and failure to provide a patient with a discharge plan is highlighted in many of the reports of the Inspector of Mental Hospitals. This will be redressed somewhat with the statutory requirement to have an individual care plan in the 2001 Act.[169]

[168] Barry et al, *Inequalities in Ireland –Hard Facts,* Trinity College, Dublin, 2001.
[169] Mental Health Act 2001, section 66(2)(g).

Chapter 5

ARTICLE 6 AND THE RIGHT TO A FAIR HEARING UNDER IRISH MENTAL HEALTH LAW

Introduction

This chapter considers the nature of civil rights and obligations under Article 6 and substantive issues related to the enforcement of specific civil rights for adults who have a mental disability under Irish law. The key feature of this chapter is an examination of the restriction on access to court under the 1945 and the 2001 Acts for compliance with the requirements of Article 6. The restrictions in the 1945 Act have effectively blocked civil action by patients in connection with their detention by placing insurmountable obstacles against such action. Apart from the significant burden or proof, the patient must seek leave in the High Court and establish the existence of either of two grounds, bad faith or want of reasonable care. The 2001 Act attempts to restate these obstacles in a less restrictive manner while retaining the requirement of High Court approval and the two grounds. The recent decision in *Blehein v. Minister for Health & Children, Ireland & Attorney General* changes this legal landscape by holding that the limitation on the High Court to the two grounds is unconstitutional.[1] It is too early to assess if this decision will result in a less onerous burden on patients and be more Convention compliant. Chapter 6 will examine the civil rights and obligations under Article 6 to assess compliance under Irish law relating to the management of property and affairs of mentally disabled adults and the proposals for reform in this area.

Article 6(1) provides:

> 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.

This Article provides for a right to a fair hearing in civil and criminal proceedings in the laws of contracting states. The right has "a position of pre-eminence in the

[1] [2004] IEHC 374.

Convention".[2] This is due in part to the importance of the right and also to the large number of applications under the Article and the consequent jurisprudence.[3] The importance of access to a court and of fair trial in a democratic society is recognised in many statements of the Strasbourg Court.[4] In common with Article 5(2) (prompt provision of reasons for detention and rights of challenge) and 5(4) (speedy review of detention), Article 6(1) seeks to guarantee prompt access to a court and a hearing within a reasonable time. There are no strict rules determining what is a reasonable time. This depends on the facts and complexity of the case. Other obligations relate to the fairness of the proceedings and the independence and impartiality of the court or tribunal.

Article 6 does not apply to all rights and obligations available under domestic law, only to those categorised as civil.[5] There is a large body of case law on what is or is not a civil right,

> According to the well established case law of the Court, the concept of 'civil rights and obligations' is not to be interpreted solely by reference to the respondent State's domestic law and Article 6(1) applies irrespective of the status of the parties, and of the character of the legislation which governs how the dispute is to be determined and the character of the authority which is invested with jurisdiction in the matter, it is enough that the outcome of the proceedings should be decisive for private rights and obligations.[6]

Article 6 cases involve civil and criminal litigation, as well as proceedings before disciplinary and administrative tribunals and administrative decisions on an individual's rights and obligations. It is not always clear into which category some of these rights and obligations would fall and problems have arisen in categorising the relations between the state and the individual. This latter category has direct application to people with mental disabilities arising from a number of factors, including: detention in psychiatric care, decisions concerning the removal of personal

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[2] Harris, O'Boyle & Warbrick, *Law of the European Convention on Human Rights,* Butterworths, Oxford, 1995, p164.
[3] In 2000, there were 10,486 new applications registered by the Strasbourg Court and of these 7,264 included complaints under Article 6.
[4] Similar recognition is given to this right in relation to criminal proceedings under the Irish Constitution. Article 38.1 'No person shall be tried on any criminal offence save in due course of law' embraces both procedural and substantive rights.
[5] Clements et al, *European Human Rights: Taking a Case under the Convention,* (2nd ed.), Sweet & Maxwell, London, 1999.
[6] *Pudas v. Sweden* (1998) 10 EHRR 380 at para 35.

rights, wider aspects of the individual's life in the community related to rights of autonomy, self-determination and participation in decisions, mainly concerning the right to manage one's property.

Civil rights and obligations

The rights and obligations that are guaranteed speedy judicial enforcement under Article 6 must be "civil." Initially, the boundary between civil and other rights and obligations was broadly synonymous with the distinction between private and public law. Rights and obligations arising in the private law relations between individuals and which could give rise to a money claim are clearly civil rights and obligations within Article 6. Rights and obligations in public law would not usually fall within Article 6. However, this has changed with the developing case law and the public law, private law distinction no longer provides a clear boundary, if it ever did. Public law rights that could give rise to a money claim are now being included.[7] In *Aerts v. Belgium* the Court held that the right to liberty is a civil right and, therefore, Article 6(1) applies to reviews under tribunals.[8] The actual lawfulness of the detention can be dealt with under Article 5(4) and does not need to be dealt with under Article 6. Wardship and guardianship proceedings are also subject to Article 6(1) because they determine civil rights.

In determining whether a right is civil, the Strasbourg Court looks at the "character" of the right or obligation and, in this way, some ostensibly public law rights have been regarded as civil rights for the purpose of Article 6.[9] In *Z v. United Kingdom,* the Court said that Article 6(1),

> does not itself guarantee any particular content for civil rights and obligations in the substantive law of the Contracting States. It will however apply to disputes of a 'genuine and serious' nature concerning the actual existence of the right as well as to the scope or manner in which it is exercised.[10]

[7] *Aerts* v. *Belgium* (2000) 29 EHRR 50.
[8] *Ibid.*
[9] *Konig v. FRG* A 27 para 90 (1978).
[10] (2002) 34 EHRR 3 para 87.

In relation to property, where state action is "directly decisive" for property rights, it will be determinative of civil rights and subject to Article 6 and the right to a fair hearing.[11] Article 6 clearly applies where a person with a mental disorder is being divested of his power to administer his property and affairs.[12] Administrative decisions must be subject to challenge before a tribunal or court to ensure compliance with Article 6. Article 6 will also be engaged where state action is directly decisive for the right of a person, who has been in psychiatric care, to maintain contact with their children.[13] The right to compensation for illegal state acts resulting in pecuniary loss is regarded as a civil right. Even where the right or obligation is in the public law domain, the impact of the loss may be decisive for private rights and obligations.[14]

The Court of Appeal in England considered if second opinions in treatment could be categorised as "civil rights and obligations" in *R (on the application of Wilkinson) v. Broadmoor Hospital.*[15] The second opinion system is not subject to a hearing by any impartial tribunal. Simon Brown LJ, held that if the second opinion procedure were the only form of review of an RMO open to the patient, it would breach Article 6(1). He said it was open to a patient to bring an action in tort for assault in relation to past treatment. In addition, it was held in *Wilkinson* that a patient can seek a full merits review of the legality of past and future treatment, thereby satisfying Article 6(1).[16] Brown LJ said that "Article 6 does not entitle a mental patient in every case to challenge a treatment plan before being subjected to it."[17] As a result of this and other cases in English law, there is a more rigorous approach to the second opinion procedure, "fairness requires that a decision by a SOAD which sanctions the violation of the autonomy of a competent adult patient should be accompanied by reasons."[18] It is not clear though that Article 6 applies to this second opinion procedure.

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[11] *Le Compte v. Belgium* (1982) 4 EHRR 1.
[12] *Winterwerp v. Netherlands* (1979) 2 EHRR 387. The Irish State has the right to take over the property of the person through the courts in wardship proceedings.
[13] *Keegan v. Ireland* (1994) 18 EHRR 342.
[14] *X v. France* A 234-C (1992).
[15] [2001] EWCA Civ 1545. Bartlett & Sandland, *Mental Health Law Policy and Practice,* Oxford, 2003, p369.
[16] *R v. Wilkinson v. Broadmoor Hospital* [2001] EWCA Civ 1545 para 34.
[17] *Ibid,* para 35.
[18] *Ibid,* para 25.

The right to have a matter determined before a tribunal may be subject to restrictions as long as the restriction does not impair the very essence of the right, has a legitimate aim and there is a reasonable relationship of proportionality between the means used and the aim sought to be achieved. These questions can be raised in relation to the limitation on access to court for psychiatric patients where such leave is rarely granted in Irish decisions.[19]

Article 6 will only apply where there is a dispute over civil rights and obligations said to exist under domestic law and where civil rights and obligations are being determined in the proceedings.[20] In *H v. Belgium,* the requirement regarding a dispute was outlined by the Court,

> Article 6(1) extends only to 'contestations' (disputes) over (civil) 'rights and obligations' which can be said, at least on arguable grounds, to be recognised under domestic law; it does not in itself guarantee any particular content for (civil) 'rights and obligation' in the substantive law of the contracting states.[21]

The dispute must be justiciable and capable of judicial resolution. Article 6 is a procedural guarantee of a right to a fair hearing in determining the civil rights and obligations the state provides,

> Whether a person has an actionable domestic claim may depend not only on the substantive content ... of the relevant civil right as defined under national law but also on the existence of procedural bars preventing or limiting possibilities of bringing potential claims to court.[22]

Where the purpose of the proceedings is not primarily about the civil rights and obligations but has a decisive impact on them, the Court held, in *Ringeisen v. Austria,* that even this will fall within the ambit of Article 6.[23]

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[19] *Ashingdane v. United Kingdom* 7 EHRR 528. Mental Treatment Act 1945, Section 260. Mental Health Act 2001, section 73.
[20] *Le Compte v. Belgium* Series (1982) 4 EHRR 1..
[21] A 127-B para 40.
[22] *Fayed v. United Kingdom* 18 EHRR 393.
[23] (1979) 1 EHRR 455.

Right of access to court

Part of the right to a fair hearing in Article 6(1) is the right of access to a court. The right of access requires that it is "practical and effective" and not "theoretical or illusory."[24] This right is particularly important in the case of vulnerable adults with mental disabilities where there is an even greater onus to ensure their rights are protected.[25] This right to a court is not absolute and can be limited in the interests of society. However, there are specific restrictions in relation to mentally disordered people that do not apply to others. The restrictions are to be found in legislation in the United Kingdom and have a long history stretching back to section 330 of the English Lunacy Act 1890, passed in order to protect those operating the lunacy legislation from vexatious or unfounded claims.[26] There is no evidence base for the assertion in *Pountney v. Griffiths* that mentally disordered people are "inherently likely" to take unfounded legal action against those caring for them, although some illnesses with a paranoid component may create a litigious disposition in the sufferer.[27]

The right of access to court, the conduct of the proceedings and the right to institute them were discussed in *Golder v. United Kingdom.*[28] This right of access is regarded "as a key feature of the concept of the rule of law."[29] The applicant in *Golder* was a prisoner. He challenged the refusal of the Home Secretary to allow him to consult a solicitor and this was held to be a violation of the right of access to a court. The Court stated that Article 6(1) contained an inherent right of access to a court,

> In civil matters one can scarcely conceive of the rule of law without there being the possibility of access to the courts ... The principle whereby a civil claim must be capable of being submitted to a judge ranks as one of the universally recognised fundamental principles of law; the same is true of the principle of international law which forbids the denial of justice. Article 6(1) must be read in the light of these principles.[30]

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[24] *Airey v. Ireland* (1979) 2 EHRR 305.
[25] *Herczgefalvy v. Austria* (1993) 15 EHRR 437. *Keenan v. United Kingdom* (1998) 26 EHRR CD 64.
[26] Mental Health Act 1983, section 139.
[27] *Poutney v. Griffiths* [1976] AC 314.
[28] (1979) 1 EHRR 534.
[29] *Op. cit.*, 2 at p.196.
[30] (1979-80) 1 EHRR 524.

The Court stated that "Article 6(1) secures to everyone the right to have any claim relating to his civil rights and obligations brought before a court or tribunal."[31] This "right to a court," of which the right of access is an aspect, may be relied on by anyone who considers on arguable grounds that an interference with the exercise of his rights is unlawful and complains that he has not had the possibility of submitting that claim to a tribunal meeting the requirements of Article 6(1).[32] The Court stated,

> it must be established that the degree of access afforded under the national legislation was sufficient to secure the individual's right to a court, having regard to the rule of law in a democratic society.[33]

The right of access must be effective in reality, as well as in law. In *Keegan v. Ireland,* the applicant, a non-marital father, complained that there was no procedure whereby he could challenge his daughter's adoption.[34] The absence of a right to a court to challenge these specific issues was held to violate Article 6(1). Even a partial or temporary interference with the right may breach Article 6(1).[35]

The right of access to a court is not absolute and it may be restricted according to the needs and resources of the community and individuals.[36] In this regard, the state is allowed some margin of appreciation, as long as the restrictions are such that the essence of the right is not impaired.[37] In *Airey v. Ireland,* the very essence of the right was impaired where a woman was refused legal aid for a High Court application for a separation order.[38] In order for her right of access to be effective, she needed legal representation and legal aid due to her financial circumstances. The Court referred to the need for legal aid as part of the right of access to court in specific circumstances where the person cannot plead his case effectively or where it is compulsory to have such representation.

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[31] 1 EHRR, 524 para 36.
[32] *Le Compte v. Belgium*, (1982) 4 EHRR 1 para 44.
[33] *Ashingdane v. United Kingdom* (1984) 7 EHRR 528 para 57.
[34] (1994) 18 EHRR 342.
[35] *Op. cit.,* 2 p197.
[36] *Golder v. United Kingdom* (1979) 1 EHRR 534..
[37] *Ashingdane v. United Kingdom* (1985) 7 EHRR 528.
[38] (1979) 2 EHRR 305.

Rules limiting the access of particular groups to the court may breach Article 14 and Article 6. In *Canea Catholic Church v. Greece,* the Court held that there would be a breach of Article 14, taken together with Article 6(1), unless an objective and reasonable justification put forward for the difference in treatment meted out compared with other churches.[39] Since no justification could be found, such a limitation was held to impair the very substance of the applicant church's "right to a court" and deemed a breach of Article 6(1). This raises the question of whether restrictions on access to a court, based on whether the defendant is acting pursuant to mental health legislation, can be viewed as an objective and reasonable justification for the purposes of Article 14.

Fair and public hearing

Individuals are entitled to a judicial procedure but the precise procedure is not specified, though the words "fair and public" are used and intended to include procedural safeguards and the right to be heard and represented. This requires judicial, rather than administrative, control in these matters. The overriding requirement is that the proceedings are fair. The open-ended nature of the provision gives the opportunity to add specific rights not listed that are essential to a fair hearing. Greater latitude applies to civil hearings compared with criminal ones. For example, the right to be present in non-criminal cases is not rigidly applied and, as long as the individual or his representative has an opportunity, it may not be absolutely necessary to be present at an oral hearing.[40]

The ingredients of fair proceedings include: the right to representation, procedural equality, judicial process, a reasoned decision, appearance in person where possible and access to information necessary to take the case. The procedural equality requires a fair balance between the parties and applies to civil and criminal cases. In *Winterwerp v. Netherlands,* the Court stated that "special procedural safeguards may prove called for in order to protect the interests of persons who, on account of their mental disabilities, are not fully capable of acting for themselves."[41] The right is not

[39] (143/1996/762/963) 16th December 1997.
[40] *X v. Sweden* 2 YB 354 at p370.
[41] *Winterwerp v. Netherlands* (1979) 2 EHRR 387 para 60.

absolute and there may be competing interests, but only those measures restricting the rights of the applicant that are strictly necessary are permissible under Article 6(1). A reasoned decision is implicit in a fair hearing and this must involve access to all information that would assist in the decision, indicating with clarity the grounds for the decision in order for the accused to exercise the right of appeal.[42] In *Winterwerp,* an emergency detention did not afford the opportunity to be heard and this was held not to satisfy the requirement of fair hearing.[43]

The word "determination" in Article 6(1) refers to the legal adjudication of the dispute, not necessarily the forum by which that decision was reached. The Court said, in *Ringeisen v. Austria,* that the nature of the legislation that sets out how the matter is to be determined and the forum are not very significant.[44] In *R (on the application of Wilkinson) v. Broadmoor,* an English case, the right to cross examine medical witnesses arose where the applicant argued that the refusal to allow him to cross examine deprived him of the right to a fair trial which, in turn, denied him the protection that a substantive merits hearing would afford to his rights under other Articles of the Convention.[45] The Court of Appeal held that given the importance of the Convention rights allegedly breached, (Articles 2, 3, 6, 8 and 14), it was necessary to suspend the application of the normal rule in judicial review that expert witnesses are not subject to cross-examination.

Legal Representation

There is no automatic right to legal aid in the determination of civil rights and obligations, but in *Winterwerp v. The Netherlands,* the Court recognised the right of access to court and,

> to be heard in person or where necessary, through some form of representation failing which, he will not have been afforded the fundamental guarantees of procedure applied in matters of deprivation of liberty.[46]

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[42] *Edwards v. United Kingdom* (2002) 35 EHRR 19.
[43] (1979) 2 EHRR 397.
[44] (1971) 1 EHRR 455 para 94.
[45] [2001] EWCA Civ 1545. *Op. cit.,* 13 p369.
[46] (1979) 2 EHRR 387para 60.

The right to legal representation in Article 6 in civil cases is found in the right of access to court, rather than under the right to a fair hearing. In *Airey v. Ireland,* the Court held that the right to court must not only be accessible, but must also be effective and, for the applicant this meant having legal representation in the court. [47] The Court recognised that the case was complex and she would be unable to act as a lay litigant in person. Arising from this case, there appears to be an obligation to provide legal assistance where "such assistance proves indispensable for an effective access to court."[48] Even where someone is represented in court, the question of fairness may arise as a separate issue.[49] The vulnerability of people with mental disorder requires that a legal representative is made available to ensure the right of access to court.

Reasonable time

The Convention wording in Article 5(4) differs from Article 6(1) in that "speedily" is used in the former and "within a reasonable time" in the latter. The person must be brought before a court or tribunal within a reasonable time. The word "reasonable" means that the person should not be caused unnecessary suffering while waiting for the proceedings to commence and "to protect all parties against excessive procedural delays."[50] Time begins to run from the initiation of court proceedings and, in legislation, requirements for maximum time limits for tribunal hearings are often specified.[51] The Court found that a delay of five and half years in paternity proceedings was in breach of Article 6.[52]

The Court has stated that in considering "reasonableness", it had to consider various factors including: the complexity of the factual or legal issues, the conduct of the applicants, the conduct of the competent authorities and the issues at sake for the applicant.[53] The state is responsible for delays caused by administrative or judicial

[47] (1979) 2 EHRR 305 para 26.
[48] *Ibid.* The civil legal aid system was subsequently put on a statutory footing in Ireland in the Civil Legal Aid Act, 1995.
[49] *P, C & S v. United Kingdom* (2002) 35 EHRR 31.
[50] *Stogmuller v. Austria* (1969) A 9 p 40.
[51] Mental Health Act 2001, section 18.
[52] *Mikulic v. Croatia* 11 BHRC 689.
[53] *Pelissier & Sassi v. France* (2000) 30 EHRR 715 para 67.

authorities.[54] Delay in the completion of wardship proceedings has been raised as an issue by a number of researchers and writers.[55] In one retrospective study carried out in the area of Old Age Psychiatry, involving 31 wardship cases over a six-year period between 1989-1995, the authors found that the procedure was time-consuming and took months, rather than weeks, to complete.[56] They regarded this aspect as a serious deficiency where a rapid response was required having regard to the paramountcy of the care of the individual.

Independent and impartial tribunal

The important feature of a tribunal is that it must be have the power to take legally binding decisions. Simply giving advice or making a recommendation is not enough.[57] The word "independent" is held to mean independent of the executive and also of the parties to the case.[58] The tribunal must be established by law to ensure independence of the executive and particular rules are set out in legislation to limit executive discretion. Appeal proceedings too are governed by the requirements of Article 6. In order to arrive at a determination of independence, the Court must look at "the manner of appointment of its members and the duration of their term of office, the existence of guarantees against outside pressures and the question whether the independent body presents an appearance of independence."[59] The appointment of members by the executive is normal and the length of time, even short term for some tribunals, is acceptable.

Impartiality is related to and dependent on independence. It means a lack of "prejudice or bias" and involves satisfying both a subjective and objective test. In *R (PD) v. West Midlands & NW London MHRT*, an English case, the difficulties in finding suitably qualified members for a tribunal was a relevant factor in considering

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[54] *R (On Application of KB, MK, JR, GM & others) v. MHRT & SOS for Health* (2003) EWHC Admin. 193.
[55] Mc Loughlin, "Wardship : a Legal and Medical Perspective", (1998) 4(4) *MLJI* 61. McCarthy & Wrigley, "Ward of Court – A Review of Utilisation in a Psychiatry of Old Age Service", 4(2) *MLJI* 24.
[56] Mc Carthy & Wrigley, "Ward of Court-A Review of Utilisation in a Psychiatry of Old Age Service" 4(2) *MLJI*, 60.
[57] *X v. United Kingdom* (1981) 4 EHRR 188.
[58] *Ringeisen v. Austria* (1979) 1 EHRR 455.
[59] *Campbell & Fell v. United Kingdom* (1985) 7 EHRR 165 para 78.

the disqualification of someone on account of bias, where in an exceptional case it might otherwise be impossible to constitute a tribunal.[60]

Article 6 and mental health detention

Two issues are raised here: the automatic presumption of incapacity based only on the fact that the person has been detained and the restrictions on the right under mental health legislation to litigate. The Court, in *Winterwerp v. Netherlands,* stated that Article 6 applies in cases where mentally disordered people are divested of the capacity to administer their property.[61] This issue arose under Dutch law and the applicant alleged that there had been a "determination of his civil rights and obligations" without the guarantees of a judicial procedure as laid down in Article 6(1). The Court stated that the capacity to deal personally with one's property involves the exercise of private rights and hence affects "civil rights and obligations within the meaning of Article 6(1)." Divesting the applicant in *Winterwerp* of that capacity amounted to a "determination" of such rights and obligations.

The automatic presumption of loss of capacity to contract due to mental illness was the line of argument used by the government in *Winterwerp.* The government further argued that his property needed protection because of his mental illness. The Court did not agree with the justification for taking over in the absence of the guarantees in Article 6(1). While acknowledging that mental illness may "render legitimate certain limitations upon the exercise of 'the right to a court', it cannot warrant the total absence of that right as embodied in Article 6(1)."[62]

Patients frequently lose out when in hospital through a system failure to ensure their property and other economic interests are protected adequately. This has a negative impact on their return to the community. The right to deal personally with one's property involves the exercise of private rights, and so affects civil rights and obligations under Article 6(1). Where the state divests the individual of such control over his property, this amounts to a determination of such rights and is subject to

[60] [2004] EWCA Civ 311 para 11.
[61] (1979) 2 EHRR 387.
[62] *Ibid,* para 75.

Article 6(1) and, without proper procedures for doing so, involves a possible breach of Article 6(1). Where an individual's right to carry out these activities is interfered with, there must be a hearing and a determination by an independent body to decide the individual's capacity in this regard in accordance with Article 6(1). These rights include rights to make a will, to contract, to give gifts of property and to vote and sit on a jury.

The restrictions on access to a court for those suffering from mental illness arose in *Ashingdane v. United Kingdom.*[63] The English Mental Health Act 1959 provided that there was no civil liability for acts done pursuant to the 1959 Act in the absence of bad faith or reasonable care. A claim could only be brought with leave of the High Court, which would only be granted if there were substantial grounds for believing the condition was met. The Court stated that the right of access is not absolute, but may be subject to limitations. These are permitted by implication, since the right of access, "by its very nature calls for regulation by the State, regulation which may vary in time and place according to the needs and resources of the community and of individuals."[64]

The Court referred to the margin of appreciation enjoyed by the Contracting States, but pointed out that the limitations applied must not restrict or reduce the access left to the individual in such a way or to such an extent that the "very essence" of the right is impaired.[65] In addition, the limitation will not be compatible with Article 6(1) if it does not pursue a legitimate aim and if there is not a reasonable relationship of proportionality between the means employed and the aim sought to be achieved,

> Whilst the final decision as to observance of the Convention's requirements rests with the Court, it is no part of the Court's function to substitute for the assessment of the national authorities any other assessment of what might be the best policy in this field.[66]

The Court agreed that the mischief the section sought to avoid was the protection of staff from being unfairly harassed by litigation and this was, in itself, legitimate in

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[63] (1985) 7 EHRR 528.
[64] *Ibid,* para 57.
[65] *Ibid,* para 57.
[66] *Ibid,* para 57.

relation to hospital staff, but commented that the protection from suit enjoyed by the officials in the social services needed closer scrutiny. The availability of the claim where there was bad faith or lack of reasonable care meant that the very essence of the right remained intact and complied with the principle of proportionality. The 1983 Act subsequently relaxed the restrictions, so that the requirement for "substantial grounds" has been removed and now permission for access will be granted where there is a reasonable case to answer. The protection that the section offered to the statutory bodies was removed, so that normal rights of action would apply to those bodies while maintaining the aim of protecting the staff working in the psychiatric services.

Irish law and the right to litigate

Constitutional law

The right to litigate and the right to have access to the courts under the Constitution are regarded as separate rights.[67] The right of access was the basis of the decision in *Macauley v. Minister for Posts and Telegraphs,* which held that the requirement of the fiat of the Attorney General to take actions against a Minister was an infringement of the personal right to have recourse to the courts in Article 40.3. In that case, the Court drew on the "full original jurisdiction" of the High Court, derived from Article 34.3.1 to have access to the High Court to defend and vindicate a legal right. In *Murphy v. Greene,* McCarthy J. said that the right of access to the courts was an unenumerated right deriving from the interaction of Article 40.3.1 with Article 34.3.1.[68] These Articles provide,

> **Article 34.3.1**
> The Courts of First Instance shall include a High Court invested with full original jurisdiction in and power to determine all matters and questions whether of law or fact, civil or criminal.
>
> **Article 40.3.1**
> The State guarantees in its laws to respect and vindicate the personal rights of the citizen.

[67] *Tuohy v. Courtney* [1994] 3 IR 1.
[68] [1990] 2 IR 566. See also Hogan & White, *JM Kelly The Irish Constitution,* Butterworths, Dublin, 2003, para 6.2.06.

There are limitations on the right of access to court including where there is an abuse of court processes and it is established that the proceedings are vexatious or frivolous.[69] The Supreme Court, in *Riordan v. Ireland (No. 4),* justified the restraint on the institution of proceedings without first obtaining the consent of the respective court where this was necessary to prevent abuse of court processes on the grounds that,

> The court is bound to uphold the rights of other citizens, including their right to be protected from unnecessary harassment and expense, rights which are enjoyed by the holders of public offices as well as by private citizens. This court would be failing in its duty ... if it allowed its processes to be repeatedly invoked in order to reopen issues already determined or to pursue groundless and vexatious litigation.[70]

This applies also to legal actions by people who have been detained in psychiatric care, necessitating that leave is obtained from the High Court to do so.

Mental Treatment Act 1945

The 1945 Act contains a restriction on access to the courts to take civil action in connection with detention, similar to section 141 of the English Mental Health Act 1959.[71] This section originated in the Lunacy Act 1890 and provides,

> **Section 260-(1)**
> No civil proceedings shall be instituted in respect of an act purporting to have been done in pursuance of this Act save by leave of the High Court and such leave shall not be granted unless the High Court is satisfied that there are substantial grounds for contending that the person against whom the proceedings are to be brought acted in bad faith or without reasonable care.

The section applies specifically to civil proceedings and does not include omissions, but refers to positive acts. The Act refers to "persons" proceeded against, but does not refer to bodies like health authorities, though it is accepted that such bodies are included. The assumption has been that public authorities are covered by the section.

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[69] *Barry v. Buckley* [1981] IR 306.
[70] [2001] 3 IR 365 at 369.
[71] *Ashingdane v. United Kingdom* (1985) 7 EHRR 528.

Arguably, they are not. The High Court must grant leave where there are substantial grounds and there is no liability without either of the two grounds, bad faith or want of reasonable care. The provision does not affect the right to apply for habeas corpus, which is open to anyone who is detained to test the legality of the detention.[72] In relation to judicial review, the Rules of the Superior Court 1986 confirm that the only requirement is that the plaintiff has a sufficient interest in the matter to which the application relates. In *Blehein v. St John of God Hospital,* the Supreme Court ruled that section 260 does not apply to a constitutional challenge to that section.[73] The English Mental Health Act 1983 has a somewhat similar provision, section 139, and, in *R v. Hallstrom and anor Ex p. W,* an English case, the Court of Appeal held that leave under this section is not required for judicial review.[74]

The Supreme Court stated in *Murphy v. Greene* that a statutory restriction on the right of access to court would not be unconstitutional where there were objective reasons for such a restriction and where the restriction was not of itself unduly oppressive.[75] Under Article 6(1), any restriction must not be such that the very essence of the right is impaired. In addition, it must have a legitimate aim and comply with the principle of proportionality between the means employed and the aim sought to be achieved. The Supreme Court acknowledged that section 260 was,

> a curtailment of the constitutional right of every individual to have access to the courts to the extent that it requires a pre-condition of leave of the court for the bringing by him of a claim for damages for an asserted wrong.[76]

The Court has stated on a number of occasions that such legislation, being an exception to Article 34 of the Constitution, must be strictly construed in the sense that it must not be availed of except where it is essential to do so.[77]

The burden of proof requires that there are "substantial grounds" for the allegation that the proposed defendant acted in bad faith or without reasonable care, in order to be given leave. This has varied in cases from higher than the civil standard to the civil

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[72] See chapter 2 for full discussion of the use of habeas corpus.
[73] Unreported Supreme Court, 31 May 2002.
[74] [1985] 3 AII ER 785.
[75] [1990] 2 IR 566.
[76] [1990] 2 IR 566 at 572.
[77] *B. v. Gallagher* [1995] 2 ILRM 433, *Murphy v Greene* [1990] 2 IR 566.

standard.[78] The Supreme Court has refused leave in a number of cases based on the failure to meet the burden of proof of substantial grounds. In *O'Dowd v. North Western Health Board,* the applicant was required to establish,

> ... that the grounds relied on must be real and not imaginary, and must be supported by credible evidence. ...these grounds must be such as to indicate either bad faith or want of reasonable care, and, accordingly, to call for an answer or explanation on the part of the person sought to be sued.... the section requires the applicant for leave to sue to establish something approaching a *prima facie* case before he can obtain such leave. ... He is not to be permitted to mount a vexatious or frivolous action or one based on imagined complaints. ... the section does no more that to require the applicant ... to discharge the same onus of proof as he would be required to discharge in pursuing a claim for damages outside the Act but to discharge it at an earlier point in time. ... As the action deals with the mentally ill or those thought to be so, it does not seem ... that this limitation is unduly restrictive or unreasonable. [79]

However, the proof requirement was somewhat confused with one judge stating that the use of "satisfied" indicated that the legislators had in mind a somewhat higher standard of proof than that which a plaintiff must ordinarily discharge in a civil case.[80] The dissenting judgment of Henchy J. stated that the grounds were established by the applicant in that the psychiatrist had signed the detention order three hours after the patient had been admitted and sedated.[81] The second point raised in the case was that the option of voluntary admission had not been offered to the patient as required under the 1945 Act.[82]

Leave to take civil action was granted by the High Court in *Murphy v. Greene,* an action for neglect, false imprisonment and defamation in connection with admission and detention in hospital.[83] The case was overturned in the Supreme Court, by a full sitting of that Court, which required that the plaintiff had to prove as a "matter of probability" the existence of facts establishing the substantive grounds of bad faith or lack of reasonable care on the part of the defendant. The Court held that the standard

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[78] *M. v. Greene,* [1990] 2 IR 566, *O'D. v. NWHB* [1983] ILRM 186. Only a handful of cases have sought leave to take civil action since 1945.
[79] [1983] ILRM 186 p190.
[80] *Ibid,* p194 per Griffin J.
[81] Mental Treatment Act 1945, section 171(1)(a) requires the patient to be examined on arrival and the order made forthwith.
[82] Mental Treatment Act 1945, section 184(4)(a)(iii).
[83] [1991] ILRM 225.

of proof is the normal civil standard and there was no need to go beyond this standard. Griffin J. stated that it was beyond question that "every individual, be he a citizen or not, has a constitutional right of access to the courts. Stated in its broadest terms, this is a right to initiate litigation in the courts."[84] He admitted that the standard imposed in *O'Dowd* was too high and that, for leave to institute proceedings, the applicant must establish, as a matter of probability, that there are substantial grounds for the contention that the proposed defendant acted in bad faith or without reasonable care. He described the provision as a "form of partial curtailment of the right of access to court."[85] It is not necessary for the court to conclude the applicant is likely to succeed in the proposed action. O'Flaherty J's statement in this case is worth noting in terms of the difficulties piled on such applicants,

> The court has to hear both sides at this stage of the proceedings. Or, more accurately, it must hear both sides before the proceedings can be launched. Because of the nature of the legislation the court will of necessity look at the individual seeking to sue. Is he a crank? Is he paranoid? Has he a case of any description? These are the first questions that must be asked and, it may be very often, the only questions that need to be answered."

This statement indicates that the focus of the judge was on the personality of the applicant, rather than the substance of the legal issue at hearing. Mc Carthy J. stated that the context of the detention was a matter for consideration and that, where an emergency existed, "the law does not require a standard of precision such as might be appropriate to other aspects of medical practice ... and that the standard of reasonable care under the Act may be quite different from such standard in ordinary medical practice."[86]

The standard required for an "examination" for detention arose in *O'Reilly v. Moroney & Mid Western Health Board,* in an application for leave to take civil action in connection with detention. The Supreme Court held that an examination by the certifying doctor from a distance satisfied the requirement of examination for a recommendation for reception under the 1945 Act.[87] It was argued, both in the High Court and in the Supreme Court, that the defendant doctor had not "examined" the

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[84] *Ibid,* p191.
[85] *Ibid,* p190.
[86] *Ibid,* p192 per McCarthy J.
[87] Unreported Supreme Court, November 16th 1993.

applicant in any real sense. Murphy J., in the High Court, "not without some hesitation" accepted that it was an adequate examination for the purposes of the certificate. In the Supreme Court, Court Egan J. dealt with the question of the adequacy of the examination in his judgment as follows,

> There is no definition of the word 'examine' in the section and the fact that Dr Moroney himself agreed that there was no physical examination or interview does not conclude the matter. Here was a case where the doctor had evidence which he considered to be reliable ... This observation, having regard to what he had been told, constituted a form of 'examination' in my opinion and justifies the doctor in pursuing the course which he did.[88]

The Court quoted with approval dicta from McCarthy J. in *Murphy v. Greene* regarding the standard of care in an emergency being different from ordinary medical practice.[89] The sole dissenting judgment of Blayney J. stated that the applicant should have been examined physically to ascertain her physical and emotional well-being and should have been given an opportunity to be heard.[90]

In one of the few cases granted leave, *Bailey v. Gallagher,* the Supreme Court held that there was no evidence of bad faith or want of reasonable care on the part of the doctor in certifying the detention.[91] The medical examination had taken place 8 days prior to the removal of the patient to the Garda station, one day over the permitted time for removal to hospital, after which the order is null and void. The detention at the Garda station was without legal justification and the defendant doctor was aware that the plaintiff was being detained. The lack of reasonable care applied to the failure to notify the Gardai that the order was out of date and bring the detention to an end. The Court stated,

> The Court cannot condone the abridgement of an innocent citizens' liberty for however short a period, save where it is authorised by law ... S,260 ... had to be given full effect. However, it is *prima facie* a curtailment of the constitutional right of every citizen of access to the courts, it must be strictly construed so as to ensure the citizen's right of access is not unnecessarily restricted [92]

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[88] *Ibid* p9.
[89] *Ibid,* p192.
[90] *Ibid.*
[91] [1996] ILRM 433.
[92] *Ibid,* p446.

Apart from *O'Dowd,* all reported applications for leave took place during the 1990s when awareness of patients' rights was growing. Only four of the reported cases have succeeded in being granted leave based on lack of reasonable care, *Kiernan v. Harris, Midland Health Board & Ors,*[93] where there was a failure to carry out any examination or offer a second opinion, *Bailey v. Gallagher,*[94] where the recommendation for the detention was out of date; *Melly v. Moran & North Western Health Board,*[95] where telephone conversations were held not to form part of the actual examination for the recommendation for detention and, therefore, no examination had taken place within the previous 24 hours as required, and *Manweiler v. Bourke & HSE* for failure to diagnose and imposition of unnecessary treatment.[96] The Court, in *Melly,* held there was a lack of reasonable care and if the matter had been tested by way of an application under the habeas corpus provisions of the Constitution then the document justifying detention would be "clearly defective on its face," though the Court expressed sympathy with the doctor and hospital authorities.[97]

The situation with regard to section 260 has changed as a result of the decision in *Blehein v. Minister for Health & Children, Ireland & Attorney General.* This case involved a constitutional challenge to section 260 of the 1945 Act by a plaintiff who had sought leave unsuccessfully to take civil action on a number of occasions between 1997 and 2001.[98] In the last of these proceedings, the plaintiff sought to include a constitutional challenge to section 260 at a late stage of the proceedings, but this was not permitted and the plaintiff was advised to commence new proceedings to challenge the constitutionality of the section.[99] Subsequently, the plaintiff argued that section 260 was a legislated denial of justice contrary to Articles 6 and 34 of the Constitution. These Articles deal with the separation of powers and the independence of the judicial function respectively. He alleged that the imposition of the conditions

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[93] [1998] IEHC 71 12th May 1998.
[94] [1996] ILRM 433.
[95] Unreported Supreme Court 28th May 1998.
[96] In *Manweiler v. Bourke & HSE Eastern Region* Unreported High Court, March 2005, the applicant was given leave to take civil action following which he succeeded in a negligence action against the health authorities.
[97] Unreported Supreme Court 28th May 1998. p10.
[98] [2004] IEHC 374, *Blehein v. Murphy* & Ors. [2000] 3 IR 359, *Blehein v. St John of Gods Hospital & Anor* Unreported High Court 30th May 2002.
[99] *Blehein v. St John of Gods Hospital & Anor* Unreported High Court, 30th May 2002.

"bad faith" and "without reasonable care" was a "disability imposed by statute" for those seeking redress against the provisions of the 1945 Act.[100] He alleged there was no objective criteria laid down by the Court where bad faith could be established and it was an impossible condition. Lack of reasonable care was difficult to establish if the profession is under attack, and had no place in the vindication of human rights in the Constitution. He said that the subordination of the courts to the legislature is not permitted by Article 6, as the independence of the judiciary is an essential cornerstone of democracy.

The State contested the application on the basis that section 260 is a legitimate restriction of rights of applicants having regard to the equality provision in Article 40 of the Constitution, which permits different treatment based on different social functions. The High Court stated that, in this kind of application, the court is confined to two grounds, bad faith and want of reasonable care, and its only discretion is in determining whether either ground is substantial. The Court held that this restriction constituted an impermissible interference by the legislature in the judicial domain, contrary to Article 6 and Article 34 of the Constitution. The High Court held that "[T]he legislature is not entitled to limit access to the High Court on specific grounds as provided in Section 260" and so, the section was declared unconstitutional on these grounds.[101] The effect of this decision is that the two grounds no longer apply and, therefore, the court is not limited to these grounds. This means that the High Court will grant leave where it is satisfied that there are substantial grounds for doing so. This also moves Irish law closer to the requirements on access to court in Article 6(1) by ensuring that the very essence of the right is preserved.[102]

It is possible, but not stated, that the High Court intended that the whole section, and not just these two restrictions, is unconstitutional, thereby removing this barrier to accessing the courts. It must also be remembered that this is a High Court decision and, while this particular issue has not been litigated before, there are Supreme Court decisions, including that of a full Supreme Court in *Murphy*, basing their decisions on the section which had enjoyed the presumption of constitutionality.

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[100] *Blehein v. Minister for Health & Children, Ireland & Attorney General* [2004] IEHC 374 p2.
[101] *Ibid,* p5.
[102] There has been no appeal to date.

Mental Health Act 2001

The impact of this decision on the 2001 Act will now be considered. The replacement of section 260 in the 2001 Act is as follows,

> **Section 73(1) provides,**
>
> No civil proceedings shall be instituted in respect of an act purporting to have been done in pursuance of this Act save by leave of the High Court and such leave shall not be refused unless the High Court is satisfied:
>
> (a) that the proceedings are frivolous or vexatious, or
>
> (b) that there are no reasonable grounds for contending that the person against whom the proceedings are brought acted in bad faith or without reasonable care.[103]

The burden of proof has been reduced to "reasonable grounds." In tandem with the change in emphasis from "leave shall not be granted" in section 260 to "leave shall not be refused" in section 73, this has created a more favourable situation for the applicant. Applying the decision in *Blehein* to section 73 will eliminate "bad faith and without reasonable care" from the section. If so, the test for the High Court is that leave will not be refused, unless the High Court is satisfied that the proceedings are vexatious or frivolous and there are no reasonable grounds for taking the action.

The aim of the provision is to protect those staff and authorities involved in the compulsory admission to hospital from unfair harassment. The English provision, section 139, was modified in the Mental Health Act 1983 to exclude proceedings against the Secretary of State, Health Authorities and National Health Service trusts.[104] Despite pressure during the passage of the 2001 Act, public authorities in Ireland are not excluded from the section and it is arguable that the section is even more inclusive by the omission of the word "person" as used in the 1945 Act, leaving it to the courts to interpret the section. Having regard to the decision in *Ashingdane v. United Kingdom,* which was held not to transgress a patient's right to a fair trial under Article 6, I believe the limitation in the 2001 Act will withstand breach of Article 6 if

[103] Mental Health Act 2001, section 73(1).
[104] Mental Health Act 1983, section 139(4).

it can be objectively justified.[105] The justification can be found in the relaxation of the burden on the patient under the 2001 Act to a greater extent than existed under the 1983 Act, so it is unlikely that the new provision will result in a breach of the right to to a court.[106] It must not infringe Article 14 and must be proportionate to the aim of protecting people from being sued in connection with compulsory admission.[107] It could be argued that there is no objective justification for the over-inclusive application of the section. The statement of Donaldson J. in *Winch v Jones,* an English case, is worth noting in regard to section 141 of the 1983 Act on the purpose of such section,

> Is intended to strike a balance between the legitimate interests of applicant to be allowed, at his own risk as to costs, to seek the adjudication of the courts on any claim which is not frivolous, vexatious or an abuse of the process and the equally legitimate interests of the respondent to such an application not to be subjected to the undoubted exceptional risk of being harassed by baseless claims by those who have been treated under the Mental Health Acts.[108]

The minimal right of access to the Court under section 260 exists but it could be argued that granting leave to four known cases since 1945 is, in effect, destroying the very essence of the right.[109] In addition, this provision, particularly where it relates to public authorities, may involve a breach of Article 14 by treating detained people differently, unless there is an objective and reasonable justification for protecting these bodies. The failure to exclude them is disproportionate to the aim of protecting individuals involved in the detention process. The number of potential applicants for leave that have been discouraged by such a result is unknown, but is a factor worth bearing in mind. Undoubtedly, the reconstituted section 73 in the 2001 Act is also overbroad as it contains no exclusions compared with section 139 of the 1983 Act. The impact of the *Blehein* decision on access will be awaited.

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[105] (1985) 7 EHRR 528.
[106] Mental Health Act 1983, section 141.
[107] (1979) 2 EHRR 387.
[108] [1985] 3 AER 97 p102.
[109] This includes the *Manweiler* case in addition to the cases already discussed at fn 91.

Legal aid

The 1945 Act has no express provision for legal aid in taking civil action under section 260, but an applicant would be entitled to apply for civil legal aid, though this service is extremely difficult to access where it is not an urgent family law matter.[110] The 2001 Act provides a right to legal representation, though this right is limited to tribunals and for appeals to the Circuit Court.[111] There is no express reference to the provision of legal aid outside these specific circumstances for an individual who wants to take a civil action and the very limited provision under the civil legal aid system will apply. If one applies the reasoning in *Airey v. Ireland* that the right to court must be effective, and taking into account the vulnerability of persons with mental disabilities, the failure to provide a comprehensive civil legal aid system directly impacts on effective access to court and potentially transgresses the very essence test by destroying access.[112] There is an alternative provision in the Human Rights Commission Act 2000 whereby an individual may apply for legal assistance for legal proceedings relating to human rights.[113] However, this is not stated in terms of an automatic right, but is dependent on the nature of the issues and many other limiting factors.

Conclusion

The limitations on the right of access to the court under the 1945 Act acts as a deterrent to taking such action and, based on the record to date, it is effective in ensuring the highest level of restriction. The aim of protecting staff from vexatious actions is a legitimate one, but the extent of the restriction is disproportionate as it protects corporate bodies and it is not clear from the wording if the section was intended to protect them. The High Court decision in *Blehein*, where it was declared that the limitation on the High Court as to the grounds for appeal,i.e. bad faith and lack of reasonable care, is unconstitutional, and modifies the section dramatically,

[110] Civil Legal Aid Act 1995.
[111] Mental Health Act 2001, section 16(2)(b) as arranged by the Mental Health Commission under section 33(3).
[112] *Airey v. Ireland* (1979) 2 EHRR 505.
[113] Human Rights Commission Act 2000, section 2.

unless the decision is overturned in the Supreme Court.[114] If the decision is upheld, this will impact on the 2001 Act creating a fairer situation for applicants and making the section more Convention compliant.

[114] *Blehein v. Minister for Health & Children, Ireland & Attorney General* [2004] IEHC 374.

Chapter 6

ARTICLE 6 AND THE PROTECTION OF THE PROPERTY OF VULNERABLE ADULTS UNDER IRISH LAW

Introduction

This chapter considers the ward of court system as it applies to the protection and management of the property rights and affairs of the individual against the background of Article 6. The requirements of Article 6 in relation to the determination of civil rights, in this instance, the property rights of the individual, are that there is speedy access to a fair hearing and right to representation before an independent and impartial tribunal. While there is a margin of appreciation enjoyed by contracting states, the limitations applied must not restrict or reduce the access left to the individual in such a way or to such an extent that the very essence of the right is impaired.[1] In addition, the limitation will not be compatible with Article 6(1) if it does not pursue a legitimate aim and if there is not a reasonable relationship of proportionality between the means employed and the aim sought to be achieved.[2] The wardship procedure, regarded as an extreme measure that effectively removes all decision-making from the ward, is outlined and considered in relation to speed of access and fair procedures along with the right to an independent hearing. The issue of proportionality is raised in relation to the protection of either property or personal rights based on the extreme impact of a declaration of wardship. The impact on other rights, such as the right to marry and the right to make a will, is considered.

The Power of Attorney Act 1996, which provides for an enduring power of attorney as an alternative system permitting some control by an adult in anticipation of future incapacity, is also considered. This power is limited to property, finance and personal care decisions.[3] The Law Reform Commission (LRC) recognises the need for law

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[1] *Ashingdane v. United Kingdom* (1984) 7 EHRR 528 para 57.
[2] *Ibid.*
[3] Powers of Attorney Act 1996 Section 4(1), the definition of personal care includes, where the donor should live and with whom, whom the donor should see and not see, the training and rehabilitation the

reform in relation to vulnerable adults and decision making.[4] These reforms propose to have a comprehensive system of proxy decision-making for incapacitated adults, as well as proper procedures for the removal of an individual's capacity to make decisions.[5] The trend in common law jurisdictions, seen in the Scottish Adults with Incapacity Act 2001 and the English Mental Capacity Act 2005, is to expand and adapt the current provisions regarding property and affairs to include proxy decision-making about care, treatment and welfare.

Origins of the ward of court system in Ireland

Originally, the jurisdiction to protect individuals, known as the *parens patriae* or Royal Prerogative, was vested in the Lord Chancellor of England, and when Ireland achieved independence in 1922 it was, by virtue of the Courts Act 1922, vested in the Chief Justice. The Chief Justice was relieved of the responsibility by the Courts of Justice Act 1936 when the jurisdiction was vested in the High Court for the purpose of exercising that jurisdiction.[6]

The ancient prerogative jurisdiction of the Crown over idiots and persons of unsound mind extended to the person, as well as to the property of those brought into its jurisdiction.[7] There have been long standing disagreements as to the existence of the royal prerogative in Ireland. The question of the survival of the prerogative is important in determining the jurisdiction of the judge in dealing with wardship matters. If the prerogative continues to exist, there are very wide powers to make decisions for wards outside of the limits of legislation. It is argued that the prerogative did not survive the constitutional changes in Ireland in 1922, as decided in *Byrne v Ireland*, involving an action against the State for negligence, where the Crown

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donor should get, the donor's diet and dress, the right to inspect the donor's papers and housing, social welfare and other benefits for donor.[3]

[4] Law Reform Commission Consultation Paper, *The Law and the Elderly* (LRC CP 23–2003). Law Reform Commission Consultation Paper, *Vulnerable Adults and the Law: Capacity,* (LRC CP 37-2005).

[5] Law Reform Commission, *Law and the Elderly* (LRC CP-23 2003) recommends the abolition of the wardship system and replacement with a whole new system. The operation of the wardship system in relation to the welfare of the person and medical treatment is dealt with under Article 8. See chapter 3 for discussion of Article 8 implications.

[6] Courts (Supplemental Provisions) Act, 1961 section 9.

[7] *In re D* [1987] IR 449.

prerogative of immunity from suit was held to be unconstitutional.[8] In *Webb v Ireland,* the Supreme Court stated,

> All royal prerogatives to be found in the common law of England and the common law of Ireland prior to the enactment of the Constitution of Saorstát Eireann 1922, ceased to be part of the law of Saorstát Eireann because they were based on concepts expressly repudiated by Article 2 of that Constitution ...[9]

If the *parens patriae* prerogative did not survive past 1922, it can be argued that the legislation then provided a statutory basis for a new and similar jurisdiction in the High Court. It is clear that the Court will rely on the legislation where appropriate, but will call on the inherent jurisdiction and apply the *parens patriae* principle without any discussion as to whether it had survived the constitutional changes in 1922.[10] The Supreme Court, in *In re ED, a Ward of Court,* made reference to the wide discretion possessed by the President of the High Court when exercising the wardship jurisdiction when the welfare of the ward was an issue.[11] The High Court applied the *parens patriae* principle and held that jurisdiction in the matter had not been circumscribed by the Lunacy Regulation Act 1871, thereby implying a level of flexibility.

Sources of law

The criteria for wardship are set out in the Lunacy Regulation (Ireland) Act 1871 (1871 Act) and in the Courts (Supplemental Provisions) Act 1961 (1961 Act). The procedure is set out in Order 67 of The Rules of the Superior Courts 1986 (1986 Rules).[12] The 1961 Act grants jurisdiction in lunacy matters to the President of the High Court. Article 34 of the Constitution provides the High Court with inherent jurisdiction to adjudicate on all matters of law and fact. In addition, Article 40.3.2 of the Constitution imposes on the State the obligation to protect and vindicate the personal and property rights of every citizen.

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[8] [1972] IR 241.
[9] [1988] IR 353.
[10] *JM v. The Board of Management of St. Vincent's Hospital (ex parte PM)* Unreported High Court (Finnegan J.) 24 October 2002.
[11] Unreported Supreme Court, March 4th 1998.
[12] Rules of the Superior Courts Order 65, deals with procedures for applications for minors, those under 18 years.

The purpose of the 1871 Act was to amend the law relating to Commissions of Lunacy and to provide more effectively for the visiting of persons "found or supposed lunatic" and to "make the other provisions for the institution, speeding, and deciding of inquiries *de lunatico* ..."[13] Subsequently, the 1986 Rules governed the procedure leading to wardship. The ward is the respondent in the inquiry and is the person alleged to be of unsound mind in respect of whom a petition for inquiry has been presented. The 1986 Rules seem to envisage that the judge has powers, which do not derive from the legislation,

> All originating applications to the Judge for the exercise by him of all or any of the powers by the Act *or otherwise conferred upon or possessed by him* (emphasis added) in respect of the persons or property of persons of weak or unsound mind ... [14]

It is clear from the foregoing that the authority of the Court originates from a variety of sources: the *parens patriae* prerogative, the legislation, the inherent jurisdiction of the Court under the Constitution, and the obligation to protect personal rights.[15] The authority of the President of the High Court should be grounded in the inherent jurisdiction of the Court under Article 34, where the Court is empowered to step in to protect an individual's personal rights under Article 40.3 of the Constitution. The inherent jurisdiction of the Court leaves the 1871 Act, which sets out the criteria for wardship and some procedures, unclear. In *In re a Ward (Withdrawal of Medical Treatment),* Hamilton CJ outlined the paramountcy principle and vesting in the High Court from the Crown as follows,

> When a person is made a ward of court, the court is vested with jurisdiction over all matters relating to the person and estate of the ward and in the exercise of such jurisdiction is subject only to the provisions of the Constitution: there is no statute which in the slightest degree lessens the court's duty or frees it from the responsibility of exercising that parental care ... In the exercise of this jurisdiction the court's prime and paramount consideration must be the best interests of the ward.[16]

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[13] Lunacy Regulations (Ireland) Act 1871, in the introduction to the Act.
[14] Rules of the Superior Courts Order 67, Section 3(1).
[15] Bunreacht na hEireann, The Irish Constitution, Article 34.
[16] [1996] 2 IR 79 at 106.

This statement emphasises the predominance of the Constitution with regard to the inherent jurisdiction and the primary focus of the best interests of the ward.[17]

The 1871 Act limits the discretion of the Court in setting out the circumstances in which the ward's property may be sold, although in practice the section is interpreted liberally. It deals with the property issues and does not deal with any specific issues related to welfare, such as the withholding of medical treatment. There is no legislation dealing with how the Court is to determine issues about the person as opposed to the property of the ward.[18] The Court, in *In re D (Midland Health Board wardship application),* made it clear that the right to protection in wardship is not limited to persons of unsound mind who are entitled to property that needs protection.[19] In the absence of legislation, the Court has to rely on either the *parens patriae* principle or the inherent jurisdiction. The President of the High Court exercises that jurisdiction and only on rare occasions, when he is not available, is that responsibility delegated by him to another judge of the High Court.

The 1961 Act confers concurrent jurisdiction on the Circuit Court in limited matters where the property of the person, who is alleged to be of unsound mind and incapable of managing his affairs, does not exceed a particular amount.[20] It is very rare for applications to be made in the Circuit Court and the procedure is far more expeditious in the High Court.[21]

Eligibility for wardship in the 1871 Act required that the person was a "lunatic" defined as "any person found by inquisition idiot, lunatic, or of unsound mind, and incapable of managing himself or his affairs."[22] The terms used in the 1871 Act, widely regarded as archaic and pejorative, are no longer used and the 1961 Act replaced the word lunatic with person of unsound mind.[23] The 1986 Rules refer to the "respondent" as a person alleged to be of unsound mind and incapable of managing

[17] [1996] 2 IR 79.
[18] *In re D (Midland Health Board Wardship application)* [1987] IR 449.
[19] *Ibid* para 455.
[20] This amount is currently €6,500 in value or if the income from the sum does not exceed €375 per annum.
[21] Courts (Supplemental Provisions) Act, 1961 section 8(2).
[22] Lunacy Regulation (Ireland) Act 1871, c 22, sections 3 & 118
[23] Courts (Supplemental Provisions) Act, 1961section 9(4)(a).

his person or property.[24] The language of wardship such as "lunacy" and "person of unsound mind," though not in current use, have survived in the absence of up to date legislation. These terms stigmatise persons who are wards and cause upset.[25] This is an aspect that can be dealt with by legislators becoming aware of the damage that such language can do to vulnerable people and their families.

In *Dolan v. Registrar of Wards of Court*, the parents of a disabled adult who had received an award of damages for injuries, challenged the court's authority to have a second medical examination which would lead to him being made a ward of court.[26] They objected, *inter alia,* to the language in the 1871 Act and were adamant that their son was not going to be labelled an "idiot, lunatic or person of unsound" as a condition of getting protection for him. They also objected on the grounds that wardship would interfere with their constitutional rights as a family and that their son would be restricted in relation to travel. They failed in their efforts due to a jurisdictional issue, and Kelly J referred to the making of a wardship order as a "judicial function which [had to be] exercised in accordance with the Constitution and with constitutional propriety."[27]The judge noted that the terms objected to were no longer used because they were terms of a bygone age.[28] Seeking to reassure the family when making the order, Kelly J. quoted from Denham J. in *Eastern Health Board v. MK,* where she stated,

> Wardship proceedings must be fair and in accordance with constitutional justice. The constitutional rights of all parties the children and the patients must be protected. Where rights are in conflict they must be balanced appropriately. The Court, while exercising this unique jurisdiction must observe due process. Consequently, if a legal right or a constitutional right is to be limited or taken away by a court this must be done with fair procedures.[29]

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[24] Rules of Superior Court, Order 67, section 1.
[25] *Dolan v. Register of Wards of Court* Unreported High Court, 19th March 2004. See also Irish Times 20th March 2004.
[26] *Ibid.*
[27] *Ibid* p14.
[28] The Courts (Supplemental Provisions) Act 1961 section 9(4)(a) permits the substituting of other expressions for the word 'lunatic'.
[29] [1999] 2 IR 99 at 111.

Unsound mind

In order to be admitted to wardship, two factors must be present: the person must have an unsound mind and must also be incapable of managing his person or property and each condition must be satisfied. There are problems with the concept of unsound mind. In some cases, the lack of capacity is obvious where the person is unconscious or in advanced stages of dementia and unable to communicate. In other situations, the President relies almost totally on medical evidence. The individual's psychiatric history is relevant to the question of capacity, but cannot be determinative of incapacity. The courts have, on occasion, held a person not to be of unsound mind, but still incapable of managing their affairs.[30]

The High Court addressed, for the first time, the double criteria for wardship in *In re Catherine Keogh.* The jury found the proposed ward was not of unsound mind, but was incapable of looking after her person or property.[31] The respondent had been awarded a large sum for personal injuries and an application to make her a ward was supported by two medical affidavits to the effect the respondent was of unsound mind and was incapable of managing her affairs. An order taking her into wardship was made, but had to be discharged on discovery of an objection lodged prior to the order and unknown to the Court. A hearing was ordered to take place before a judge and jury and the test applied was whether the person is "of unsound mind and incapable of managing himself or his affairs." They held that the word "and" was conjunctive and orders for wardship could be made only where both requirements are satisfied. No details were provided in the court report as to how the jury found the individual did not have an unsound mind, but was incapable of managing her affairs. The decision may have been influenced by the large award of damages involved.

This case raises the prospect of lack of future management where someone does not fit the criteria in use and safeguards are needed. Even where the criteria are set out, the High Court has discretion as to whether wardship is the appropriate course of action and must be satisfied that the ward needs protection and will benefit from being

[30] *In re Catherine Keogh* Unreported High Court, Finnegan J., 15th October 2002.
[31] Unreported High Court, Finnegan J., 15th October 2002.

admitted to wardship. These additional criteria of "appropriateness" and "benefit" are not included in the 1871 Act and arise from the operation of the *parens patriae* power.

Despite the vagueness of unsound mind, the policy of the Ward of Court Office is to refuse to issue an inquiry unless the medical evidence has the term unsound mind on the affidavit. It is not adequate to state that the respondent suffers from a learning disability as this will not satisfy the Act.[32] The vagueness of the criteria means that the assessment is open to a very broad interpretation of incapacity. This may breach Article 6 arising from the proportionality test and the need to have a reasonable relationship between the aim of the intervention and the means used.

The Court, in *Masterman-Lister v. Brutton & Co. & the Home Counties*, an English case concerned with the right to litigate, held that the capacity required by the law is issue specific, i.e. the capacity to understand the nature of the transaction when it is explained.[33] Kennedy LJ stated,

> It is common ground that all adults must be presumed to be competent to manage their property and affairs until the contrary is proved, and that the burden of proof rests on those asserting incapacity. ... if there is clear evidence of incapacity for a considerable period then the burden of proof may be more easily discharged, but it remains on whoever asserts incapacity. Furthermore, it has to be recognised that when a person is treated as a patient, whether or not as a result of an order of the court, he is thereby deprived of civil rights, in particular his right to sue or defend in his own name, and his right to compromise in litigation without the approval of the court. They are important rights, long cherished by English law and now safeguarded by the European Convention on Human Rights. In *Re Cummings* [1852] I De GM&G 537 Knight Bruce LJ said at 557-
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> > It is the right of an English person to require that the free use of his property, and personal freedom, shall not be taken from him on the ground of alleged lunacy, without being allowed the opportunity of establishing his sanity or denying his insanity before a jury as a contesting party, not merely as a subject of inquiry.[34]

The Court went on to state that this requirement is underlined by Articles 6 and 8 of the Convention. This means that, even when the issue did not seem to be contentious,

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[32] In *In re Catherine Keogh* Unreported High Court, Finnegan J., 15th October 2002. The court was reluctant to use this term for an incapable person. 'Learning disability' alone is not enough to establish support for the petition without more. Affidavits for medical reports also cause problems.
[33] [2002] EWCA Civ 1889.
[34] *Ibid* para 17.

a district judge who was responsible for case management would almost certainly require the assistance of a medical report before being able to be satisfied that capacity existed. A litigant in personal injuries may be able to decide about the proceedings and to settle his claim but not have the capacity to manage money. This should not exclude him from the proceedings, but he may have to be made a ward of court in Ireland, preventing any involvement in legal matters. Until the *Masterman* case, there was a shortage of information about criteria for assessing whether someone is mentally capable of managing and administering his property and affairs.[35] In *Masterman,* Kennedy LJ approved a test of capacity in relation to specific decisions,

> ... a person's ability to manage his or her property and affairs requires an ability to make and communicate, and where appropriate give effect to all decisions required in relation to them. So the mental abilities required include the ability to recognise a problem, obtain and receive, understand and retain relevant information, including advice; the ability to weigh the information (including that derived from advice) in the balance in reaching a decision, and the ability to communicate that decision.[36]

Reference was made to *White v. Fell,* a case with similar facts, in which Boreham J. stated that that very few people are able to manage all their affairs without some help and that the expression "incapable of managing her own affairs and property" must be construed in a common sense way and does not require proof of complete incapacity.[37] In *Masterman,* Wright J. said the court should only take over the individual's function of decision-making "when it is shown on the balance of probabilities that such person does not have the capacity sufficiently to understand, absorb, and retain information (including advice) relevant to the matters in question sufficiently to enable him or her to make decisions based upon such information."[38] This guidance is directly relevant to the determination of civil rights and obligations under Article 6.

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[35] *Masterman Lister v. Brutton & Co and Jewell & the Home Counties Dairiies* [2002] EWCA Civ 11889 para 17.
[36] *Ibid,* para 26.
[37] Unreported 12th November 1997, Australia.
[38] *Masterman Lister v. Brutton & Co and Jewell & the Home Counties Dairies* [2002] EWCA Civ 11889 para 20.

The ward of court assessment relies on reports from medical assessors confirming that the person has an unsound mind and is unable to manage his person or affairs. The assessment for unsound mind in wardship is usually carried out by psychiatrists, though the legislation does not require specialist expertise, so there is an element of arbitrariness in terms of the forseeability of the law. The terms "unsound mind" are not defined in the legislation and are likely to be left to the discretion of medical experts applying the standard of practice in that area. The use of unsound mind as the single criteria that results in a finding of general incapacity removes the person's total decision-making power is over-broad, denies the right to specialist assessment, takes no account of the ward's or carer's wishes and may well transgress the proportionality requirement in Article 6. What is needed is a clear understanding of capacity. The Court, in *Winterwerp v. Netherlands,* said there was no definition of unsound mind and stated in relation to psychiatric detention,

> ... the Convention does not state what is to be understood by the words 'person of unsound mind' ... it is a term whose meaning is continually evolving as research in psychiatry progresses, an increasing flexibility in treatment is developing and society's attitude to mental illness changes, in particular so that a greater understanding of the problems of mental patients is becoming more widespread. [39]

The difference between the use of unsound mind for wardship and that used to assess unsound mind for psychiatric detention is the scope of the terms for wardship which must include other conditions, such as head injuries and dementias, that do not necessarily have associated mental disorders. The test used by the Court of Protection in England is, having considered the medical evidence, "that a person is incapable, by reason of mental disorder, of managing and administering his property and affairs."[40] The use of word "incapable" is indicative of a more proportionate response, taking the patients actual abilities into account. The Mental Capacity Act 2005 provides that, "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

[39] *Ibid* para 37. This interpretation of person of unsound mind was followed by Budd J. in the High Court in *Croke v. Smith & Eastern Health Board* [1995] IEHC 6 31st July, 1995.
[40] Mental Health Act 1983, section 94(2).

disturbance in the functioning of the mind or brain."[41] The criteria for admission to wardship in Ireland needs to be clarified.

Procedures for wardship

The standard procedure is the most common procedure leading to wardship and arises under section 15 of the 1871 Act. In the absence of rules, the next of kin are regarded as the most appropriate applicants for wardship. Each application is supported by two medical affidavits. The medical visitor from the Office of Wards of Court may visit and report on any aspect of the respondent's life and an inquiry by the High Court may be initiated on foot of the report of the medical visitor. An inquiry order is made if the medical evidence is satisfactory. A court appointed medical visitor makes an independent report to the President on the nature and origin of the mental illness and assesses the prospect of recovery. The report is then referred to the President for a decision. This report is confidential and does not have to be shown to the respondent. There is no requirement for a multi-disciplinary assessment.

The proposed ward is given notice and informed of his right of objection which must take place within seven days of the application. The proposed ward must make this objection without any access to the report indicating why it is being proposed to take him into wardship. This is clearly an issue relevant to Article 6 and the requirement of "equality of arms." If there is no objection, the case is listed for hearing.[42] It is very unusual to have objections to petitions for admission to wardship.[43] Notice of any objection must be signed and witnessed by the solicitor. A hearing must then take place before a judge or judge and jury. The lack of a mandatory requirement that such vulnerable adults are legally represented raises serious issues under Article 6, even allowing for the practice of having representation in all cases.[44]

The judge may require a personal examination of the respondent and may then order that the inquiry be held before a jury, formerly known as the *de lunatico inquirendo*.[45]

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[41] Section 2(1).
[42] Ward of Court Office, Information Document on Wardship www.court/wards.ie
[43] *In re Catherine Keogh* Unreported High Court, (Finnegan J.) 15th October 2002.
[44] *Airey v. Ireland (*1979) 2 EHRR 305.
[45] Rules of Superior Courts, Order 67, rules 10-16.

This involves the judge laying out the requirements regarding the conduct of the inquiry, the time, venue, procedure and general conduct of the inquiry. Alternatively, the respondent will be asked to appear before the judge for a personal examination and the judge can order that an inquiry before a jury would take place when satisfied that the respondent is not competent to "form and express a wish in that behalf."[46] The hearing is in public, but no publication of the names of those involved is permitted. When a decision has been made taking the person into wardship the committee, the person to whom the ward's affairs are committed, is the contact between the Wards of Court office and the ward.

One respondent to a wardship application successfully challenged efforts to have him made a ward of court before a jury.[47] He convinced the jury he was not of unsound mind or unable to manage his person or his affairs. He also succeeded in having the case heard in open court. The case arose because his solicitor was pressured into making an application for wardship in the context of a family will dispute and following the respondent's admission for psychiatric care. The case highlights the importance of due process, the right to a hearing and representation for the individual. There is no requirement advising an individual that he should seek an independent solicitor or get an independent second medical opinion.

The issue of independence and bias was raised in *In re ED, A Ward of Court* and concerned an appeal by the daughter of a ward against a number of orders made by the President.[48] The appellant also raised the issue of jurisdiction in the case. At the time of the hearing, the President was a governor of the hospital in which the ward lived and the appellant believed he was biased and should have disqualified himself from hearing the case. The President stated that the motivating force of the judgment was the welfare of the ward. The perception of bias is not what one particular person considers to be bias, but what a reasonable person would consider biased. Furthermore, he was satisfied that no reasonable person would be justified in considering that the President of the High Court, who is involved in the hospital and charities, would be influenced in reaching such a decision. The Supreme Court held

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[46] *Ibid,* section 19.
[47] Irish Times report, 22nd July 1997. (No title available)
[48] Supreme Court IESC 4th March, 1998.

that the orders made by him were within his jurisdiction and there was evidence which justified him in exercising his discretion and no bias. The question of impartiality in Article 6 is relevant. Impartiality means a lack of prejudice or bias and the court must comply with the subjective and objective test,

> ... the existence of impartiality for the purposes of Article 6(1) must be determined according to a subjective test, that is on the basis of the personal conviction of a particular judge in a given case, and also according to an objective test, that is ascertaining whether the judge offered guarantees sufficient to exclude any legitimate doubt in this respect.[49]

The involvement of the President in the institution is difficult to divorce from the judgment, but the Supreme Court was of the view that the judgment of the President was acceptable based on the reasonable person test.

Urgent Procedure

There are a number of alternative procedure used in situations where the standard procedure is not appropriate, such as urgent situations or where the family do not want to petition for an inquiry.[50] In these circumstances, the Registrar initiates the petition and asks a medical visitor to examine the respondent and report back.[51]

Limited Assets Procedure

In situations where the person owns little property, there is a less complex procedure involved.[52] This involves a petition and one medical certificate or affidavit and the Registrar can initiate the proceedings. A report from a medical visitor must be provided, as well as any other the Registrar thinks necessary for evidence and the judge can make an order without further inquiry. The notice and objection rules are similar to the standard procedure.

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[49] *Hauschildt v. Denmark* (1989) A 154 para 46.
[50] Lunacy Regulation (Ireland) Act 1871, section 12. *JM v. St. Vincent's Hospital (ex parte PM)* Unreported High Court (Finnegan J.) 24 October 2002.
[51] There were 35 such applications from a total of 191 in 2001 and 13 out of a total of 131 in 2002.
[52] Lunacy Regulation (Ireland) Act 1871, section 68. Where the value of the property is less that €6,350.00, or the income from the property is less than €380.00.per annum. These applications are rare and there were none in 2001-2002.

Temporary procedure

This procedure is used where medical evidence confirms that the person is "of weak mind and temporarily incapable of managing his affairs."[53] The 1871 Act does not refer to the management of the person. The nature of the incapacity, the reason for it and its expected length of time must be explained. There is a right of objection within four days of the documents being served but without any access to the report on which the application is based. A "guardian" will be appointed to act for a specific period, up to six months, and this period can be renewed only once after which the person is discharged or admitted under the standard procedure. A medical visitor must visit one month prior to the expiration of the order and report on the person's mental and physical condition. There is limited information on the operation of the temporary procedure on how guardians are appointed and their role.[54]

New procedure

During the past year, 2004-2005, the President has adopted an approach designed to afford protection to an adult with limited assets found on medical evidence to be incapacitated, without subjecting the person to the full consequences of wardship. Where the amount involved is less than €30,000 and the President is satisfied with an undertaking from the family or carer of the person that they will apply the amount for the benefit of the ward and will account to the Registrar of Wards for the funds when asked, authorisation will be given to this effect. The procedure is initiated and completed by correspondence, no formal order is required and it follows the usual background check by the Registrar. This is a really useful and practical development as an interim solution to the gaps. Presumably the safeguards rest with the Registrar of Wards. There are many questions that could be raised if the definition of incapacity is the same as for wardship, what rights of appeal or complaint are open to the person who may object to particular relatives being involved.

The courts have on occasion creatively used the *parens patriae* power under the wardship jurisdiction to create a third party right. In *In the Matter of JR, a Ward of*

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[53] *Ibid,* section 103.
[54] Few applications are made using this provision.

Court the right to residency of the ward's cohabitee arose in the context of the proposed sale of the ward's dilapidated house when the ward needed residential care.[55] The High Court held that the cohabitee of a ward was entitled to rely on the promise made by the ward that she would have a right of residence in the house. The ward had made a will in favour of the cohabitee and High Court ordered a sale of the house and the purchase of another suitable one giving a right of residence to the cohabitee.

The Committee

The committee is the person to whom the affairs of the Ward are committed and is commonly, though not always, a family member. It is the duty of the committee to ensure the care, treatment and comfort of the ward. To this end, the committee is required to visit the ward or, if residing with the ward, report on his needs and permit visits by the medical visitors.[56] The President can appoint a committee of the person separately from a committee of the estate, but usually the affairs of the person and property are committed to one person. Where there is opposition to the committee, or where there is a disagreement, or conflict of interest, or where no relative resides in the country, the President can appoint the General Solicitor for Minors and Wards to act as committee. The committee can only do what is permitted by the Court and has no inherent power or authority. Typically, the role of the committee involves collecting the pension, letting a farm or selling a house.

> ... the Committee of the Person has rights and duties and these may include litigation on behalf of the ward. Indeed, this is especially so if the Committee of the Estate is taking a view which the Committee of the Person believes is having a detrimental effect on the person of the ward. In such a conflict it is open to the President of the High Court to sanction proceedings on behalf of the ward by the Committee of the Person.[57]

[55] [1993] ILRM 657.
[56] It is accepted that these medical visitors do not exist due to lack of resources.
[57] *In re K (Ward of Court)* [2001] 1 IR 339.

The committee is bound by rules regarding the management of the ward's money and an annual account is held in the Office of Wards of Court of all monies received and disbursed.[58]

Standard of proof

The onus of proof regarding incapacity rests on the person asserting the need for wardship and, while the standard of proof lacks clarity, it appears to be the civil standard. The level of incapacity and the basis on which it is judged is not set out in the legislation, but depends on current practice. The 1871 Act requires the judge to conduct an inquiry and hearings are inquisitorial. The rules of evidence are relaxed and the hearing is administrative in nature.[59]

Effect of a declaration of wardship

Wardship is a very extreme measure that takes no account of the functional approach to decision-making, thus leading to a "one size fits all" approach. The most significant aspect of admission to wardship is that the individual loses all rights to make any decisions about his person or property and this may apply for life.

> By and large wardship is for life, although there are cases (especially where a person has recovered damages for a brain injury and is quite young when the Declaration Order is made) where the ward recovers sufficiently to apply successfully to be discharged from wardship and remitted to the management of own affairs.[60]

The court is vested with jurisdiction over all matters relating to the person and estate of the ward.[61] The declaration of wardship results in a significant loss of liberty for the individual, both personally and in relation to his property and affairs. The ward is not allowed to move at will from his agreed residence and may be required to live in a particular setting. All changes, such as hospital care, must be notified to the Office of

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[58] Rules of the Superior Courts, Section 62 of Order 67 rule 57.

[59] A discussion on the standard of proof arose in the *In re a Ward (No 2)* [1996] 2 IR 79 and there was considerable divergence on the standard of proof, even though the case was not about the status of wardship, but the legality of withdrawal of treatment.

[60] McLoughlin N.,"Wardship: A Legal and Medical Perspective" (1998) 4(2) *MLJI,* p64.

[61] *In re a Ward of Court(Withdrawal of Medical Treatment)* [1996] 2 IR 79 p106.

the Ward of Court. In effect, the Court takes over all decision making for the ward and the committee carries out day to day matters, including specific areas directed by the Court. This effectively removes the ward from participation in any legal matters, such as buying or selling property. A ward can only be a plaintiff in legal proceedings if the President of the High Court authorises the committee to bring those proceedings on behalf of the ward. The ward may be able to make a will if the President confirms that he has testamentary capacity to do so based on medical evidence and the opinion of his solicitor. Being a ward does not prevent a person from being sued or facing criminal prosecution and the Court can authorise representation of the ward in those proceedings.

The ward retains ownership of any property and money although these may be dealt with or used in accordance with the orders made by the Court. On the death of the ward after a Grant of Probate or Administration is issued, his estate is distributed according to his will or under the rules of intestacy.[62] The 1871 Act sets out circumstances in which the property can be sold. One of the criticisms of this aspect is that there is no provision for long-term investment in property or to prevent diminution in the value of property.[63]

There are a limited number of safeguards provided in the current system. The Registrar can request the committee to report on the "residence, physical and mental condition, maintenance, comfort and such other matters in relation to the ward as he may wish to be informed of."[64] The Act mandates that medical and legal visitors have a duty to visit the ward but this is not done due to lack of resources.[65] The committee has no authority to change the residence of the ward without the permission of the judge or Registrar.[66] A further concern is that there is no obligation to inform the ward's GP, any organisations, carers, other doctors, or local health services that the person is a ward, though in practice this happens when services are being organised.

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[62] Succession Act 1965.
[63] It has been reported that there is €420m held by the various courts for minors and wards. Reviewed in 2001 to advise on best practice and Investment Committee set up as advisory group for investment strategies and best practice guidelines. This has been improved with the new legislation, Trustee (Authorised Investments) Order 1998.
[64] Lunacy Regulation (Ireland) Act 1871, sections 57-58.
[65] This provision is not applied due to resource constraints.
[66] Rules of Superior Courts, Order 67, rule 59.

The omission is a significant deficit in relation to the management of the ward and can lead to arbitrariness and inconsistencies. It also adds to the disconnectedness between the centralised system around the formality of being a ward and the day to day life of the ward.

Where the ward is in psychiatric care, part of the order is that he stays there until further order from the Court.[67] Wards in psychiatric detention have no specific rights under the 1945 Act although the President of the High Court can request the Inspector of Mental Hospitals to visit and report on their circumstances.[68] Patients have a right to send an unopened letter to the President, though this is a bit unrealistic in view of the level of incapacity of wards and the saving section regarding wards in the 1945 Act is not clear on whether the rights in the Act clearly apply to wards or not. [69] The 2001 Act will not change anything in this regard due to the saving clause carried over from the 1945 Act regarding the power of the High Court.[70] The matter of review of wards in psychiatric detention rests with the High Court, but raises issues under Article 5(4) and Article 14, unless there is objective and reasonable justification for the difference in treatment of wards compared with fellow patients who have a right to review of detention in the 2001 Act.

The individual will always have legal representation even though this is not based on statute. The capacity assessment for entry to wardship is a general one rather than issue specific and where the person satisfies the criteria of unsound mind and is incapable of managing himself or his affairs, then autonomy is removed. This would seem to be disproportionate to the aim of protecting the property or welfare of the individual and not in keeping with the least restrictive alternative principle. In this sense it may not satisfy the requirements based on the *Winterwerp* tests. The length of time to complete a wardship application is regarded as too long at a minimum of three months.

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[67] Department of Health & Children, *Report of the Inspector for Mental Hospitals for year ending 2003,* Dublin, 2004, recorded a total of 100 wards of court detained in psychiatric care.
[68] Mental Treatment Act 1945, section 241.
[69] *Ibid,* section 266.
[70] Schedule to the Mental Health Act 2001 Act and Mental Treatment Act 1945 section 283.

The principal purpose of wardship is to protect the property and welfare of the adult and manage it for his benefit. The majority of wardship applications relate to the management of property and affairs and fewer are solely about personal welfare.[71] The law governing wardship originated at a time when there was little understanding of mental disability and when there was no recognition of the right to autonomy, self-determination, or of the principle of the least restrictive alternative. The situation is different now with recognition of these important human rights.

Wardship and other civil rights

Marriage

The statutory prohibition on the ward entering marriage dating from Marriage of Lunatics Act, 1811 has been repealed in England, but not Ireland. If the person does not have contractual capacity, it is difficult to contract a valid marriage.[72] Where a married person is made a ward of court, this does not automatically invalidate the marriage if the person at the time of the marriage had the requisite capacity. Article 6(1) requires that any limitations on this civil right are proportionate to the aim of protecting incapacitated people. The restrictions must not be such that the very essence of the right to marry is impaired unless this accords with a legitimate aim. "Some people who are wards might quite possibly be able to understand the nature of the marriage contract and this is one of the many aspects of the wardship jurisdiction which would merit revision."[73] The related right to a sexual relationship and to reproduction are discussed in chapter eight.

Testamentary capacity

There is no automatic right to ensure a ward is enabled to make a will and the onus is on the ward to contact the Registrar of Wards if he wants to make a will. Where the President has medical evidence of testamentary capacity, the ward can be authorised to instruct a solicitor to make a will, provided the solicitor is satisfied that the ward is

[71] Information from the Ward of Court Office 2004.
[72] See Chapter 8 for discussion of the right to marry.
[73] *Op.cit.*, 60 at p62.

capable of doing so. After the ward's death, the assets are distributed according to the will or under the rules of intestacy.[74]

Voting

There is no statutory restriction on voting, but there is a common law rule that people who are mentally incompetent are not entitled to vote. This does not appear to be enforced and there are no arrangements for assessing capacity. Those wards who live in psychiatric hospital or residential centres may be unable to establish residency for the purpose of being on the Register of Electors. This issue is raised from time to time, remains fundamental to citizenship and needs to be clarified.

Discharge from wardship

An application can be made to be discharged from wardship based on medical evidence to the effect that the ward is of sound mind and capable of managing his affairs. There is no automatic review of wardship unless the committee or representative of the ward takes the initiative to apply to the President. This would appear to conflict with fair procedures, as the requirement to initiate the review is quite onerous. The Court, in *Matter v. Slovakia,* said that "it may be appropriate ... that the domestic authorities establish after a certain lapse of time whether such measure continues to be justified. Such a re-examination is particularly justified if the person concerned so requests it."[75]

The legislation gives no guidance on the level of capacity to be arrived at for discharge, other than being of sound mind and capable of managing one's affairs generally. Based on the *Keogh* case, it appears that if both requirements are not present, the person should not be in wardship.[76] Reliance is placed on family or medical personnel to identify any change and initiate proceedings. This is obviously an arbitrary approach to continuing incapacity and may not be justifiable as being proportionate to the aim of the protective jurisdiction. The gap in the statutory

[74] Succession Act 1965.
[75] (2001) 31 EHRR 32 para 68.
[76] *In re Catherine Keogh* Unreported High Court, (Finnegan J.) 15th October 2002.

obligation to review the continuing incapacity contrasts with the decision in the English case, *Masterman-Lister v. Brutton & Co. & the Home Counties.*[77] The presumption of continuance of incapacity is no longer acceptable, as ruled by Kennedy LJ in the *Masterman.*[78] If there is clear evidence of incapacity for a considerable period, the burden of proof may be more easily discharged.

The 1871 Act mandates regular visits to the ward by medical or legal visitors, involving four visits annually for those in the community and one visit annually for those in residential care.[79] The purpose of the visit to the wards is to "make inquiries and investigations as to their care and treatment and mental and bodily health, and the arrangements for their maintenance and comfort, and otherwise respecting them ..."[80] These visits do not take place due to resource constraints. Clearly, this is a breach of statutory requirements, perhaps causing people to remain in wardship longer than necessary.[81]

Conclusion on wardship

The criteria used for wardship, "unsound mind" and "weak mind," coupled with the lack of a specialist assessment, need to be revised to a narrower more specific criterion taking account of individual difference. The relationship of proportionality between the interference, taking no account of individual difference, and where precise criteria for values like autonomy and self-determination are not part of the assessment of capacity, would not seem to accord with the aim of protecting the individual and property. The procedure does not acknowledge partial capacity or an ability to carry out some tasks and not others and is not in keeping with maximising autonomy and enabling participation. Criticisms of the wardship system centre on the complexity and inflexibility of the procedures. The results of one study found that the

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[77] *Masterman-Lister v. Brutton & Co. & the Home Counties* [2002] EWCA Civ 1889.
[78] *Ibid,* para 17. This is an important statement in view of the rigid ward of court system where the burden of release from warship rests on the ward or his representative rather than having a statutory based periodic review of continuing incapacity
[79] Lunacy Regulation (Ireland) Act 1871, section 57.
[80] *Ibid,* section 56.
[81] These visits would have provided an important connection between the ward and the High Court instead the limited connection through the committee who may have only very limited contact. Even if this system, of two centuries ago, were in operation it would probably eliminate many doubts regarding the continuing incapacity of the ward and concerns regarding the day to day life of the Ward.

system does not lend itself to rapid response.[82] Whether this might breach the requirement of reasonable time in Article 6 is not clear, but one of the frequent complaints relates to the length of time to complete wardship proceedings. The lack of automatic review of the need to continue with wardship adds to the arbitrariness of the system with the onus on the allegedly incapacitated person or the committee to initiate a review of continuing wardship, rather than having an automatic periodic review built into the system. This gap is heightened for the 100 wards currently in psychiatric detention who are not entitled to review of their continuing detention under either Act.[83] These failures are in breach of Article 6 and the right to a fair hearing, as well as breach of Article 5(4) and the need for review of continuing detention.

Wardship is used as a method of last resort, but in the absence of less extreme or once off interventions, questionable arrangements have arisen for dealing with persons in order to avoid wardship. When a person is detained in hospital, he is often denied the right to deal with his property on the assumption of incapacity due to detention, but without an assessment of his actual capacity. This situation occurs also in relation to the voluntary admission of the compliant incapacitated patient. The automatic presumption of incapacity may stem from the 1945 Act, which provides that patients incapable of deciding to enter hospital voluntarily should be detained.[84] This Act also provides that when a person "becomes mentally incapable of expressing himself as willing or not willing to remain" in the hospital, he should be discharged or detained.[85] The implication from these sections is that detention is equated with mental incapacity and, as a result, informal arrangements are made for dealing with their affairs.

There are advantages to informal arrangements, such as flexibility and lack of bureaucracy, but it is likely that these situations are open to abuse, loss of property and exploitation, in the absence of even minimal control. Alternatively, where nothing is done, the patient may lose his home, job and security. Even when a person is a ward, that person is not necessarily protected from abuse, nor are the authorities

[82] McCarthy & Wrigley, "Ward of Court – A Review of Utilisation in a Psychiatry of Old Age Service", 4(2) *MLJI* 24.
[83] *Op.cit.*, 67.
[84] Mental Treatment Act 1945 sections 163 and 184 as amended by Mental Treatment Act 1961 section 7.
[85] *Ibid,* section 195.

forced to provide services such as residential care, and it is not clear if wardship can be used to assert rights to particular services that the court believes are appropriate.[86] The recent initiative by the President of the High Court to have an *ad hoc* system that provides a level of protection without subjecting the individual to the full wardship proceedings is welcome. The modern legal response to the problem of capacity lays great emphasis on maximising autonomy and the Law Reform Commission has proposed a number of changes to deal with these difficulties.[87] One way in which this can be done is by having in place a broader enduring power of attorney.

Powers of Attorney

At the other end of the scale from wardship and the protection of the right to autonomy and self-determination lies the enduring power of attorney. The Powers of Attorney Act 1996 (1996 Act) provides for an enduring power of attorney (EPA) system that permits the adult to control what happens in future and acts as an advance directive in anticipation of a state of incapacity. This power is limited to property and finance, business affairs and some personal care decisions. The personal care decisions include where the donor should live and with whom, but it specifically excludes health care decisions.[88] This is the only legal mechanism, apart from wardship, that provides for the proxy management of an incapacitated person's affairs. The EPA intends power to be effective during any subsequent mental incapacity of the donor. Mental incapacity is defined as "incapacity by reason of a mental condition" to manage and administer his property and affairs.[89] The right to self determination is upheld in this process to the extent that people can choose who they wish to act for them in the event of incapacity.[90] An assessment by a doctor is

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[86] *Op.cit.* ,60 p 63.

[87] Law Reform Commission, *Vulnerable Adults and the Law: (Capacity* LRC CP 37-2005.)

[88] Powers of Attorney Act 1996 Section 4(1), the definition of personal care includes, where the donor should live and with whom, whom the donor should see and not see, the training and rehabilitation the donor should get, the donor's diet and dress, the right to inspect the donor's papers and housing, social welfare and other benefits for donor.[88]

[89] Powers of Attorney Act 1997, section 4(1).

[90] Since the introduction of the legislation, 448 EPAs have been registered in contrast with the English system of 15,000 annually though these do not deal with personal decisions. (Approximate figures given by Ward of Court Office.) The figures for Ireland are low and it is likely that some of the reasons are, that the population at large is unaware of the existence of such a procedure, or do not understand that they maintain full control over their lives unless and until they become mentally incapacitated. There has never been a public awareness campaign.

required at the time of creating the power and the individual's capacity to do so must be affirmed by a solicitor.

There are various rights included in the 1996 Act, the right to object, for example, to the appointment of a particular attorney.[91] This issue arose in *In re the Powers of Attorney Act 1996 Hamilton and Williams,* involving an objection that the attorneys were unsuitable and the High Court held that the lack of a business skill was not a valid objection because "unsuitable" in the Act has no connection with the ability to manage property.[92] This lack of suitability would arise only if it impacted adversely on the administration of the estate of the donor. The attorney must act in the donor's best interests, taking account of wishes and must permit and encourage the donor to participate, applying the least restrictive alternative principle.[93] While there are prohibitions from being appointed as an attorney, these are quite narrowly drawn and do not prevent relatives of the donor from acting as solicitor, doctor and attorney respectively.[94]

There is no express provision regarding the degree of incapacity that is needed to establish a power of attorney. Nor is there any information on how a power might be revoked prior to registration. There is no obligation in the legislation to inform the donor that he is entitled to revoke the EPA.[95] The law must be predictable in its effects, so that patients will know the circumstances in which their rights may be removed and the grounds relied on, such as the protection of health.[96] There are difficulties with the categories of nominated persons who must be consulted and the lack of guidance for separated persons and cohabitees.[97] The right to self-

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[91] These grounds include: that the power is not valid, the power is no longer valid and subsisting, the donor is not mentally incapable, the attorney is unsuitable, that fraud or undue pressure was used to induce the donor to create the power

[92] [1999] 3 IR 310. In *Re W (Power of Attorney)* [2000] 1 All ER 175, an English case, the Court held that hostility towards the attorney on the part of other interested parties did not mean the attorney was unsuitable

[93] *Ibid,* section 6(7).

[94] Anyone connected with the owner of the nursing home where the donor resides.

[95] It is likely that this may breach the right to private life of the individual under Article 8 where the laws are not sufficiently clear.

[96] *Glass v. United Kingdom* (2004) 39 EHRR 15. Law Reform Commission, *The Law and the Elderly* (LRC CP 23–2003) p71.

[97] Enduring Power of Attorney Regulations, SI No.196, 1996 Reg 5.

determination could be enhanced further with more flexibility regarding who can be nominated by the donor.[98]

While the Office of the Wards of Court and the High Court have general supervisory powers in relation to EPAs, few questions are asked about the EPAs. There are concerns about the lack of supervision of attorneys. This calls into question the rights of vulnerable adults and the need for a higher standard of protection.[99] Improved supervision of the attorneys to eliminate the possibility for exploitation is a priority.[100] This includes the lack of independent monitoring of the acts of the attorney, along with lack of an independent medical assessor and legal advisor. Although some safeguards exist, these are not adequate to ensure that those appointed act in the best interests of the incapacitated person. Some of these issues are the subject of current law reform.[101]

Law reform

The protection of individuals in the determination of civil rights and obligations in Article 6 highlights the need for reform of Irish law in this area. This applies in particular to the lack of a reasonable relationship or proportionality in the level of interference or means used having regard to the aim of the protection of property and personal affairs under the ward of court system.[102] This is recognised by the Law Reform Commission (LRC) with the publication of two Consultation Papers that are concerned "with legal mechanisms and responses to the needs of vulnerable people."[103] These reforms propose to replace the wardship system with a comprehensive structure that will assess capacity, enhance and enable decision-making capacity and provide proxy decision-making where necessary. The LRC

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[98] *Ibid.*
[99] *Herczgefalvy v. Austria* (1992) 15 EHRR 437.
[100] Department of Health and Children, *Protecting our Future,* Dublin, 2002. Report of the Working Group on elder abuse Government Publications, Dublin. Enduring Power of Attorney Regulations SI No.196 (1996) para 5. Article 8 issues may be engaged in relation to private life and bodily integrity and the failure to ensure that the procedures accord with the law.
[101] *Op. cit.*, 87.
[102] *Ashingdane v. United Kingdom* (1984) 7 EHRR 528 para 57. See chapter 3.
[103] Law Reform Commission Consultation Paper, *The Law and the Elderly* (LRC CP 23–2003) and Law Reform Commission Consultation Paper, *Vulnerable Adults and the Law* (LRC CP 37-2005). The Reports endorsed the recommendations of the Working Group on Elder Abuse the "the response to elder abuse be placed in the wider context of health and social care services for older people." Government Publications, *Protecting our Future,* Dublin, 2002.

second report stresses that the law on capacity should reflect capacity, rather than lack of capacity, ensuring that it would be enabling rather than restrictive in nature thereby complying with constitutional and human rights standards.[104]

Law Reform Commission Proposals -General Principles

The principles proposed in the LRC Report to underpin reforms include respect for human and constitutional rights, a co-ordinated and integrated service and legislation which should be simple, usable and allow for flexibility to meet individual needs.[105] These rights include rights to equality and non-discrimination, to bodily integrity, to protection of the person, to liberty, family rights, privacy, property rights and the right not to be subjected to inhuman and degrading treatment.[106] The interests and welfare of the adult concerned should be the paramount consideration. Other principles that should be included in legislation on this area include the presumption of capacity, assistance to decision-makers and carers, the maximum preservation of capacity, flexibility in legal response, informal measures for one-off decisions and joint representation.[107] In this regard, Clive states,

> The legal framework must ensure that inappropriate consequences are not attached automatically to measures of protection. In particular, a measure of protection should not result in an automatic restriction of legal capacity unless that is necessary. [108]

Many of these principles are included in the English Mental Capacity Act 2005, including the presumption of capacity and the requirement that a lack of capacity cannot be established unless all practicable steps to help the person to make a decision have been taken without success.[109] The LRC recommends that a predominantly functional approach should be taken to the assessment of legal capacity. This would

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[104] *Op.cit.,* 87 p211.
[105] Law Reform Commission Consultation Paper, *The Law and the Elderly* (LRC CP 23–2003)
[106] *Ibid,* para 6.09.
[107] Law Society of England, the British Medical Association and Making Decisions Alliance *Joint Charter on Mental Capacity and Decision Making* 1998.
[108] Clive E., *Council of Europe Report of Specialists on Incapable and Other Vulnerable Adults* Scottish Law Commission 1997 para 3.34.
[109]Mental Capacity Act 2005, section 1 See also chapter 3 for discussion of self-determination and mental capacity.

involve issue specific decision-making, but it recognizes that where an adult's lack of capacity is profound and enduring, a new functional determination may be unnecessary in every situation in which a decision has to be made.[110] The proposed definition of lack of capacity is as follows,

> A person will lack capacity if they are unable to communicate their choice by any means where communication to a third party is required to implement a decision.[111]

In these circumstances, the principle of the least restrictive alternative or proportionality must be observed and the protective mechanisms should be the minimum in order to ensure the maximum preservation of the right to autonomy and self-determination and this should uphold the doctrine of proportionality.[112] It should ensure that those with legal capacity should have the right to make choices, even if these are risky or perhaps irrational. The wishes of the person should be taken into account in any decision about him and other interested parties, including relatives, should have a say consistent with the best interests of the person. In keeping with the requirements under Article 6(1), there should be a right to legal representation before an independent body and a right of appeal.

Recommendation (2004) 10 provides that member states should ensure that there are mechanisms to protect vulnerable persons who do not have the capacity to consent or who may not be able to resist infringements of their human rights.[113] It also states that the law should provide measures to protect, where appropriate, the economic interests of persons with mental disorder. The explanatory memorandum to the Recommendations states that any arrangements by another person regarding the vulnerable person's finances should be carefully regulated and be subject to review by monitoring bodies to ensure the interests and welfare of the person concerned remain the paramount consideration.[114] This point is particularly relevant to Irish

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[110] *Op.cit.*, 87.
[111] *Op.cit.*, 87 para 3.49.
[112] Council of Europe, Committee of Ministers, *Recommendation (2004) 10 on the protection of human rights and dignity of persons with mental disorder*, Article 7. Article 8 supports the principle of the least restrictive intervention.
[113] *Ibid.*
[114] Council of Europe Recommendation (2004) 10 *Explanatory memorandum* para 56 & 57.

arrangements, formal and informal, for managing the property of incapacitated individuals.

Law Reform Commission proposals for assessing capacity

While the concentration of the LRC first report was on the elderly, many aspects of the report are applicable to other vulnerable adults and decision-making.[115] The removal of civil rights in the same manner for all people in wardship is not proportionate to the aim of protecting the individual's right to protection of property. The LRC proposes that any interferences should involve the least restrictive alternative in keeping with human rights principles and, as a result, a decision on incapacity may not always be necessary. It would also accord with the requirement of proportionality in decision-making.

Law Reform Commission proposed structures

The LRC proposes a unified system for persons and property where more than one guardian could be appointed for different aspects of the person's life. There would be four levels in the substitute decision-making process in ascending order: the Personal Guardian, the Public Guardian, the Tribunal and the Court. A new independent Office of the Public Guardian as overall supervisor of the guardians and attorneys in the enduring power of attorney system is proposed. There would be a right of appeal to a tribunal against any decision by the Public Guardian.

The LRC proposes that the Personal Guardian should be entitled to take minor emergency health care decisions on behalf of the protected adult. The LRC considers that attorneys under the enduring power of attorney system should also be entitled to make these decisions if the specific authority is contained in the EPA. They believe there should be provision for the donor to establish the nature of such authority and its extent, unless it is excluded by the donor.[116] If the donor becomes a ward, this would not automatically invalidate the power, but the court could invalidate it. The LRC has

[115] The Law Reform Commission has published a follow-up report that includes all vulnerable adults. *Vulnerable Adults and the Law* (LRC CP 37-2005).
[116] *Op.cit.*, 87 at para 3.14, 15.

stated that the EPA would only be displaced by a guardianship order if this were absolutely necessary, as the scope of the attorney would be limited by the terms of the EPA and this limitation could be overcome by a court order if necessary.

The LRC suggests that a tribunal is the most appropriate system for making decisions regarding capacity and would provide greater flexibility in procedures, such as the strict rules of evidence and would also be less formal and intimidating.[117] The main functions of the tribunal would be to decide issues of general legal capacity, make Guardianship orders, appoint Personal Guardians, make Adult Care Orders and receive appeals from decisions of the Public Guardian. Applications to the tribunal for the various orders could be made by anyone in need of protection and by bodies like the Health Services Executive, the Public Guardian or the Mental Health Commission. There will be a range of decisions to be made on the vulnerable adult's behalf and as a once-off decision or on a continuous basis. The procedures will be as informal as possible, but in line with administrative law and rules of constitutional justice. This would involve being informed about the application and the right to object, to have an advocate to explain the issues as well as legal representation, to produce witnesses, to be notified of relevant hearings, to be given access to documents and to be provided with reasons for decisions.[118] A right of appeal to the Circuit Court is also an essential part of the system. The LRC recommends that certain major health care decisions, such as the removal of life support or organ donation, would only be made by the President of the High Court. These proposals seem to accord with the requirements of Article 6 and the right of access to an independent and impartial tribunal and to have a fair hearing with the attendant rights, including legal representation and a hearing within a reasonable time.

Conclusion

The criteria for entry to wardship are very broad and not legally defined in terms of current practice in psychiatry and do not specify requirements for a capacity assessment. This situation runs the risk of being disproportionate to the aim of protecting the person or property of the individual. The lack of a legal requirement

[117] *Ibid,* at para 1.47.
[118] *Ibid,* at para 6.52.

regarding a specialist medical assessment permits a degree of discretion. While there is a right of access to a court in the determination of the removal of civil rights for the purpose of wardship, as required by Article 6, many aspects are arbitrary and unclear. The right to legal representation is dependent on accepted practice, rather than having a sound basis in statute. This places the proposed or current ward at a disadvantage in seeking to object to wardship or challenge its continuity. The notification requirements are not clearly laid out and while, in practice, proposed wards may be given information, there is no provision requiring this in law. The time scale for objections is inadequate and creates a significant burden if the initiating report is not available. There should be a representative such as a proxy, who would receive such information on behalf of an incapacitated person and who would assist in making decisions during hearings or afterwards. The procedure is not regarded as speedy and this aspect has been subject to criticism within the care service.[119] These factors need to be addressed in terms of compliance with Article 6. The continuity of wardship for an individual should be accompanied by a substantive review based on his best interests. A review is also needed for wards receiving inpatient psychiatric care.

The wardship system is in need of significant reform to ensure the right to autonomy and self-determination of the incapacitated person is respected and to comply with the requirement of proportionality under Article 6. There are many difficulties, most importantly the total removal of the individual's decision-making capacity based on vague criteria rather than a capacity assessment. The language used is anachronistic and as a consequence of this stigmatising terminology and the total removal of legal personhood people may be deterred from using the procedure in appropriate cases. The system for the management of property and affairs is haphazard and random, involving loose procedures and limited safeguards. Unless large sums of money and property are involved, informal systems of hospital management of a patient's affairs apply and in general there is no code of practice or clear procedures for accountability. The new procedure may fill the gap, but compliance with Article 6 on this procedure is difficult to assess.

[119] *Op.cit.*, 82 p60.

The lack of a legal framework for individuals without capacity raises issues under Article 6 in the context also of the informality of current decision-making in Irish law in relation to property and affairs. In law reform on capacity in Scotland, England and Australia, emphasis is on appointing an attorney to manage property and affairs and make welfare decisions for the individual. In other international contexts, the Hague Convention on the International Protection of Adults concerns the protection of adults in "international situations" who cannot protect their own interests due to an impairment or insufficiency of their personal faculties. The measures that can be applied involving the Hague Convention include the following: the determination of incapacity and the institution of a protective regime, the placement of such adults under the protection of a judicial or administrative authority, the appointment of guardianship and a body or person to take charge of the adult's affairs for representation or assistance and placement of the adult in a protective environment. Generally, the judicial and administrative authorities of the Contracting State where the person has habitual residence will have a preference over others in exercising such protective jurisdiction.

The LRC proposes a comprehensive structure focusing on the needs of the individual in order to enhance autonomy and self-determination in relation to property and other welfare matters. The LRC recommends that proposed capacity legislation would involve the formulation of a code of practice for health care professionals. The code of practice would provide guidelines in relation to assessing a person's capacity to make a healthcare decision. It could also provide guidance on urgent situations where treatment can be carried out without the consent of the adult concerned. It is envisaged that the code of practice would specify which major healthcare decisions would require court approval where a patient lacks capacity to make the decision.[120] It is proposed to expand the enduring power of attorney to include some medical decisions by the attorney, thereby further enhancing the right to self-determination. The LRC proposals will contribute to a comprehensive human rights based approach to the determination of the civil rights of incapacitated adults. While these proposals are at an early stage they would appear to meet the standard required under Article 6 by providing for fair procedures in access to court, representation, rights of appeal and

[120] *Ibid.* See chapter 3 for full discussion of medical decision-making.

by ensuring that interferences with an individual's civil rights will be proportionate and based on actual ability.

Chapter 7

ARTICLE 2 AND THE RIGHT TO LIFE UNDER IRISH LAW

Introduction

This chapter considers the right to life and the obligations on the state to safeguard this right under Article 2 and examines the enforcement of these rights in Irish law in relation to people with mental disorder. It has long been accepted that individuals in detention are in a vulnerable position, thereby creating a greater onus on the state to protect the lives of such people. This is particularly important in relation to death in custody because of the knowledge both of the vulnerability of such individuals and the higher suicide risk associated with them. These obligations on the state to prevent the arbitrary deprivation of life will be examined with regard to the action of state agents, non-state agents, individuals taking their own lives and the risk to the public from mental disorder. The corresponding duty on the state to investigate such deaths and the rights of families is also examined.

Article 2 provides,

> 1. Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.
> 2. Deprivation of life shall not be regarded as inflicted in contravention of this Article when it results from the use of force which is no more than absolutely necessary:
> (a) in defence of any person from unlawful violence;
> (b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained
> (c) in action lawfully taken for the purpose of quelling a riot or insurrection.

The right to life is regarded as the most fundamental right of all and cannot be derogated from at any time and, as such, its provisions must be strictly construed.[1] The state is required to refrain from the intentional and unlawful taking of life and to take appropriate steps to safeguard the lives of those within its jurisdiction.[2] Article 2

[1] *McCann v. United Kingdom* 31 EHRR 97 para 147.
[2] *Edwards v. United Kingdom* (2002) 35 EHRR 19 para 54.

does not confer a right to die or "create a right to self determination" in choosing to die.[3] It does not give an unconditional protection for life and it is not concerned with the quality of life. A whole range of complaints have been considered under Article 2, including risks from a public health programme, as well as criminal actions resulting in the death of a detainee.[4] Article 2 does not require ruling out all possible medical risks to individuals where the overriding good of the general community is at stake, such as a vaccine programme which contains recognised minimal risks.[5] However, the failure to protect against known risks from a violent in-mate may be sufficient to engage Article 2.[6] The purpose of the Article is to ensure that the safeguards provided therein are practical and effective.[7]

Positive obligations

Both positive and negative obligations arise in the requirement to protect life and not to take life except in exceptional circumstances. This means that states must provide in law for the protection of human life and in general the taking of life must be illegal. Article 1, Protocol 6 provides for the abolition of the death penalty and a prohibition on its reintroduction, but permits states to make provision in its law for the death penalty in war or threat of war situations. This creates an additional obligation on the state to refrain from extraditing a person to a state where there is a real risk that the death penalty will be imposed.[8] It is necessary for the sending state to get agreement that the death penalty will not be used before extradition goes ahead. The Article, therefore, has an extraterritorial application to protect those liable to deportation from serious risk to life apart from the death penalty. Most of these cases are dealt with under Article 3, but it is probable that Article 2 extends to cases where the loss of life is likely to take place outside the state's territory.[9]

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[3] *Pretty v. United Kingdom* (2002) 35 EHRR 1, para 39.
[4] *Association X v. United Kingdom* 14 D & R 31, *Edwards v. United Kingdom* (2002) 35 EHRR 19.
[5] *Association X v. United Kingdom* 14 D & R 31.
[6] *Edwards v. United Kingdom* (2002) 35 EHRR 19.
[7] *McCann v. United Kingdom* 31 EHRR 97 paras 146-147.
[8] *Cyprus v. Turkey* (1976) 4 EHRR 482.
[9] Ovey & White, *Jacobs and White European Convention on Human Rights,* (3rd ed.), OUP, Oxford, 2002, p47.

Positive obligations arise in relation to the protection against unlawful killing by agents of the state[10] and by non-state agents, such as other patients or prison inmates.[11] The obligation also requires protection against suicide, in circumstances where the risk is known to the state.[12] The obligation also extends to the protection of the public against a known risk from a mentally disordered person.[13] These obligations increase in relation to people with mental disorder in detention. There is a duty on the state to carry out an investigation following loss of life in such circumstances, to establish the facts, assign responsibility and accountability for the death.

The deportation of a severely ill prisoner was raised in *D v. United Kingdom,* and was opposed on the basis that he would not be able to access medical treatment and therefore his life expectancy would be shortened.[14] He alleged his removal to St Kitts would violate Articles 2, 3 and 8, and deny him an effective remedy under Article 13. He alleged a violation of Article 2 on the basis that there would be a direct causal link between his expulsion and his accelerated death such as to give rise to a violation of the right to life. The Court held that the threat to his life stemmed not from factors for which the government could be held responsible, but from his own fatal illness in conjunction with the lack of medical treatment in St Kitts. The complaints raised under Article 2 were not divisible from the complaints under Article 3, regarding the consequences of the decision for his life, health and welfare. Following a finding by the Court of a breach of Article 3, it was not thought necessary to examine his complaint under Article 2.

Action by state agents

Article 2 places a positive duty on the state to protect life against the unlawful use of force by agents of the state, which is no more that "absolutely necessary."[15] The use of the terms "absolutely necessary" means that a stricter and more compelling test of

[10] *McCann v. United Kingdom* 31 EHRR 97.
[11] *Edwards v. United Kingdom* (2002) 35 EHRR 19.
[12] *Keenan v. United Kingdom* (2001) 33 EHRR 38 para 92.
[13] *Osman v. United Kingdom* (2000) 29 EHRR 245 para 56.
[14] (1997) 24 EHRR 423.
[15] *McCann v. United Kingdom* 31 EHRR 97. See p 257 *et seq* for discussion of positive duty to investigate suspicious deaths.

necessity must be used when the right to life is engaged.[16] The Court in *McCann v. United Kingdom,* said that the use of force must be strictly proportionate to the achievements of the aims set out in Article 2.[17]

Harris believes that Article 2 could require the state to take positive steps to make adequate provision for medical care or for food and shelter or a healthy working environment.[18] If this were established such a duty could have significant benefits for community care for mentally disordered people in recognition of the associated benefits to society. The public vaccination scheme aimed at the health of the total population was held to trump any negligence action from the resultant few deaths.[19] In this case, the Court held that where a small number of fatalities occur in the context of a vaccination scheme with the sole purpose of protecting the health of society by eliminating infectious diseases, this cannot be said to be an intentional deprivation of life within the meaning of Article 2(1). Nor could it be said that the state has failed to take adequate and appropriate steps to protect life. This case was declared inadmissible on the grounds that appropriate steps had been taken with a view to the safe administration of the scheme. The word "intentional" should be given its ordinary meaning, i.e. where the purpose of the prohibited action is to cause death.[20]

The duty of medical staff in emergencies arose in *Glass v. United Kingdom* and the Court stated that in a situation where there are adequate provisions for high professional standards and for the protection of the lives of patients, then,

> errors of professional judgment (even if established) on the part of a health professional in the treatment of a particular patient are not of themselves sufficient to call that State to account from the standpoint of its positive obligations under Article 2 of the Convention to protect life ...[21]

The applicant in *X v. Ireland,* complained that the refusal to grant a medical card providing for free treatment for her disabled child, along with additional welfare

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[16] *Ibid,* para 149.
[17] *Ibid,* para 214.
[18] Harris, O'Boyle & Warbrick, *Law of the European Convention on Human Rights,* Butterworths, London, 1995, p40.
[19] *Association X v. United Kingdom* (1978) 14 D & R 31.
[20] *Re A (Conjoined Twins)(Surgical Separation)* [2004] 4 All ER 961.
[21] (2004) 39 EHRR 15.

benefits, breached her child's right to life under Article 2.[22] The Commission left open the question of whether the negative prohibition on the taking of life could, in certain circumstances, lead to positive action to provide health care. The complaint could not be substantiated as the child had received medical care, so her life was not actually endangered. A related issue arose in *Scialacqua v. Italy,* where the Commission stated that,

> even assuming that Article 2 can be interpreted as imposing on States the obligation to cover costs of certain medical treatments or medicines that are essential in order to save lives, ... this provision cannot be interpreted as requiring states to provide for financial cover for medicines that are not officially recognised medicines.[23]

The requirement for hospitals to have regulations for the protection of their patients' lives is an aspect of state obligations under Article 2. This includes an obligation to establish an effective judicial system for ascertaining the cause of a death which occurs in hospital and any liability on the part of the medical practitioners concerned.[24]

Duty of the state to protect the public from risk of unlawful killing by a mentally disordered person

The nature of the state's positive obligations under Article 2(1) following the death of a member of the public was outlined by the Court in *Osman v. United Kingdom.*[25] The applicant complained that the police had failed to protect the lives of her husband and son as required by Article 2. The Court stated that there was an obligation on the State under Article 2 that extended beyond its primary duty to secure the right to life and to refrain from killing intentionally and unlawfully. That obligation also included taking appropriate steps to safeguard the lives of those within its jurisdiction. This decision established a three part obligation on the state to protect the person's right to life by: (a) creating effective criminal law measures, (b) providing policing and criminal justice systems to enforce those measures and (c) taking reasonable operational

[22] Application no. 6839/74 7 DR 78
[23] (1998) EHRR CD 164.
[24] *Erikson v. Italy* 29 (2000) EHRR CD 152 p7.
[25] (2000) 29 EHRR 245.

measures where there is a "real and immediate risk to the life of a particular individual from the criminal acts of another private person."[26] In order to establish a breach of this Article, it must be established,

> that the authorities knew or ought to have known at the time of the existence of a real and immediate risk to the life of an identified individual or individuals from criminal acts of a third party and that they failed to take measures within the scope of their powers which, judged reasonably, [they] might have been expected to take to avoid that risk.[27]

This obligation is required to be interpreted in a way which does not impose "an impossible or disproportionate burden" on the resources and choices of the authorities.[28] The impact of the *Osman* decision is that there are positive obligations on professionals with responsibilities under mental health legislation "to take appropriate preventative measures in respect of patients whom they know (or ought to have known) to be so dangerous as to be a threat to the lives of others."[29]

Duties to protect mentally ill detainees from suicide

There is also a duty to take reasonable care to protect detained patients from suicide and where there is "a real and immediate threat of suicide."[30] This duty arises from the complete control which police and prison authorities have over prisoners along with the known special danger associated with suicide among this population. In the prevention of suicide by the mentally disordered in detention and seclusion, Article 3, rather than Article 2, is engaged. The reason for this is that the killing is carried out by the individual, not the state or others. Under English law, there is a common law duty to take reasonable steps to prevent the suicide of a detainee.[31] In *Knight v. Home Office* the Court held that the standard of care provided for a mentally prisoner in a prison hospital was not required to be as high as the standard provided in a psychiatric

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[26] *Ibid,* para 115.
[27] *Ibid,* para 116.
[28] *Keenan v. United Kingdom* (2001) 33 EHRR 38 para 90.
[29] Jones R., *Mental Health Act Manual* (9th ed.), Thomson, London, 2004, p773.
[30] *Keenan v. United Kingdom* (2001) 33 EHRR 38 para 92.
[31] *Knight v. Home Office* [1990] 3 All ER 237.

hospital outside prison.[32] The judge did not elaborate on what was the appropriate standard.

The issue of self-determination and capacity are aspects that must be borne in mind when any treatment is being imposed even with the intention of preventing suicide. There are conflicts and dilemmas in overriding the wishes of the competent adult but in principle the law has engaged in a balancing exercise and resolve the balance where the conflict is between self determination and the right to life by overriding the right to self-determination in favour of life.[33] More recently the case law has upheld the absolute right of the competent adult to refuse any medical treatment. However, societal interests are often weighted in the balance against absolute rights to self determination.[34]

The applicant in *Keenan v. United Kingdom,* alleged breaches of Articles 2 from the failure to protect her son's life following his death in prison from suicide and that she had no effective remedy for her complaints.[35] He had a history of severe mental illness and recurrent imprisonment requiring special care and was often in the health care centre of the prison for observation. Following a proposal to move him to the ordinary prison area, he deteriorated, became aggressive and was placed in an unfurnished cell in the health centre on 15 minute watch. A doctor with limited experience in psychiatry certified him as fit for segregation within the prison punishment block and he was locked up for 23 hours out of 24. He was later transferred to a cell in the hospital and put on observation, but sent back to the segregation unit again and received extra time due to earlier assaults on prison officers. He committed suicide during this time.

The advice given to the family was that they would not succeed in an action in negligence because he was already mentally ill and there was no indication that he suffered any worsening in his condition or that he had developed any new condition due to his segregation and treatment in prison. His mother's legal aid application was

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[32] *Ibid,* p 243.
[33] *Airedale NHS Trust v Bland* [1993] AII ER 821.
[34] Kennedy & Grubb, Medical Law 3rd ed., Dublin, 2000, p 917.
[35](2001) 33 EHRR 38.

discharged on the basis of no reasonable prospect of success in her legal action. The forensic psychiatrist for the family confirmed that paranoid schizophrenia was not compatible with segregation and he should have been in the hospital wing. In the opinion of the forensic psychiatrist, the notes were inadequate in that there was no information as to why the decision to leave him in the health centre was reversed, even though he had been suicidal. There were good reasons for regular monitoring of his mental state and this was not done. The second prison doctor did not apply the correct standard of care, did not have psychiatric qualifications and should not have taken a different course than that recommended by the attending psychiatrist. The remedies available to prisoners were discussed and included: complaints procedures; the Prison Ombudsman; judicial review; and an action for negligence, assault and misfeasance in public office.

The Court referred to the primary duty on the state to secure the right to life which also extends, in appropriate circumstances, to a positive duty on the authorities to take preventative operational measure to protect an individual whose life is at risk. The Court stated,

> ... not every claimed risk to life can entail for the authorities a Convention requirement to take operational measures to prevent that risk from materialising. For a positive obligation to arise, it must be established that the authorities knew or ought to have known at the time of the existence of a real and immediate risk to the life of an identified individual from the criminal acts of a third party and that they failed to take measures within the scope of their powers which judged reasonably might have been expected to avoid that risk.[36]

The authorities are under an obligation to protect the health of persons deprived of liberty.[37] In the context of prisoners, the Court emphasised that persons in custody are in a vulnerable position and that the authorities are under a duty to protect them. The Court was struck by the lack of medical notes on Keenan, who was an identifiable suicide risk and undergoing the additional stresses that could be foreseen from the application of segregation and disciplinary punishment. The Court said that it was incumbent on the state to account for any injuries suffered in custody and that the

[36] *Keenan v. United Kingdom* (2001) 33 EHRR 38 para 90.
[37] *Hurtado v. Switzerland* Comm. Report 8 July 1993 Series A No. 280 para 87.

obligation is particularly stringent where that individual dies.[38] The prison authorities are required to discharge their duties in a manner compatible with the rights and freedoms of the individual concerned. The Court said that there are general measures and precautions to diminish the opportunities for self-harm without infringing on personal autonomy. Whether any more stringent measures are necessary in respect of a prisoner and whether it is reasonable to apply them will depend on the circumstances of the case. The Court held that the issues raised regarding the standard of care with which *Keenan* was treated in the days before his death fall to be examined under Article 3, not Article 2.[39] These issues apply *mutatis mutandis* to people detained in psychiatric care who are generally more vulnerable than prisoners.

Duty to protect a detainee from being killed by non-state agents

The third issue involving detainees is the protection against the homicidal assault by private individuals. The applicants in *Edwards v. United Kingdom,* alleged a breach of Article 2 arising from the failure of the authorities to protect the life of their son, who had been killed by another detainee while in prison on remand.[40] They also complained that the investigation into their son's death was not adequate or effective as required by the procedural obligations under Article 2. He had a serious mental illness and was arrested by police for inappropriate behaviour towards other people. Following a mental health assessment by an approved social worker and phone calls with a psychiatrist, it was decided he was fit to be detained in the police station. No "exceptional risk" form was filled in, but note was taken of the risk to females if he was not treated by the mental health team. He demonstrated disturbed behaviour in court, but there was no consideration even of a hospital assessment and no psychiatric reports were ordered. His parents were concerned about his mental state. Information about his mental state was given to some, but not passed on to essential members of the prison staff, such as the health screening officer in prison.

Another mentally disturbed prisoner, Linford, was placed in the same cell and killed the applicant's son. The applicants were awarded a small sum as compensation for

[38] *Keenan v. United Kingdom* (2001) 33 EHRR 38 para 91.
[39] *Ibid,* para 98.
[40] *Edwards v. United Kingdom* (2002) 35 EHRR 19.

funeral expenses. A private non-statutory inquiry was set up to examine the events around the death, the practice and proceedings, care and treatment of Edwards. The conclusion of the inquiry was that both Linford and Edwards should not have been in prison or sharing a cell and there was a collapse of the protective mechanisms that ought to have operated to protect this vulnerable prisoner. The shortcomings identified by the inquiry included poor record keeping, inadequate communication, limited agency cooperation and missed opportunities to protect Edwards. No doctor was asked to see him, he should have been admitted to the health care centre, and he should have been remanded to hospital for assessment. There was a failure to notify prison staff that he was mentally ill. The prison health care worker was inadequately trained to recognise his mental state. The mental state of the second prisoner, Linford, was ignored, despite knowledge of risk.

Following the inquiry, the family was advised that no civil remedy was available to them. The family alleged there was a breach in the positive obligations imposed on the authorities to protect the life of their son and while the scope might vary, "it was particularly stringent where an individual died in custody."[41] The essential question was whether the prison authorities knew or ought to have known of the extreme danger in placing Linford in same cell as Edwards. The Court was satisfied that information was available to confirm Linford's history of violence and should have been brought to the attention of the prison authorities. The Court concluded that the failure of the agencies, the medical staff, the police, the prosecution and the court to pass on information to the prison staff and the inadequate screening on arrival in prison constituted a breach of Article 2.

Duty to carry out an investigation

The positive duty to protect life includes the effective enforcement of the law. This involves the proper investigation of suspicious deaths, including death in custody, followed by prosecution where appropriate. There is a requirement to have some form of effective official investigation when individuals have been killed as a result of the

[41] *Ibid,* para 56.

use of force.[42] The purpose of the investigation is to secure the effective implementation of the domestic laws which protect the right to life and in those cases involving state agents or bodies to ensure accountability for deaths in their responsibility. The form of the investigation may vary with the circumstances. The authorities must act of their own motion once the matter has come to their attention and cannot leave it to the initiative of next of kin to lodge a complaint.[43]

The investigation must also be effective in the sense that it is capable of leading to a determination of whether the force used in such cases was or was not justified in the circumstances and to the identification and punishment of those responsible.[44] This is not an obligation of result, but of means. The authorities must have taken the reasonable steps available to them to secure the evidence concerning the incident, including *inter alia* eye witness testimony, forensic evidence and, where appropriate, a visit to the scene of the crime and a ballistics examination as well as an autopsy which provides a complete and accurate record of injury and an objective analysis of clinical findings, including the cause of death. The Court has said that the investigation must be independent, effective and reasonably prompt. It must have a sufficient element of public scrutiny and the next of kin must be involved to an appropriate extent.[45]

> The essential purpose of such investigation is to secure the effective implementation of the domestic laws which protect the right to life and, in those cases involving State agents or bodies, to ensure accountability for deaths occurring under their responsibility. What form of investigation will achieve those purposes will vary in different circumstances.[46]

Any deficiency in the investigation, which undermines its ability to establish the cause of death or the person responsible, will risk falling foul of this standard.[47] The lack of power to compel witnesses, along with the private character of the

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[42] *McCann & Others v. United Kingdom* (1996) 21 EHRR 97.
[43] *Ibid,* para 69.
[44] *Ayhan & Ayhan v. Turkey* Application no. 41964/98 26th June 2006 para 88. See page 268 of this chapter for reference to inadequate investigation of murder of two women, former patients.
[45] *Jordan v. United Kingdom* Application no. 23954/94 May 24th 2001 paras 106-109.
[46] *Edwards v. United Kingdom* (2002) 35 EHRR 19 para 105.
[47] *Jordan v. United Kingdom* May 24th 2001 para 120.

investigation, was held to have excluded next of kin in *Edwards* and failed the test of an effective investigation.[48]

The Court in *Edwards* held that a procedural obligation arose to investigate the circumstances of the death. He was a prisoner and the State was under an obligation to initiate and carry out an investigation which fulfilled the requirements set out. Civil proceedings would not satisfy the state's obligation in this regard. No inquest had been held and criminal proceedings did not involve a trial at which witnesses were examined. The Court regarded the lack of compulsion of witnesses, who were either eye witnesses or had material evidence related to the circumstances, as a diminishing factor in the effectiveness as an investigating mechanism. The parents were not represented nor able to question witnesses and had to wait for the report to see the evidence. They were not regarded as involved in the procedure to the extent necessary to safeguard their interests. The lack of power to compel witnesses failed to comply with the requirements of Article 2 and, to that extent, there was a violation of this Article.[49]

Where the incident lies within the exclusive knowledge of the authorities, as with people in custody, strong presumptions of fact will arise in respect of injuries and death. The burden of proof rests with the authorities to provide a satisfactory and convincing explanation.[50] The Court asserted that the standard of proof in such cases is "beyond reasonable doubt" and, where the events are within the exclusive knowledge of the authorities, as in the case of people in custody, strong presumptions of fact will arise in respect of injuries and death occurring during detention. There was no evidence that his injuries had been examined carefully by the medical profession at any time while in custody. No effort had been made to investigate the complaints for some years, despite efforts by the applicant. The Court concluded that the injuries Edwards sustained were inflicted while in custody and the responsibility of the state was engaged. There had been a violation of the State's obligations under Article 2 with regard to conducting an effective investigation.

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[48] *Edwards v. United Kingdom* (2002) 35 EHRR 19 para 87.
[49] Violation of Article 13 and the right to an effective remedy.
[50] *Op.cit.*, 28 p774.

Irish law and Article 2

Constitutional law

The right to life is protected as a personal right in Article 40.3.1 of the Constitution and Article 40.3.3 protects the right to life of the unborn. The protection of life in Article 2 of the Convention is complementary to the protection of life under the Constitution. The right to life in the Constitution has been raised mainly in relation to abortion,[51] but also in relation to a variety of other situations, such as the protection of the lives of witnesses in a trial.[52] None have involved psychiatric detention. The Constitution was amended in 2001 to enter a new provision, Article 15.5.2, which prohibits the imposition of the death penalty under any circumstances. The consequent amendment to Article 28.3.3 permits no derogation, even in war or national emergencies.[53] On the basis that the last execution took place in 1954, these amendments were largely symbolic. The death penalty was finally abolished by the Criminal Justice Act 1990. While Article 15.5.2 reflects Article 1 of the Sixth Protocol, it goes further by not permitting any exception in either war or emergency situations.

Legislation

The Mental Treatment Act 1945 obliges that a report on the death of any patient in a mental institution be given to the coroner within twelve hours of the death.[54] There is no obligation on the coroner to hold an inquest if he is satisfied in relation to the circumstances of the death, provided the death is due to natural causes. Where he decides to hold an inquest, it should be held before a jury.[55] There is also an obligation on the hospital to inform the Inspector of Mental Hospitals about the death.[56] The coroner cannot investigate any matter which might lead to a finding of

[51] *McGee v. Attorney* [1974] IR 284 at 312.
[52] *Burke v. Central Independent Television plc* [1994] 2 IR 61, involving the upholding of a claim for privilege in order to the protect the identity and lives of informants who had contributed vital information in a libel trial.
[53] Hogan & Whyte, *JM Kelly: The Irish Constitution,* Butterworths, Dublin, 2003, para 4.2.115.
[54] Mental Treatment Act 1945, section 268.
[55] Coroners Act 1962.
[56] Mental Treatment Act 1945, section 272(e).

culpability.[57] Coroners were restricted in relation to findings of suicide until the enactment of the Criminal Law (Suicide) Act 1993 when the act of suicide was decriminalised, permitting coroners to return such a verdict.

There is no express provision in the Coroner's Act 1962 requiring the family of the deceased to be in attendance at the inquest. The High Court, in *State(McKeown) v. Scully,* held, *inter alia,* that the rules of natural and constitutional justice were departed from in failing to give the widow and next-of-kin an opportunity to be heard at the inquest.[58] The General Prisons (Ireland) Act 1877 provides that the coroner holding an inquest "on the body of a prisoner" must allow sufficient time for the attendance of the "nearest relative" at the inquest.[59] Notice of the time and place must be given to the spouse or family or personal representative. The coroner may write to the family to inform them of the inquest and should be prepared to adjourn an inquest if he believes they have not been properly notified. These provisions are in keeping with the requirements under Article 2 in providing that the family do not have to initiate the involvement.[60] The family should have an opportunity to cross-examine witnesses, address the jury and give any evidence that may be of assistance to the inquest.[61]

Investigation

The Barr Inquiry was set up by the government to examine the circumstances leading to the death of John Carthy who was shot dead by a Garda Emergency Response Unit (ERU) in March 2000. He had a history of psychiatric illness and was living in his own home at the time. The Gardai were aware he had a gun and the situation they were addressing escalated leading to his death. The ongoing inquiry is wide-ranging and involves his family.[62] The question as to whether the force used was "absolutely necessary" was not satisfied by the evidence at the Coroner's Inquest due to a conflict between the evidence of the State Pathologist and members of the ERU. At the inquest, the test applied was whether the killings were "reasonably justified," which is

[57] *Greene v. McLoughlin* Unreported Supreme Court, 26th January 1995.
[58] [1984] ILRM 133.
[59] General Prisons (Ireland) Act 1877, section 56.
[60] *Edwards v. United Kingdom* (2002) 35 EHRR 5 para 69.
[61] *State(McKeown) v. Scully* [1984] ILRM 133.
[62] The Inquiry was expected to report by July 2005.

a lower and less stringent standard than the "absolutely necessary" standard in Article 2.[63] There is considerable doubt as to whether the actions of the Gardai could have met the Article 2 test of absolutely necessary or that the actions were proportionate to the actual threat involved. It remains with the final report to ascertain whether the Article 2 test is satisfied in the case.[64]

Two independent non-statutory inquiries have published reports following the deaths of children who were earlier denied hospital care.[65] These cases would not normally engage Article 2 unless a finding of criminal negligence were made or the families were denied a proper investigation.

Death in detention

During 2003, there were 249 deaths in psychiatric care, including 13 by suicide.[66] This figure includes 19 sudden, or unexplained, deaths of inpatients in hospital or while on leave. The Mental Treatment Act 1945 requires that each of these deaths must be reported to the Minister for Health and Children.[67] All cases are reported to the coroner and all were the subject of post-mortems, but not all would have involved inquests. The report of the Inspector of Mental Hospitals has raised the issue of hospital deaths and urged caution in relation to drug prescribing, frequent review of medication and its side-effects and the avoidance of polypharmacy to avoid deaths of patients.[68] The Inspector's report emphasised the importance of thorough medical examination of all patients with physical health problems before prescribing anti-psychotic or anti-depressant medication. The issue of the protection of patients from the fatal side-effects of prescribed medication may engage Article 2 where their physical vulnerability is a known factor. The 2001 Act does not have specific obligations, like the 1945 Act, to report deaths to the Department of Health and

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[63] Irish Council for Civil Liberties, *Submission to Joint Oireachtas Committee on Justice, Equality, Defence and Womens' Rights on the Garda Investigation of the Shooting of Mr. John Carthy at Abbeylara on 20th April, 2000* 30th November, 2000.
[64] As of February 2006 this report has not been published.
[65] Department of Health and Children, *Report into the death of Bronagh Livingstone,*2003. *Report into the death of Roisin Ruddle* 2004.
[66] Health Research Board Report, *Activities of Irish Psychiatric Services,* Dublin, 2003.
[67] Mental Treatment Act 1945, section 272.
[68] Department of Health and Children, *Report of the Inspector of Mental Hospitals for year ending 2001*, Government Publications, Dublin, 2002, p12.

Children or to the Mental Health Commission. This deficit will have to be remedied in the review of the 2001 Act or included in the code of practice to be prepared by the Mental Health Commission.

The Commission has said they will investigate the circumstances surrounding the choking to death of a patient from an untreated infection to her throat following the ingestion of part of a coat hanger.[69] The Inquest brought in a verdict of death from misadventure, but the Commission want more detail regarding the action taken at the time.

Two women, former psychiatric patients, living in sheltered housing adjacent to a psychiatric hospital were murdered in 1997.[70] The State has failed to find anyone responsible, following a botched attempt to prosecute an innocent homeless man. Following increased media attention during 2005, the Minister for Justice decided that a Senior Counsel would chair an Inquiry into the facts surrounding the Garda investigation. There is clearly a positive State duty to investigate these deaths and an inquiry into Garda activity does not properly investigate or assign responsibility for their deaths. The Court has pointed out that the obligation to investigate is not confined to cases where the suspects are agents of the state. Accordingly, even if the authorities are not involved in the killing that does not exclude the procedural obligation under Article 2 to carry out an effective investigation into the circumstances surrounding such deaths.[71]

In the reported cases from prisons during the 1999/2000 period there were 16 deaths in custody, including nine suicides by hanging, one by overdose and five from natural causes. One prisoner was stabbed to death by another who was known to have a violent disposition and who received life imprisonment as a result.[72] A new set of Prison Healthcare Standards were introduced in 2004 and provide a comprehensive strategy for suicide and self-injury in prison consistent with national guidelines.[73] On

[69] Irish Times Report, 7th February 2005.
[70] Irish Times Report, 23rd June 2005.
[71] *Tanrıkulu v. Turkey*, Application no. 23763/94, para 103. See page 262 *et seq.* for requirements in such investigations.
[72] Department of Justice, *Annual Report of Prison Services,* Government Publications, Dublin, 2003.
[73] Department of Justice, *Prison Health Care Standards,* Government Publications, Dublin, 2004, para 3.3.

the death of a prisoner, Rule 140 of the Rules for the Government of Prisons, 1947 provides that the Governor will immediately notify the coroner, the Minister for Justice and nearest relative where possible. The word "prison" is interpreted widely and includes any place where a person is in legal custody. There is a mandatory requirement to have an inquest into the death of every prisoner.[74]

There is some evidence that not all such deaths are actually reported.[75] The death of a fourteen year old boy, Brian Rossiter, in September 2002, who was allegedly assaulted while in Garda custody and died in hospital some days later, is to be the subject of an inquiry ordered by the Minister for Justice following a campaign to have his death investigated. Witnesses confirm that an assault occurred in Garda custody. Even though the case does not concern a person with a mental disorder, it concerns a child who is treated similarly to a vulnerable adult under the Convention.[76] The Court in *Edwards* emphasised that persons in custody are in a vulnerable position and the authorities are under a duty to protect them, a duty that is even greater when children are involved.[77] The obligation requires the State to account for any injuries suffered and this involves an even greater obligation when the person dies. The Rossiter case raises issues that would seem to engage Article 2.

Conclusion

The positive obligations on the state under Article 2 to take appropriate steps to protect life from the actions of the state and others and to carry out proper investigations indicate that that there is evidence of compliance in some aspects, such as family involvement in the inquest, and uncertainty in relation to others, like failure to have robust investigation of deaths in psychiatric care or Garda custody. The identification of these inadequacies are arising almost by default, as a result of a lack of a comprehensive approach to the management, investigation and publication of information of deaths in psychiatric care or in Garda custody. No information is available from the Inspector of Mental Hospitals on these deaths, apart from a few

[74] Prisons (Ireland) Act 1877, section 56.
[75] Browne, "Inaccurate Garda records on deaths in custody," The Village Magazine, 8th -14th July 2005 p5.
[76] *Z v. United Kingdom* (2002) 34 EHRR 3.
[77] *Edwards v. United Kingdom* (2002) 35 EHRR 19 para 54.

comments on the need to tighten up the approach to medication. Questions arise regarding the responsibility for deaths resulting from the practice of polypharmacy and inadequate examination prior to prescribing medication, as highlighted in some reports. There is a minimalist approach to information concerning these deaths and they receive little attention in what are otherwise detailed reports.

This lack of information applies also to homicidal killings of members of the public by people with mental disorder about which there are no statistics. Such deaths result in criminal prosecution and, if found guilty but insane, the mentally disordered person is committed to the Central Mental Hospital. Recent developments in Ireland, such as the Carthy Inquiry and the concern with rates of suicide, have engendered a greater focus on avoidable deaths involving mentally disordered people. The Carthy Inquiry provided the family of the dead man with a forum to be heard, whereas in other deaths in psychiatric care, there is no guarantee of involvement unless an inquest is held. The State has not adequately or effectively investigated murders to find the person responsible. The approach to cases lying outside the boundary of the criminal law or the coroner's remit is unsatisfactory with regard to independent, effective investigative obligations or to have a sufficient element of public scrutiny.[78] These deficiencies may be serious enough to engage Article 2.

[78] *Jordan v. United Kingdom* May 4th 2001 para 107.

Chapter 8

ARTICLE 12 AND THE RIGHT TO MARRY AND FOUND A FAMILY UNDER IRISH LAW

Introduction

This chapter considers the right to marry and found a family under Article 12 and examines Irish law against the requirements of Article 12 in relation to people with mental disorder. Two key issues are considered in this chapter. First is the legal basis of the right to marry and the scope of the restrictions imposed on people who have a label of mental disorder or mental disability. The second is the right to found a family, which is a broader question and involves consideration of limitations that may be imposed on mentally disordered people exercising reproductive rights, that embraces a right to a sexual relationship and a right not to be sterilised. The tension between benign paternalism and the right to autonomy is at the core of law reform in this difficult area that also falls within Article 8 and the right to respect for private and family life.[1] The Law Reform Commission has tentative proposals for changes that will impact on such rights in Ireland and these will be considered.[2]

Article 12 provides:

> Men and women of marriageable age have the right to marry and to found a family, according to the national laws governing the exercise of this right.

This Article is closely connected with Article 8 and the right to respect for private and family life. The Court regards the two parts of Article 12 as being closely related.[3] In *Goodwin v. United Kingdom,* the Court stated that Article 12 "secures the fundamental right of a man and woman to marry and to found a family."[4] The scope of the obligation is not clear, but the rights guaranteed in national law must recognise the right to marry and found a family in principle. The right to marry is confined to

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[1] See chapter 3 for discussion of private and family life.
[2] Law Reform Commission, *Consultation Paper Vulnerable Adults and the Law: Capacity,* (LRC CP 37-2005).
[3] *Rees v. United Kingdom* (1986) 19 EHRR 56, *Cossey v. United Kingdom* (1990) 13 EHRR 622.
[4] (2002) 35 EHRR 18 para 98.

legally formalised heterosexual relationships, but there does not have to be the prospect of cohabitation.[5] The role of national laws is to govern the exercise of the right to marry. Any restrictions imposed by national law must be for a legitimate purpose, be proportionate to the aim of the restriction and not impair the very essence of the right.[6] The precise detail of such rights, such as the age of marriage, will vary from state to state. Harris refers to the "limited" approach of the Court to this Article by comparison with their "imaginative" interpretation of Article 8.[7] The jurisprudence of the Commission and the Court has given a narrow margin of appreciation to national authorities in matters involving intimate aspects of private life, such as rights, to a sexual relationship, to marry and found a family.[8]

The right to marry

The issue of the suspension of the right to marry arose in *F v. Switzerland* in accordance with the Swiss Civil Code because the applicant was held to be primarily at fault with regard to the dissolution of an earlier marriage. The Court held that the temporary suspension of the right to marry was a disproportionate means to achieving the aim of stability of marriage.[9] Applying the "very essence of the right" test, the Court stated that,

> The exercise of the right to marry gives rise to personal, social, and legal consequences. It is subject to the national laws of the Contracting States but the limitations thereby introduced must not restrict or reduce the right in such a way or to such an extent that the very essence of the right is impaired.[10]

The Court refused to accept the argument by the government that the temporary prohibition of remarriage is designed to preserve the rights of others, namely those of the future spouse of the divorced person. The Court ruled that Article 12 was breached in *Goodwin v. United Kingdom,* where a biological male, who had

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[5] *Rees v. United Kingdom* (1987) 9 EHRR 56. *Hamer v United Kingdom* (1982) 4 EHRR 139.
[6] *Cossey v. United Kingdom* (1990) 13 EHRR 622.
[7] Harris, O'Boyle & Warbrick, *Law of the European Convention on Human Rights,* Butterworths, London, 1995, p 433.
[8] *Norris v. Ireland* (1989) 13 EHRR 186, *Dudgeon v. United Kingdom* (1982) 4 EHRR 149.
[9] *F v. Switzerland* (1988) 10 EHRR 411.
[10] *Ibid,* para 32.

undergone gender reassignment surgery and was living as a woman, was precluded from marrying a male partner.[11]

Detention and the right to marry and found a family

Most of the case law concerns prisoners. The Commission, in *X & Y v. Switzerland*, rejected a complaint under Articles 8 and 12 by two fellow prisoners who were married to each other and objected to the denial of conjugal facilities.[12] The Court placed particular emphasis on the necessity to restrict these rights for the prevention of disorder or crime. The refusal to allow the prisoner to marry, either in prison or on temporary release, arose in *Hamer v. United Kingdom,* and was held to violate Article 12 due to the length of imprisonment, as a result of which the right to marry would have been unacceptably delayed.[13] National authorities may not deprive "a person or category of persons of full legal capacity of the right to marry."[14] The Commission left open whether it might, exceptionally, be possible to prohibit a patient's marriage on the grounds of special dangerousness and the consequential risk posed to the partner. Personal liberty is not a precondition to the exercise of the right.

A long-term prisoner complained in *X v. United Kingdom* of being deprived of conjugal rights, in the sense of being able to found further family and of being able to exercise his parental rights.[15] The Commission stated that,

> ... Although the right to found a family is an absolute right in the sense that no restrictions similar to those in paragraph 2 of Article 8 of the Convention are expressly provided for, it does not mean that a person must at all times be given the actual possibility to procreate his descendants. It would seem that the situation of a lawfully convicted person detained in prison in which the applicant finds himself falls under his own responsibility, and that his right to found a family has not otherwise been infringed.[16]

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[11] (2002) 35 EHRR 18 para 98.
[12] (1978) 13 DR 241.
[13] (1982) 4 EHRR 139.
[14] *Ibid,* para 60.
[15] (1975) 2 D & R 105.
[16] *X v. United Kingdom* (1975) 2 D & R 105.

Other issues that have arisen in the context of prison include the right to artificial insemination by a wife where the husband is serving a life sentence for murder.[17] The refusal to allow the procedure was held in the English courts not to breach Article 12.

Different considerations apply to mentally disordered persons in detention where, unlike prisoners, they have no control over their illness that led to the detention. Any prohibitions in general terms would be in danger of breaching Article 12.[18] Where there are limitations on sexual relationships between patients, or a patient and spouse, these would have to be strictly justified. Jones believes that it may be necessary for a policy to be formulated which permits sexual relationships, but includes well defined exceptions.[19] There are no specific restrictions on a mentally disordered person marrying as long as he has capacity to contract a marriage. This can take place in prison and hospitals in the United Kingdom.

> Subject to a mental patient having the mental capacity to contract a marriage, and the level of understanding required is basic, there is now no restriction on patients whether detained or not, marrying with a fellow-patient or a non-patient and any interference with the right would normally violate Article 12. The need for capacity to understand the responsibilities normally attaching to marriage is unlikely to offend Article 12.[20]

Thorold refers to the importance of maintaining relationships, including conjugal visits for marital relationships, that contribute to positive long-term prognosis in mental health.[21] Any limitations on such relationships would have to be strictly justified and a general prohibition "would be in danger of breaching Article 12."[22]

Restrictions on the right of a married person to cohabit arose in *Re Jennifer Connor* who was placed on a mental health guardianship order under the Mental Health (Northern Ireland) Order 1986 on the basis of cognitive impairment and history of mental disorder.[23] The hospital trust believed it was necessary for her safety and

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[17] *R v. Secretary of State for Home Dept. ex parte Mellor* (2001) 59 BMLR 1.
[18] Jones R., *Mental Health Act Manual(* 9th ed.), Thomson, London, 2004, p812.
[19] *Ibid,* para 5-057 p812.
[20] Thorold O., 'The Implications of the European Convention on Human Rights for United Kingdom Mental Health Legislation', [1996] *EHRLR*, pp619-636, p634.
[21] *Ibid,* p 635.
[22] *Op.cit.,* 18 p812.
[23] [2004] NICA 45 (14th December 2004).

welfare to restrict her periods of cohabitation with her husband and she challenged the necessity and proportionality of such decision based on Articles 8 and 12 of the Convention, dealing mainly with the issues raised under Article 8.[24] The Court of Appeal commented, in relation to Article 12, that it would be slow to accept there was an absolute right to unlimited cohabitation with a spouse, regardless of the circumstances. There may be situations of "real and immediate threat" to the life of a spouse, so that the right to life would take precedence over the cohabitation right under state obligations.[25] The Court of Appeal held the right of cohabitation as a qualified right which could be interfered with where it was necessary in a democratic society and was proportionate.

Irish law on right to marry and found a family

Constitutional law

There is no express guarantee of the right to marry and found a family in the Constitution.[26] Articles 41 and 42 of the Constitution recognise the family as the most important fundamental unit in the Irish State holding special rights and duties vested in it that do not apply to the non-marital family. The right to procreate was held not to derive from Article 41, but the High Court held, in *Murray v. Ireland,* that this Article protected only those rights which can properly be said to belong to the institution of the family itself as distinct, from the personal rights which each individual member might enjoy.[27] The right to beget children is an unspecified right protected by Article 40.3, the personal rights provision. The right is not absolute and can be lawfully restricted.[28] In *Murray v. Ireland* a married couple, both long term prisoners, wished to engage in conjugal relations and have a child.[29] The Supreme Court held that there was an unspecified constitutional right to procreate, but certain constitutional rights were not available to those in prison. This right was limited by the need to maintain the integrity of the prison system and could not be provided.

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[24] See Chapter 3 p 152 for discussion of the Article 8 implications of this case.
[25] [2004] NICA 45 (14th December 2004) para 31.
[26] The Constitution Review Group recommended that such a provision be included in Article 41 of the Constitution.
[27] [1985] IR 352.
[28] *Ryan v. Attorney General* [1965] IR 294.
[29] [1991] ILRM 465.

The equality provision of the Constitution prohibits invidious or unjustifiable discrimination by the State between different classes of people, but expressly permits the State to have due regard to difference in capacity and social function. However, the Supreme Court, in *In re a Ward (withholding medical treatment),* held that the loss of capacity did not result in the reduction of personal rights under Article 40.3.1 and 40.3.2 of the Constitution.[30] These rights include the right to privacy including self-determination. These rights are important in the context of Article 12.

Common law

Under the common law if a person is capable of understanding the legal consequences and responsibilities which form an essential part of the concept of marriage; that the relationship of marriage is monogamous, interminable, except by death, or divorce, capacity is present. The free and informed consent of both parties is essential for a valid marriage. This involves an understanding of the nature and responsibilities of marriage at the time of the marriage. Where facts become known after the marriage that would have deterred one party from entering the contract of marriage, this may result in a nullity decree.[31] Nullity of marriage can be sought where a person did not, at the time of the marriage, have the requisite capacity. The burden of proof is on the party alleging the incapacity.[32] It is rare for nullity to be granted on the grounds of incapacity to consent.[33] In *ME v. AE,* one spouse was suffering from paranoid schizophrenia at the time of the marriage and was unable to give full and free and informed consent.[34] It is much more common to rely on the ground of inability to form and sustain a normal marital relationship. Where capacity is at issue in nullity proceedings, psychiatrists or psychologists may carry out examinations for the court. Psychiatric evidence has been very persuasive in establishing that paranoid schizophrenia existed at the time of the marriage in a number of cases where nullity

[30] [1995] 2 ILRM 401.
[31] *O'M(M) v. O'C(B)* [1996] 1 IR 208.
[32] *Durham v. Durham* (1965) 10 PD 80.
[33] *Legeyt v. O Brien* (1834) Milw. Rep. 325.
[34] [1987] IR 147 (HC).

decrees were granted.[35] A decree of nullity can also be sought on the basis of the petitioner's own mental disorder at the time of the marriage.[36]

There is no presumption that a person with an intellectual disability or a mental disorder does not have the capacity to marry. The required understanding of the nature of marriage is not pitched at a high level. In an English case, *Sheffield City Council v. E,* a 21 year old woman functioning at a 13 year old level wanted to marry a 37 year old man with a history of sexually violent crimes and the local authority wanted to prevent the marriage. The Court rejected the assertion that capacity should be assessed in relation to the particular marriage proposal in question, but that, in assessing a person's capacity to marry, the Court is not concerned with the wisdom of the decision, which has nothing to do with the nature of the contract of marriage the person has chosen to enter.

> There are many people in our society who may be of limited or borderline capacity but whose lives are immensely enriched by marriage. We must be careful not to set the test of capacity to marry too high, lest it operates as an unfair, unnecessary and indeed discriminatory bar against the mentally disabled.[37]

He emphasised the nature of the contract as the relevant factor and is the same in all cases.[38] The Court said the appropriate test to be applied in such a case was whether E had the capacity to marry and the appropriate test was that proposed in *Re Park's Estate, Park v. Park.*[39] The Court had no jurisdiction to consider whether it was in E's best interests to marry, or to marry S, and it was not concerned with the wisdom of her marriage in general or her marriage to S in particular. A person had to understand the nature of the marriage contract, meaning that he or she had to be mentally capable of understanding the duties and responsibilities that normally attached to marriage. It was not enough that someone appreciated that he or she was taking part in a marriage ceremony or understood its words. The contract of marriage was, in essence, a simple one, which did not require a high degree of intelligence to comprehend. There were, therefore, two aspects to the inquiry into whether someone had capacity to marry: (i)

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[35] *R v. R* Unreported High Court, December 1984, *DC v. DW* [1987] 7 ILRM 58, *WK v. MC* Unreported High Court, July 1992.
[36] *DC v. DW* [1987] 7 ILRM 58.
[37] [2004] EWHC 2808 Fam para 144.
[38] *Ibid,* para 85.
[39] [1953] 2 All ER 1411.

did he or she understand the nature of the marriage contract? and (ii) did he or she understand the duties and responsibilities that normally attached to marriage? The law was set out by Singleton LJ in *In the Estate of Park deceased, Park v. Park,*

> Was the deceased ... capable of understanding the nature of the contract into which he was entering, or was his mental condition such that he was incapable of understanding it? To ascertain the nature of the contract of marriage a man must be mentally capable of appreciating that it involves the responsibilities normally attaching to marriage. Without that degree of mentality, it cannot be said that he understands the nature of the contract. [40]

Capacity to marry was raised in *M v. B & Others,* an English case, where the local authority sought a declaration that the adult, S, with severe learning disabilities, lacked capacity to marry and also sought an injunction preventing her parents from removing her from the jurisdiction for an arranged marriage.[41] Evidence indicated that S did not understand what was involved in marriage and would not be able to cope with the responsibilities involved. The Court held she did not have capacity to give a valid consent to marry. An injunction was also justified to protect her from harm and justified under Article 8 to prevent her private life from being jeopardised by the arranged marriage.

Marriage legislation

The Marriage of Lunatics Act 1811 was passed to prevent the marriage of "lunatics" and provides that where a person has been found to be lunatic by "inquisition" or where, as a "lunatic or person under a phrenzy," his person or estate has been committed to the care or custody of trustees, and such person marries before being declared sane, that marriage is void, even if it occurs during a lucid period. The Law Reform Commission has recommended that that this Act be repealed on the grounds that it renders void a marriage which could be valid if judged by the common law test of insanity and is over-inclusive.[42] This Act is still on the statute books as its purpose is to render void the marriage of a person who was a ward of court at the time of the marriage This legislation assumes that all wards would not understand the nature of

[40] [1954] P 112 at p 127.
[41] [2005] EWHC 1681 (Fam) July 28th 2005.
[42] Law Reform Commission, *Report of Nullity of Marriage* (LRC 9 1984) recommended repeal of this Act as it does not address the issue of capacity to marry and is over inclusive.

the marriage contract. It is of current concern as it is referred to in the recent legislation, the Civil Registration Act 2004. It appears to be lacking in proportionality, having regard to the aim of the provision, the protection of wards of court from exploitation. The lack of issue specific capacity assessment for wards of court which, is based only on a general capacity assessment, means the provision is excessive. This law is anachronistic, does not accord with current thinking on autonomy and appears to impair the very essence of the right to marriage for those wards of court with capacity to contract a marriage. The Marriages (Ireland) Act 1844 provides for the entry of a caveat against granting a marriage certificate to a named person.

The Civil Registration Act 2004 provides for marriages to take place in locations other than the Registry Office provided such locations are approved by the Minister and expenses are paid by those seeking the separate location.[43] This would indicate that marriages can take place in hospitals, although, if the location must be open to the public, this would be unlikely to include prisons. The UK Marriage Act 1983 permits patients detained under long-term powers in the Mental Health Act 1983 to be married in hospital.[44] The Law Reform Commission has recommended that the Marriage of Lunatics Act 1811 be repealed.[45]

Criminal law the right to have sexual relationship

Rights to sexual relations and to found a family are matters of much greater controversy in relation to incapacitated adults. These rights are directly linked to Article 8 and the right to have privacy in sexual relationships and the right to family life but are important for Article 12 rights also.[46] It is an issue that raises great controversy and tension between the individual right to greater autonomy and the paternalism of either the family or the state in protecting the individual against any exploitation or exposure to trauma. Many of the sterilisation cases reported in the 1990s in England in relation to people with an intellectual disability are an indication

[43] Civil Registration Act 2004, section 52.
[44] DHSS Circular No. HC (84) 12.
[45] *Op. Cit.*, 2 para 6.51.
[46] See chapter 3 for discussion of family life.

of the extent of parental concern about the possibility of pregnancy.[47] In recent years, the English courts have been less willing to exercise the inherent jurisdiction and permit such procedures, unless there is clear evidence of exposure to risk.[48]

The Criminal Law Sexual Offences Act 1993, section 5, provides that it is an offence where a person has or attempts to have sex with a person who is "mentally impaired," unless they are married to each other. A defence is available to a person who did not know and had no reason to suspect that the person was mentally impaired. Mental impairment is defined as,

> suffering from a disorder of the mind, whether through mental handicap or mental illness, which is of such a nature or degree as to render a person incapable of living an independent life or of guarding against serious exploitation.

The definition of mental impairment in the Act is regarded as outmoded and unsatisfactory. The test of ability to guard against serious exploitation constitutes a better measure of the ability to consent than the does the second test, the ability to lead an independent life. Where someone is partially dependent, this does not in any way preclude him from being capable of giving consent. The Law Reform Commission *Report on Sexual Offences Against the Mentally Handicapped* stated that a sexual relationship between persons with an intellectual disability or a mental illness should not in itself constitute an offence.[49] The effect of section 5 is that, apart from marriage, a sexual relationship between two mentally impaired people may constitute a criminal offence, as there is no defence of consent where both are presumed to give real consent. Difficulties also apply to a relationship between two people, one of whom had a mental impairment and one who does not. The question here is whether the difficulties and barriers in the legislation are a proportionate response to the mentally disordered person who wants to exercise his right to a relationship, to marry and found a family. The barriers may impact on the very essence of the right under Article 12, unless they are justifiable as being for the legitimate aim of protecting the

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[47] *Re LC (Medical Treatment: Sterilisation)* [1997] 2 FLR 258, *Re S (Medical Treatment: Adult Sterilisation)* [1998] 1 FLR 944, *Re A (Mental Patient: Sterilisation)* C.A. 20 Dec. 1999.
[48] *Re S (Medical Treatment: Adult Sterilisation)* [1998] 1 FLR 944.
[49] Law Reform Commission, *Report on Sexual Offences against the Mentally Handicapped* (LRC 33-1990).

individual against exploitation. The criminal law needs to achieve a balance between paternalism and autonomy,

> It may swing the balance too far in the direction of depriving mentally ill or disabled persons of the right to a sexual life compatible with their physical, mental and emotional capacities. The policy adopted in s.5 of the Act of 1993 may be faulted on this ground. Even allowing for the tacit assumption that prosecutorial discretion will diminish the incidence of 'hard cases', the section fails to reflect the right of persons who are mentally impaired ... to have a sexual life.[50]

The Law Reform Commission is considering this issue and how section 5 might be amended "to ensure that relationships between adults with limited decision-making ability would be lawful where there is real informed consent."[51]

Sterilisation

Compulsory sterilisation and abortion are interferences with the right to found a family in Article 12. Article 8 could be engaged in this regard in relation to the right to respect for private and family life. The Irish courts possess inherent jurisdiction in relation to sterilisation of the mentally disabled based on Article 34 of the Constitution, which gives the High Court full original jurisdiction to decide all matters of law and fact.[52] The focus for justification in cases of non-consensual sterilisation should be on the rights and interests of the individual rather than on broader issues, like benefit to society, in order to comply with Article 12.

Article 40.3.1 of the Constitution guarantees to protect and vindicate the personal rights of the citizen and this extends to adults without capacity,

> The loss by an individual of his or her mental capacity does not result in any diminution of his or her personal rights recognised by the Constitution, including the right to life, the right to self-determination, and the right to refuse medical care or treatment.[53]

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[50] O'Malley, *Sexual Offences: Law, Policy and Punishment,* Round Hall Sweet & Maxwell, Dublin, 1996, p133.
[51] *Op. cit.,* 49 para 6.26.
[52] *In re D (Application by The Midland Health Board)* [1988] ILRM 251. Also Cooney T., "Sterilisation of the Mentally Handicapped", (1989) 11 *D.U.L.J.* pp56-73, Donnelly M., "Non-Consensual Sterilisation of Mentally Disabled People: The law in Ireland" (1997) *IR Jurist* 297.
[53] *In Re a Ward of Court* [1995] 2 ILRM 401.

The Report of the Commission for the Status of People with Disabilities assumed that, despite the lack of specific legislation, sterilisations that take place are authorised on the basis of medical and psychological opinion and with parental agreement, though the extent of the procedure is not known.[54] No case involving non-consensual sterilisation has come before the courts in Ireland to date. Generally, in other jurisdictions, a distinction is drawn between therapeutic and non-therapeutic sterilisation, with leave of the courts being necessary for non-therapeutic sterilisation for a mentally disabled person. The Canadian Supreme Court has affirmed this distinction in *In re Eve,* stating,

> The grave intrusion on a person's right and the certain physical damage that ensues from non-therapeutic sterilisation without consent, when compared to the highly questionable advantages that can result from it, ... it can never be safely determined that such a procedure is for the benefit of that person. Accordingly, the procedure should never be authorised for non-therapeutic purposes under the *parens patriae* jurisdiction.[55]

The Law Reform Commission's *Report on Sexual Offences against the Mentally Handicapped* stated that the approach in *Eve* would be preferred on this issue, that non-consensual sterilisation would only be sanctioned for therapeutic purposes.[56] A decision based on best interests would not be regarded as sufficient having regard to the constitutional rights outlined in *In re a Ward (withdrawal of medical treatment).*[57] The Report of the Commission on the Status of People with Disabilities recommended that there should be a legal prohibition on sterilisation on the basis of disability alone. Where it was to take place, every effort should be made to ensure that informed and free consent exists.[58] Where this is not possible, the courts should be involved, taking account of a range of issues including: necessity, least restrictive alternative, ensuring that fair procedures are observed by having an assessment of the person's welfare and that full consultation with parents, carers and advocates takes place. The General Medical Council in England struck off a practitioner from the medical register based on a finding of professional misconduct in relation to cases where non-therapeutic

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[54] Department of Justice, Equality and Law Reform, Report of the Commission for the Status of People with Disabilities, *A Strategy for Equality,* Government Publications, Dublin, 1996.
[55] (1986) 31 DLR (4th) 1.
[56] *Op. cit.,* 49 para 41.
[57] *In Re a Ward of Court* [1995] 2 ILRM 401.
[58] *Op. cit.,* 54.

sterilisation procedures were carried out on a number of adults with intellectual disability.[59] The decision was upheld by the Privy Council, which said that not enough consideration had been given to a number of issues, including: alternatives to sterilisation, consulting other professionals, the women's capacity or their best interests.

The Scottish Adults with Incapacity Act 2004 provides that the Court of Session must approve any sterilisation where there is no serious malfunction or disease of the reproductive organs.[60] The treatment must be required to safeguard and promote the physical or mental health of the adult. The adult. must not oppose the treatment or resist its being carried out. The Law Reform Commission recommends that,

> proposed capacity legislation should provide that any proposed non-consensual sterilisation of a person with limited decision-making ability where there is no serious malfunction or disease of the reproductive organs would require an application to the court.[61]

The wording used is similar to that in the Scottish Act. Interference with personal rights of a mentally disabled person with or without capacity would need "strict justification" to avoid breaching Article 12. Mental capacity legislation will address some of these issues and provide a legal framework within which decisions can be made along with, or on behalf of, individuals with mental disability.[62]

Conclusion

This chapter examined Irish law on the right to marry and found a family and the related rights to a sexual relationship and to be protected from non-therapeutic sterilisation. Irish law faces challenges in relation to these matters. The law relating to marriage and the automatic deprivation of the right of some people, such as wards of court, is in need of reform. The assumption that all wards are incapable of understanding the requirements of marriage is disproportionate to the aim of

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[59] *Pembrey v. The General Medical Council* [2003] UKPC 60, 97 of 2002.
[60] Adult with Incapacity Act 2000, section
[61] *Op. cit.* 2 para 6.62.
[62] Law Reform Commission *Consultation Paper Law and Elderly* (23-2003), *Consultation Paper Vulnerable Adults and the Law: Capacity* (LRC CP 37-2005).

protection. In effect, the Marriage of Lunatics Act 1811 destroys the very essence of the right to marry without proper justification and is in breach of Article 12. Related to this issue is the right of people with mental disabilities to have a sexual relationship, a complex and difficult area. The challenge is to achieve the correct balance between the paternalism of the State, through protective mechanisms like the criminal law, and the right to autonomy and self-determination required by the individual with mental disability. Interventions in this intimate area of personal relationships must be strictly necessary to comply with Article 12.

The Law Reform Commission is examining this area and intends to have proposals for appropriate reform of the criminal law that might contribute to the achievement of the requisite balance. The Commission is also addressing the issue of sterilisation, an important aspect of the right to found a family. Individuals with mental disability may be the subject of applications to the courts for declaration as to legality of non-therapeutic sterilisation. No application has come before the Irish courts to date, but the Report of the Commission for the Status of People with Disabilities addressed this issue in 1995 and made recommendations that would provide significant and badly needed safeguards.[63] The Law Reform Commission has also recommended that all non-therapeutic sterilisations of people without capacity to consent must be the subject of a court hearing that would ensure the individual's rights and interests are protected.[64] These proposals would accord with the requirements of Article 12, as they would pursue the legitimate aim of protecting the individual against arbitrary action and be proportionate to this aim.

[63] *Op.cit.*, 54.
[64] *Op. cit.*, 2.

Chapter 9

ARTICLE 3, ARTICLE 5, ARTICLE 8 AND THE PROTECTION OF CHILDREN WITH MENTAL DISORDER UNDER IRISH LAW

Introduction

This chapter considers the admission and treatment of children with mental disorders to hospital and the safeguards in Irish law to meet the requirements of the Convention in this regard. A number of factors place children in a different context from vulnerable adults, one of which is the application of different statutes to children in addition to mental health legislation. Another factor is that Convention case law, particularly *Nielsen v. Denmark*, recognises parental authority as a predominant factor in consenting to care and treatment for children.[1] Although there is increasing recognition of children's rights regarding consent to medical treatment, there is still a strong element in both the Convention and domestic case law recognising parental authority to make decisions for children.[2] The question that may arise as a result of having various legal bases for the admission of children is how to ensure the standard of safeguards is adequate, having regard to the Convention.[3] International Covenants, such as the UN Convention on the Rights of the Child and the Convention on Human Rights and Biomedicine, recognise the decision making autonomy of children as a factor associated with age and maturity.[4] These covenants also require that children are treated in an appropriate environment.[5] In common with vulnerable adults, children may need independent representation where they are receiving psychiatric treatment and also may need a range of safeguards to prevent them from being exposed to unwarranted interferences by the state or other individuals in their lives. This chapter will address the enforcement of Convention rights in Ireland for children with mental disorder in relation to the deprivation of liberty, the right to respect for

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[1] (1988) 11 EHRR 175.
[2] *HW & CW v. NWHB* [2001] 3 IR 622.
[3] Children can be admitted by parents and by means of a court order.
[4] Convention on the Rights of the Child Article 12 and Convention on Human Rights and Biomedicine 1997 Article 6(2).
[5] Council of Europe, Committee of Ministers, *Recommendation 2004 (10) on the protection of the human rights and dignity of persons with mental disorder.*

private and family life, including the right to self-determination and the right to protection from inhuman and degrading treatment.

Article 5 and deprivation of liberty

There are two routes for child admission to mental health care: one is by means of parental authority and the other is through mental health legislation. Parental responsibility is a significant factor in any decision to admit a child for mental health care. In *Nielsen v. Denmark,* a mother with sole custody of a 12 year old child, consented to his voluntary admission against the child's and his father's wishes and, as a result, he had no rights under Danish legislation.[6] The Court held that this was not a deprivation of liberty such as to engage Article 5, but was a legitimate exercise of parental rights over the child,

> ... the rights of the holder of parental authority cannot be unlimited and that it is incumbent on the State to provide safeguards against abuse. However, it does not follow that the present case falls within the ambit of Article 5 ... The restrictions imposed on the applicant were not of a nature or degree similar to the cases of deprivation of liberty specified in paragraph 1 of Article 5. In particular, he was not detained as a person of unsound mind so as to bring the case within paragraph (1)(e).[7]

The Court held there was no evidence of bad faith on the mother's part and that she had expert medical advice. It must be possible for the holder of parental rights to have such a child admitted to hospital and this was a responsible exercise by the mother of her custodial rights in the interest of the child.[8] The question raised by one commentator was whether detention by a private person, not the State, may fall within Article 5, or at least require regulation by the State.[9] Further to this is the question as to whether confinement in a hospital does not involve a deprivation of liberty in the sense of Article 5, solely because it involves a private person, in this case a parent. Applying the test for deprivation of liberty, the concrete situation of the child in *Nielsen* was that he was subject to the total control of the staff.

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[6] *Nielson v. Denmark* (1988) 11 EHRR 175.
[7] *Ibid*, para 72.
[8] *Ibid,* para 72-73.
[9] Mowbray A., *Cases and Materials on the European Convention on Human Rights,* Butterworths, Bath, 2001, p158.

The Commission decision was completely at odds with that of the Court, having held that the child was detained, as the doctor in charge of the hospital had taken the decision to admit him and so State responsibility was engaged. The Commission did not believe that parental responsibility was unrestricted in decisions regarding their children. This view accorded with the dissenting judgment of Pettiti J. in the Court, who commented that in a field as sensitive as psychiatric committal, unremitting vigilance was required to avoid abuse of both legal systems and hospital structures.[10] Due to their vulnerability, persons subject to committal decisions must be entitled to the protection of the law. This was even more important in the case of a minor who was already the victim of parental conflict. Many commentators believe that this decision is inconsistent with the decision in *Ashingdane v. United Kingdom* and suggest that "the better approach would have been to hold that the hospitalisation constituted a deprivation of liberty but that it was lawful and justifiable."[11] Jones suggests that *Nielsen* may not be followed.[12]

> Insofar as the judgment of the Court creates a further exception to the right to liberty where a child is detained with parental consent, *Nielsen* creates a clear disparity in the way in which Article 5 applies to children, as opposed to adults ... It is arguably of greatest concern that parental consent to detention, in the face of complete opposition by a child, can cancel out the protection which Article 5 offers.[13]

This case highlights the limited protection available to children who are not formally admitted or provided with safeguards.[14] The situation may change following the decision in *HL v. United Kingdom,* where the Court recognised that the applicant, a vulnerable adult, was subject to the complete control of the staff and lacked recourse to the safeguards enjoyed by detained patients.[15] The Court held that *HL* was effectively deprived of his liberty and was subject to the requirements of Article 5 on this basis. It is likely that similar arguments could be made in relation to children

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[10] *Nielsen v. Denmark* (1988) 11 EHRR 175.
[11] (1985) 7 EHRR 528. Ovey and White, *Jacobs & White European Convention on Human Rights* OUP, Oxford, 2002, p106. Harris, O'Boyle & Warbrick in *Law of the European Convention on Human Rights,* Butterworths, London, 1995, argue that Article 5 may involve positive obligation to control 'private detention' p102.
[12] Jones R., *Mental Health Act Manual* (9th ed.), Thomson, London, 2004.
[13] Kilkelly U., *The Child and the European Convention on Human Rights,* Ashgate, Dartmouth, 1999, pp36, 37.
[14] (1988) 1 EHRR 373.
[15] *HL v. United Kingdom* (2004) 40 EHRR 32. See chapter 3 for full discussion.

admitted voluntarily and subject to similar levels of control. Harris argues that Article 5 could involve a positive obligation to control private detention.[16] This might involve ensuring that parental decisions regarding detention are subject to testing as to whether detention is in the child's best interests, necessary, legal and not arbitrary.

The decision of the Court in *Storck v. Germany* changes the *Nielsen* situation by requiring that there is adequate supervision of all deprivations of liberty.[17] The responsibility of the state is engaged if the state fails to secure rights and freedoms under the Convention and is required to take appropriate steps to provide protection against an interference with those rights either by state agents or by private parties. This applies to the right to liberty and the requirement on the state to take measures to provide effective protection of vulnerable persons. This includes reasonable steps to prevent a deprivation of liberty about which the authorities have or ought to have knowledge.[18] The applicant in *Storck* was 15 years old when first admitted to a children and young person's unit. She spent 7 months there. She was subsequently admitted, with the assistance of her father, to a private psychiatric clinic with no formal authorisation and placed in a locked ward from 1977-1979. The Court held she was deprived of her liberty on the basis that those caring for her exercised complete and effective control over her, including her assessment, treatment, contacts, movements and residence. These control factors are similar to those applied in *Nielsen*. There was evidence that she resisted her stay in hospital and had escaped, but was forced to return and had to be "fettered" to prevent her leaving. The notion of compliance in admission, where the person does not have capacity to resist admission, is recognised by the Court and does not result in loss of safeguards,

> The right to liberty is too important in a democratic society for a person to lose the benefit of the Convention protection for the single reason that he may have given himself up to be taken into detention[19]

[16] Harris, O'Boyle & Warbrick, *Law of the European Convention on Human Rights*, Butterworths, London, 1995.
[17] Application no. 61603/00 16th June 2005.
[18] *Ibid*, para 102.
[19] *Storck v. Germany* Application no.61603/00 16th June 2005 para 75.

Such individuals are not to be equated with consenting capable adults in relation to deprivation of liberty. The State was held to have failed in its duty to protect the applicant's right to liberty and violated Article 5.

Parental rights as a distinct category arose again in *Koniarska v. United Kingdom* in which the Court distinguished the position of the applicant, a 17 year old girl with a personality disorder placed in local authority accommodation, from *Nielsen* on the grounds that *Koniarska's* detention was ordered by the courts, which did not have parental rights over her.[20] This reasoning would appear to have ruled out the possibility of the state being bound to take measures to shield children from unjustified deprivations of liberty carried out by parents or other private individuals. The grounds for the decision might suggest by extension that Article 5(1)(e) does not incorporate any positive obligation on the state to protect children against interferences with liberty carried out by private persons.[21] This conclusion would leave a serious gap in the protection from arbitrary detention of children.[22] However, the decision in *Storck v. Germany* refers to the positive obligation on the state to protect the right to liberty under Article 5 and the right to personal integrity under Article 8 against infringements by private persons.[23] To this end, the state is obliged to exercise supervision and control over private psychiatric institutions.

Adults are entitled to a review of detention under Article 5(4), but where this does not apply to children, it does not appear to amount to discrimination under the Convention. This issue arose in *Bouamar v. Belgium,* where the applicant complained that he was not entitled to a review following arrest. Both the Commission and the Court held that, because the arrest stemmed from a protective rather than a punitive procedure for minors, the different application of the criminal justice regime was objective and reasonable and met Article 14 requirements.[24] Where there is a deprivation of liberty coming within Article 5(1) of the Convention, it is unavoidable

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[20] Application no.33670/96 12th October 2000.
[21] Ovey and White, *Jacobs & White European Convention on Human Rights,* (3rd ed.), OUP, Oxford 2002, p106.
[22] Fennell P., "Informal Compulsion: "The Psychiatric Treatment of Juveniles under Common Law", (1992) *JSWFL* 311-333 at 332.
[23] *Storck v. Germany* Application no.61603/00 16th June 2005 para 150.
[24] *Bouamar v. Belgium* (1989) 11 EHRR 1.

that the individual is entitled to a regular review of that detention under Article 5(4), whether a vulnerable adult or a child.

Irish law and Article 5

Constitutional law

Articles 41 and 42 of the Constitution recognise and favour the married family as the natural, primary and fundamental unit group of society possessing inalienable and imprescriptible rights, which the courts have actively protected from intrusions by the State. By virtue of the powerful protections that the family as a unit receives, the protection of children as individuals within the family is more problematic. The rights of parents were endorsed in *HW & CW v. North Western Health Board* by the Supreme Court in holding that the State could not subject a child to a medical test against the wishes of the parents,

> The Constitution plainly accords a primacy to the parent and this primacy ... gives rise to a presumption that the welfare of the child is to be found in the family exercising its authority as such.[25]

In a dissenting judgment, Keane CJ held that the Court had an inherent jurisdiction, derived exclusively from the Constitution and distinct from its *parens patriae* jurisdiction, to protect the personal rights of the child where such rights are not protected by other organs of the State or by the child's parents. Article 42.5 of the Constitution provides for State involvement in the care of children in certain limited circumstances where the parents cannot care or they have "failed in their duty to their children." In such circumstances, the State can take over and make arrangements for the children. According to Martin, this case is "proof of the assertion that there is a near-automatic presumption that parents' rights cannot generally be interfered with by the Courts in matters of medical treatment where the risk to the child from not receiving the treatment is minimal."[26] The Strasbourg Court, until recently, adopted a similar approach, holding that parental rights in the voluntary admission of a child lay

[25] [2001] 3 IR 622.
[26] Martin F., "Parental Rights to withhold consent to medical treatment for their child: A conflict of Rights", (2001) 7 *ILT,* p114-119 at 117.

outside the scope of Article 5, falling instead within the sphere of private parental responsibility.[27] The decision in *Storck v. Germany* clarifies state responsibility regarding the supervision of all deprivations of liberty, whether public or private.[28]

Mental Treatment Act 1945

There is no express provision in the 1945 Act for the detention of children, defined as those under 16 years old. This age group can only be admitted as willing or unwilling voluntary patients with the consent of their parents or guardian and then only with a letter from a doctor indicating that he has examined the child and confirming the child will benefit from the admission.[29] The issue of capacity to consent to admission or treatment does not arise and the common law applies instead. While enjoying voluntary status, the child has no express rights in terms of leaving hospital or refusing treatment, and is effectively under the control of the hospital staff and is *de facto* detained. Parents can give written notice of their intention to remove the child and they are then at liberty to do so at any time.[30] In these circumstances, the 1945 Act makes no provision for detaining such children if it is in their best interests, where there is a risk to themselves or to others. Where the parents of such child are incapable, or refuse, or neglect to perform parental duties, the 1945 Act requires the doctor in charge to inform the Minister for Health and Children who may make directions on this basis.[31] There is no information as to what "directions" the Minister can make or if the Minister has power to have the child detained, or even if this provision is ever used.

It is more likely in practice, that the provisions of the Child Care Act 1991 (1991 Act) would be used to place a child at risk in the care of the HSE and, if appropriate, in the psychiatric hospital. The 1991 Act provides that the welfare of the child is the paramount consideration in all decisions.[32] In addition, the 1991 Act requires that, as

[27] *Nielsen v. Denmark* (1988) 11 EHRR 175.
[28] Application no.61603/00 16th June 2005.
[29] Mental Treatment Act 1945, section 191(3).
[30] *Ibid,* section 194(2).
[31] Mental Treatment Act 1945, section 196.
[32] Child Care Act 1991, section 24.

far as practicable, due consideration be given to the wishes of the child having regard to his age and understanding.[33]

Where there is conflict in the family, due to separation or for other reasons that may impact on the admission, the only statutory safeguard provides that the doctor recommending the admission must confirm there is a benefit to the child.[34] What "benefit" means is not known, but it could simply be that there is no other more appropriate service. This is further borne out by the Reports of the Inspector of Mental Hospitals indicating that children as young as 11 years are being admitted to adult wards in the absence of suitable services.[35] During 2003, there were 24 admissions to psychiatric care of children under 16 years and 685 admissions of those aged 16-19 years.[36] The question must be raised as to whether the *de facto* detention of these children in inappropriate places with no safeguards could be proportionate to the aim of the detention, the treatment of mental disorder, having regard to the decision in *Aerts v. Belgium.*[37] The *Nielsen* case would not support such a view, except that these admissions must be sanctioned by the admitting psychiatrist and, to this extent, it is arguably a public action and subject to Article 5.[38] Jones comments that the *Nielsen* case might not be followed and that it is likely that the Court would hold that "a parental consent to the admission of a mentally competent 16 or 17 year old child to a psychiatric hospital violates Article 5 if the child objects to the admission."[39] The decision in *Storck v. Germany* clarifies uncertainties following *Nielsen* by effectively placing responsibility on the state to ensure there are Convention safeguards for all who have been deprived of their liberty.[40]

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[33] This requirement is in keeping with the UN Convention on the Rights of the Child and the Article 6 of the Convention on Human Rights and Biomedicine and Council of Europe, Committee of Ministers Recommendation (2004) 10 Article 29(2).
[34] Mental Treatment Act 1945, section 191(3).
[35] Department of Health and Children, *Report of Inspector of Mental Hospitals for year ending 2003,* Government Publications, Dublin, 2003, p132. Irish College of Psychiatrists 2005 confirms there are 4 inpatient beds for children for the whole of Dublin.
[36] Health Research Board, *Activities of Irish Psychiatric Services 2003,* Dublin, 2004.
[37] (2000) 29 EHRR 50 para`46.
[38] *Nielsen v. Denmark* (1989) 11 EHRR 175.
[39] *Op. cit.,* 12 p463.
[40] Application no.61603/00 16th June 2005.

Mental Health Act 2001

The principles section of the 2001 Act will apply to decisions about the admission, care and treatment of persons admitted to psychiatric care.[41] The word "person" is not defined in the Act and, because there is no express reference to the exclusion of children from the principles, it is likely that they apply to both the voluntary admission and the detention of children.[42] This is further borne out by other sections of the Act that have expressly included or excluded children.[43] These principles require that the "best interests" of the person are the principle consideration balanced against the rights of others.[44] The 2001 Act requires that due regard is to be had to respect the right of the person to dignity, bodily integrity, privacy and autonomy.[45] Where the person is being admitted and treated, "as far as reasonably practicable," he must be notified and entitled to make representations in relation to it and consideration must be given to these representations. The District Court will be expected to bear these principles in mind when making detention orders for children, as will the hospital in the case of the voluntary admission of a child. The principles are the only source of safeguards for the child in the 2001 Act. The interpretation of best interests in English cases has established that a patient's best interests are not limited to medical best interests and encompass "medical, emotional and all other welfare issues."[46] When adults are being compulsorily admitted under the 2001 Act, there is a benefit requirement associated with the admission while no such requirement applies to children. This may engage Article 14, unless there is objective and reasonable justification for the difference.

The 2001 Act provides for voluntary admission but does not have an express provision dealing with the voluntary admission of children. A child is defined as a person under 18 years.[47] A voluntary patient is defined as someone "receiving care and treatment in an approved centre who is not the subject of an admission or a

[41] Mental Health Act 2001, section 4.
[42] *Ibid,* sections 23 and 69 specify inclusion or exclusion of children.
[43] Mental Health Act 2001, section 23(1).
[44] *Ibid,* section 4(1).
[45] *Ibid,* section 4(3).
[46] *Re MB (Medical Treatment)*[1997] 2 FLR 426, *Re A (Male Sterilisation)*[2000] 1 FLR 549.
[47] Mental Health Act 2001, section 2(1). Unless he has been married.

renewal order."[48] The Act does not provide any guidance on the involvement of parents in the voluntary admission of the child. The English Mental Health Act 1983 provides that any 16 or 17 year old "capable of expressing his own wishes" can admit himself as an informal patient to hospital, irrespective of the wishes of his parent or guardian.[49] The Mental Health Act 1983 Code of Practice provides that, where the 16 or 17 year old is incapable of expressing his own wishes, the consent of the parents should be obtained or consideration given to the use of the 1983 Act.[50] These provisions meet human rights standards to a greater extent that the 2001 Act, pursuant to which no choices are offered or differentiations made between younger children and the competent 16 or 17 year old.

Where the parents want to remove the child and the child has a mental disorder, the child may be detained and placed in the custody of the Health Service Executive(HSE). This detention can continue for three days during which an application for a detention order must be made to the court.[51] The Mental Health Act provides,

> **Section.-23(3)**
>
> Where a child is detained in accordance with this section, the health services executive shall, unless it returns the child to his or her parents, or either of them, or a person acting in *loco parentis*, make an application under *section 25* at the next sitting of the District Court held in the same district court district or, in the event that the next such sitting is not due to be held within 3 days of the date on which the child is placed in the care of the health services executive, at a sitting of the District Court, which has been specially arranged, held within the said 3 days, and the health services executive shall retain custody of the child pending the hearing of that application.

In this regard, the 1991 Act applies as if the child is being taken into care on an initial emergency care order, which will have to be obtained within three days. There is no express reference in the 2001 Act to the applicant for the order, but under the 1991, Act this would normally be a social worker from the HSE. The problem with this provision is that, at present, no out of hours or weekend social workers are available.

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[48] *Ibid,* section 2(1).
[49] Mental Health Act 1983, section 131(2).
[50] Para 31.9.
[51] Mental Health 2001, section 24(3). Under the Health Act 2004 the Health Service Executive (HSE), replaced the health boards in January 2005.

The section also suggests that the HSE may return the child to his parents, even though the psychiatrist and staff may believe the child should not be discharged. This is an ambiguity that needs further explanation to avoid conflict and confusion about responsibilities, as well as the lack of forseeability of effect in the provision.

The criteria for detention is the presence of mental disorder and the provisions applying in the 2001 Act for adults apply also to children.[52] It will be necessary to meet the *Winterwerp* criteria and ensure the detention is in accordance with a procedure prescribed by law. The District Court will be involved in all detentions of children under 18 years, but will be limited to deciding on the initial or continuing detention order and to permitting some treatments also.[53] The following provisions of the 2001 Act are relevant. The procedure for admission where a child needs detention is as follows,

> **Section 25 (1)**
> Where it appears to a health board with respect to a child who resides or is found in its functional area that –
> (a) the child is suffering from a mental disorder, and
> (b) the child requires treatment which he or she is unlikely to receive unless an order is made under this section, then, the health services executive may make an application to the District Court for an order authorising the detention of the child.

The question that arises here is the interpretation of "unlikely." Does this relate to the child's unwillingness to be admitted or the parents' refusal to allow the child to be admitted? There may be implications for treatment in the community if the child is in an area where there are no day care facilities and he may, therefore, be unlikely to receive treatment. Children living in an area with good services are less likely to be detained than children from areas with limited services. Without further guidance, this section could be interpreted very liberally, permitting arbitrary intervention. Section 25(2) requires that the applicant for the order, the HSE, must not make an application without a report from a consultant psychiatrist subject to the following section,

> **Section 25(3)**

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[52] Mental Health Act 2001, section 3. See chapter 1 for a full discussion of the definition of mental disorder.
[53] Mental Health Act 2001, sections 25 & 61.

Where –

(a) the parents of the child, or either of them, or a person acting in *loco parentis* refuses to consent to the examination of the child, or

(b) following the making of reasonable enquiries by the health board, the parents of the child or either of them or a person acting in *loco parentis* cannot be found by the health board,

then a health services executive can make an application under subsection (1) without any prior examination of the child by a consultant psychiatrist.

Where a child has a mental disorder and requires treatment, a detention order can only be made if the parents refuse to consent to an examination or cannot be found. The above section, therefore, applies only if the parents are unwilling to admit the child on a voluntary basis, refuse the examination or cannot be found. These sections provide for making a detention order in the absence of parental involvement and where the parents are unwilling or unavailable to consent to the examination of the child. The presumption seems to be that, where the HSE is not involved, parents are only permitted to make voluntary admission applications. Parents who believe their children need a secure admission are not in a position to apply to the Court. Even though they may have consulted with various professionals who support the admission, they are prevented from making an application and must involve the health authorities as applicants. This may be regarded as an excessive and unnecessary interference which is not justifiable. It may also violate Article 8 if a decision is made without giving parents an opportunity to be involved in the decision-making process. There is no provision in the Act to give parents copies of court orders or to give them to the child, where appropriate, having regard to age and understanding.

Section 25(8)

Between the making of an application for an order under this section and its determination, the court, of its own motion or on an application of any person, may give such directions as it sees fit as to the care and custody of the child who is the subject of the application pending such determination, and any such direction shall cease to have effect on the determination of the application.

Following an application without an accompanying psychiatric assessment, the court can "give such directions as it sees fit as to the care and custody of the child," which can mean detention. There is no specific time scale in the legislation for the provision of a report in such circumstances or the period a child might be in detention pending a

final determination. Where there is no "objective medical expertise" confirming mental disorder, unless there is an emergency, this could engage Article 5(1). In *Litwa v. Poland,* the Court said that detention is such a serious intrusion that it is only justified where other less severe measures have been found to be insufficient to safeguard individual or public interest and that deprivation of liberty must be necessary in the circumstances.[54] The child should be seen at least by a general practitioner prior to a court application and the 1991 Act should be invoked as a first option and as a least restrictive alternative. The 2001 Act does not make provision for detained children to choose to be voluntary, in contrast to adults, and there is no requirement to return to court to have the order struck out in such circumstances, in contrast to the least restrictive alternative. These issues raise concerns about the law being overly intrusive, lacking in forseeability in its effect, even allowing for a margin of appreciation and the importance of some flexibility.

The Children Act 2001 provides mainly for children involved with the criminal justice system and it contains provisions that could usefully be included in the 2001 Act. One such provision is the family conference that might guard against inappropriate placement of children with behaviour problems in the mental health care system.[55] The English Mental Health Act Code of Practice recognises the difficulty of using mental health legislation instead of children's legislation and the importance of identifying the primary purpose of the proposed intervention. A seriously mentally ill child may need to be detained under the 2001 Act, whereas a behaviourally disturbed child may need secure accommodation under the Children Act 2001. This is an important issue in light of the limited resources for behaviourally disturbed children. The English Code also states that any intervention in the life of the child should be the least restrictive possible and result in the least segregation from family, friends, community and school. Amnesty International highlights the lack of appropriate services and refers to the inappropriate placement of children who have behaviour

[54] [2001] 33 EHRR 53.

[55] An example of such case *DG v. Ireland,* (2002) 35 EHRR 1153. See also report in Irish Times 3rd April 2003 for report of case involving a 17 yr old who was psychotic and was sent to Mountjoy Prison in the absence of more appropriate accommodation because the Court does not have power to make a hospital order-it can merely recommend that such person will get treatment while in prison.

problems, but do not have a mental disorder as a serious cause of concern and a breach of Articles 20 and 37(c) of the UN Convention on the Rights of the Child.[56]

The periods of detention under the 2001 Act are for 21 days in the first instance, followed by three months and periods of six months.[57] The court must sanction each extension to the detention order. A psychiatrist must examine the child and give a report to the court.[58] There is no provision to challenge a detention in between the admission and renewal order, or between each renewal order, which could last for six monthly intervals, raising the issue of proportionality in relation to the aim of the detention. There is provision for absence on leave at the discretion of the consultant psychiatrist for the unexpired period of the detention order.[59] This permission can be subject to such conditions as the psychiatrist considers appropriate and can be withdrawn in the interests of the child. If the child is absent without leave, the clinical director "may" arrange to bring the child back and, if unable and there is "a serious likelihood of the person causing immediate and serious harm to himself or herself or other persons," the clinical director can request Garda assistance.[60] The Garda are empowered to enter any dwelling or premises and take all "reasonable measures necessary for the return of the patient ... including, where necessary, the detention or restraint of the patient."[61]

A number of provisions of the 1991 Act will apply to children detained under court order and sent into mental health care. The 1991 Act provides that, in any decision before a court, the welfare of the child is the first and paramount consideration and that the child's wishes must be considered, having regard to age and understanding.[62] The child's rights in the 1991 Act include the power of the court: to join the child as a party to the proceedings, to appoint a legal representative for the child, or to appoint *guardian-ad-litem* where appropriate.[63] There is no statutory right to legal representation for the child, it is left to the court to ensure representation. This is

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[56] Amnesty International, *Mental Illness, The Neglected Quarter,* Dublin, 2003, p67.
[57] Mental Health Act, sections 25(9) & (10).
[58] *Ibid,* section 25(11).
[59] *Ibid,* section 26(1).
[60] *Ibid,* section 27(1).
[61] *Ibid,* section 27(1)(2).
[62] Child Care Act 1991, section 24.
[63] *Ibid,* sections 26(1) & 25(1).

contrary to requirements in UN Convention on the Rights of the Child and in Recommendation (2004) 10 providing that, "a minor subject to involuntary placement should have the right to assistance from a representative from the start of the procedure."[64] There is no express provision for the regulation and involvement of the Garda in the removal of a mentally disordered child to hospital and their involvement will have to be included in the proposed code of practice.

The admission and detention of children in adult psychiatric hospitals may fail to satisfy the relationship between the grounds of permitted deprivation of liberty relied on and the place and conditions of detention as outlined in *Aerts v. Belgium.*[65] Recommendations (2004) 10 states that children must not be detained in an adult facility, unless it would benefit the child.[66] This requirement of benefit applies to the child being admitted voluntarily under the 1945 Act, but not the 2001 Act. The District Court is not required to take "benefit" into account when making a detention order for a child, but it is taken into account for adult admission. This effectively treats such children differently from adults without any justification and might engage Article 14 of the Convention where the impact of the omission is significant, such as detention in an inappropriate place. In *Pretty v. United Kingdom,* the Court stated,

> For the purpose of Article 14 a difference in treatment between persons in analogous or relevantly similar positions is discriminatory if it has no objective and reasonable justification, that is if it does not pursue a legitimate aim or if there is not a reasonable relationship of proportionality between the means employed and the aim sought to be achieved.[67]

The rights applying to adults with regard to information about the detention, including information about the treatment, do not apply to children, even taking account of age and understanding. This clearly conflicts with the principle of respecting dignity and autonomy. It may not be a breach of Article 5(2), as the purpose of that Article is to enable the person to challenge the detention and this is automatically provided for in the courts. On a broader view, information is part of the empowerment of a person

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[64] Council of Europe, Committee of Ministers, *Recommendation (2004) 10 on the protection of the human rights and dignity of persons with mental disorder*, Article 29(3).
[65] (2000) 29 EHRR 50. See also, Department of Health and Children, *Report of the Inspector of Mental Hospitals for year ending 2003,* Government Publications, Dublin, 2004, referred to the increasing number of children in adults wards, some as young as 11 years.
[66] Article 29(4).
[67] (2002) 35 EHRR para 88.

that enhances his right to autonomy and self-determination and, while the failure to provide information to the child or representative may not breach Article 5(2), it may be serious enough to engage Article 8 as an aspect of respect for private life. The Guiding Principles of the English Code of Practice Mental Health Act 1983 indicate that children should be kept as fully informed as possible about their care and treatment and their views and wishes should be considered, having regard to age and understanding.

Article 8 and the right to self determinaton

The Court, in *Nielsen v Denmark,* held that the right to consent to treatment is part of family life under Article 8.[68]

> Compulsory medical treatment, however minor, may constitute an interference with the right to respect for private life. However, such treatment will not infringe the Convention as long as there is proportionality between the interference which it creates and the need to protect the public interest which it serves. This has been found to be particularly important where children are concerned, because they have limited possibilities to protect their own rights.[69]

In *Storck v. Germany,* the Court referred to persons in need of psychiatric treatment, "in particular," and the obligation on the State to secure to its citizens their right to physical integrity under Article 8 of the Convention. "The State cannot completely absolve itself of its responsibility by delegating its obligations in this sphere to private bodies or individuals" [70] The use of the words "in particular" indicates that the Court had in mind wider application than psychiatric facilities, that there are also other areas of care where the state may have obligations to secure the right to physical integrity under Article 8. With regard to children this might include residential centres where children or adults with intellectual disability are found to be deprived of their liberty without a court or other authorisation. The Court held that the State remained under a duty to exercise supervision and control over private psychiatric institutions. Such institutions, in particular those where persons are held without a court order, need not only a licence, but also competent supervision on a regular basis of whether the

[68] (1989) 11 EHRR 175 para 61.
[69] *Op. cit.,* 13 p150.
[70] Application no. 61603/00 16th June 2005 para 103.

confinement and medical treatment is justified. This statement indicates that institutions caring for children, deprived of their liberty must have state supervision as to whether treatment and detention should continue.

Parental rights were raised in *Glass v. United Kingdom,* a case involving medical treatment in which the Court held that where there is no emergency and the parents of the child object to the course of action planned by the doctors, the case should be referred to the High Court for determination based on its inherent jurisdiction.[71] Otherwise, it would constitute a violation of the right to respect for the private life of the child under Article 8. The Court, in *Johanssen v. Norway,* held that parental rights may be overruled in the child's best interests, as long as the interference is justified under Article 8(2) because "the parent cannot be entitled under Article 8 to have such measures taken as would harm the child's health and development."[72] This decision is strengthened by the outcome in *Storck* requiring the state to exercise supervision and control over the actions of private individuals.

Article 25 of the UN Convention on the Rights of the Child requires state parties to recognise the rights of the child, who has been placed by the competent authorities for the purpose of care, protection, or treatment of his physical or mental health, to a periodic review of the treatment provided. Some of the issues that need consideration in this regard are that children often have voluntary status, even though they are admitted against their will to hospital.[73] There are no safeguards in these circumstances, even though the children are *de facto* detained. The common law applies to consent to treatment for such children with parents or those in *loco parentis* giving proxy consent. Article 12 of the Convention on the Rights of the Child and Article 6 of the Convention on Human Rights and Biomedicine both require that the opinion of the minor be taken into consideration as an increasingly determinative factor in proportion to age and maturity. This latter Convention states in the Explanatory Report that the minor's opinion could even lead to the conclusion that his consent should be necessary, or at least sufficient, for some treatments.[74] Fennell

[71] (2004) 39 EHRR 15.
[72] (1996) 23 EHRR 33.
[73] *Nielsen v Denmark* (1989) 11 EHRR 175.
[74] Council of Europe, *Explanatory Report for Convention on Human Rights and Biomedicine,* 1996, para 44.

comments that "the rhetoric of autonomy has been notably absent from case law on treating children without consent" and he questions "whether the correct balance has been struck between children's rights to make their own treatment decisions and the need to protect their health." [75] The question that is raised following the decision in *Storck* is whether the child is independently autonomous or subject to parental veto. The applicant was 15 years old and a minor when first admitted for psychiatric care and the decision in this case regarding supervision and control over private institutions would seem to apply to children as well as vulnerable adults.

Irish law and Article 8

Mental Treatment Act 1945

There is no provision for consent to treatment for a child who is admitted as a voluntary patient and the common law will apply to admission and treatment, which will be given on the basis of best interests and in accordance with the professional standard.[76] Nor are there any safeguards for the imposition of treatments. If a parent disagrees with a treatment regime, then he can remove the child, or the HSE will activate the 1991 Act if the child is at risk. In relation to consent to treatment, a person becomes an adult for the purpose of decision-making for medical treatment at 16 years under the Non Fatal Offences against the Person Act 1997.[77] In *Gillick v. West Norfolk and Wisbech Health Authority,* an English case, the House of Lords held that the mature minor or "*Gillick* competent" child under 16 years could make decisions about medical treatment and parental rights had to yield to the child's right "when he reached a sufficient intelligence and understanding to be capable of making up his own mind on the matter..."[78] A *Gillick* competent child must be able to understand the nature of the proposed treatment, its side effects and the consequences of not receiving it and, where the child has a mental disability, that must be taken into account, particularly if it is fluctuating.[79] The refusal of treatment by such child can be

[75] Fennell P., *Treatment without Consent*, Routledge, London, 1995, p277.
[76] *Dunne v. National Maternity Hospital* [1989] IR 91.1
[77] Non Fatal Offences against the Person Act 1997, section 23.
[78] [1986] AC 112 p186.
[79] *Re R (A Minor)(Wardship: Medical Treatment)* [1992] 1 FLR 190 p200.

overridden by the courts or by parents.[80] The *Gillick* decision would have to be balanced against parental rights in the Irish Constitution. An aspect of the right to privacy is the child's right to confidentiality, which is not considered in either the 1945 Act, or the 2001 Act. The English Mental Health Act Code of Practice provides that children's rights to confidentiality should be strictly observed and that any limits on this obligation should be made known to the child who has capacity to understand them.[81]

Mental Health Act 2001

The presumption in the 2001 Act is that children, defined as those under 18, are not capable of consenting to medical treatment, despite the provisions of the Non Fatal Offences against the Person Act 1997. There is no express provision in the 2001 Act for refusal of treatment for mental disorder, so it is not clear what might happen if a competent child who is voluntary refuses treatment, particularly those between 16 and 18 years. The common law will apply and permit treatment to be given on the basis of parental consent and the best interests of the child. The best interests are no longer limited to medical best interests under English law and include "medical, emotional and all other welfare issues."[82] Where a parent wishes to remove a child against the advice of the consultant psychiatrist, the child can be detained subject to the 1991 Act until there is a hearing in the District Court. The 2001 Act has no express provision on whether treatment can be administered during this time and, therefore, the common law will continue to apply.

Where children are detained the requirement laid down in *Herczgefalvy v. Austria,* that where treatment of a competent adult without consent must be convincingly shown to be necessary, applies.[83] In the absence of decisions on this area in Irish law, persuasive authority may be found in *Gillick v. West Norfolk & Wisbech Area Health Authority*[84] and in *Re R,*[85] both English cases, holding that a minor under 16 may give valid consent based on intelligence and understanding. Jones advocates that blanket

[80] *Re W* [1992] 4 AII ER 627.
[81] Mental Health Act Code of Practice 1983 para 31.21.
[82] *Re MB(Medical Treatment)*[1997] 2 FLR 426, *Re A (Male Sterilisation)* [2000] 1 FLR 549, p555.
[83] (1993) 15 EHRR 437.
[84] [1985] 3 All ER 402.
[85] [1991] 4 All ER 177.

consent forms should not be used and that consent should be sought for each component of a child's care and treatment.[86] In relation to consent to treatment for children who are under court order, the 2001 Act provides,

> **Section 61.—**
>
> Where medicine has been administered to a child in respect of whom an order under *section 25* is in force for the purposes of ameliorating his or her mental disorder for a continuous period of 3 months, the administration of that medicine shall not be continued unless either—
>
> (*a*) the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the child, and
>
> (*b*) the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist, following referral of the matter to him or her by the first-mentioned psychiatrist,
>
> and the consent or, as the case may be, approval and authorisation shall be valid for a period of 3 months and thereafter for periods of 3 months, if, in respect of each period, the like consent or, as the case may be, approval and authorisation is obtained.

The section does not guarantee independence in the second opinion provided, nor is there any requirement of authorization by a child psychiatrist with a second opinion from another child psychiatrist. The section permits medication to be given to the child for three months without any reference to a second opinion at the outset. This provides a lower standard of protection than that applying to adults who are asked to consent. It is not clear what happens if different medications are used and whether time runs from the start of each treatment or from the start of the first treatment. It is arguable that the "stabilising period" of three months is excessive, particularly where children are concerned, and also in view of the long periods of detention provided for in the legislation. The imposition of medication in English law may involve reasonable force and can be used where valid consent has been obtained in relation to a refusing mentally capable or incapable child.[87] The decision to use force may involve a balance between continuing treatment, which is forcibly opposed, and

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[86] *Op. cit.*, 12 p744.
[87] *Re MB (Medical Treatment)*[1997] 2 FLR 426 p439.

deciding not to continue with it. It is arguable that the government has a positive obligation to ensure the right to both private and family life is protected for these children under Article 8, even where the admission is carried out by parents. There is no representative to act for the child in these circumstances, leaving them more vulnerable. Fennell posits the need for the second opinion safeguards to apply to informally admitted children who are given neuroleptic or major tranquillisers with potentially long lasting side-effects.[88] Under Irish law, this recommendation would also need to apply to children under court order.

The decision in *Storck* requires a higher standard of safeguard applying to children with regard to state supervision and control over treatment to protect against interferences with private life under Article 8.[89] The Court stated in that case that even a minor interference with the physical integrity of an individual must be regarded as an interference with the right to respect for private life under Article 8, if carried out against the will of the person.[90] Fennell argues that the control required for the imposition of serious treatments on incapacitated adults, which arguably could include neuroleptics for children who do not resist but do not consent and are not otherwise deprived of liberty, could "tip the balance" in favour of establishing a deprivation of liberty requiring use of the Mental Health Act to ensure effective protection of Article 5 and Article 8 rights."[91]

Section 25

> (12) Psycho-surgery shall not be performed on a child detained under this section without the approval of the court.
> (13) A programme of electro-convulsive therapy shall not be administered to a child detained under this section without the approval of the court.

There is no detail provided on what reports are required by the court for psychosurgery or ECT approval and whether one report from the child's consultant psychiatrist will be adequate. This is a situation where independent opinions are essential. This indicates that parents can consent to both these treatments without

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[88] *Op. cit.*, 75 p276.
[89] Application no. 61603/00 16th June 2005.
[90] *Ibid,*, para 143.
[91] Fennell P., "The Mental Capacity Act 2005, the Mental Health Act 1983, and the Common Law", *Journal of Mental Health Law* 2005.

court approval where the child is voluntary. The safeguards in the 2001 Act for treatment of children are extremely limited and may not conform to the requirements under Article 8(1) with regard to family consultation and having an independent representative, or advocate. There is no recognition in the legislation of the capacity of a 16 year old with regard to consent, yet common law decisions in other jurisdictions permit those under 16 to make decisions based on maturity and understanding.[92] This applies also to those 16-18 year olds, most of whom are competent to consent. This is out of step with many of the international human rights documents and the Convention on Human Rights and Biomedicine on the recognition of the capacity to consent, where the opinion of the minor should be taken into consideration as an increasingly determining factor in proportion to his or her age and degree of maturity.[93] As a result of this sparsely drafted law, it is likely that there will be unnecessary interference with the private lives of older children with regard to the right to self determination, unless such interference is convincingly shown to be necessary as required by Article 8.[94]

Article 3 and children

Children are entitled to protection and effective deterrence against serious breaches of personal integrity.[95] In *Z v. United Kingdom,* the applicant alleged that the local authority had failed to protect four children from inhuman and degrading treatment contrary to Article 3.[96] There was a positive obligation on the Government to protect children from abusive treatment contrary to this provision. The authorities had been aware of the serious ill-treatment and neglect suffered by the four children over a period of years at the hands of their parents and failed, despite the means reasonably available to them, to take any effective steps to bring it to an end. The Court held that the State had failed to provide the applicants with adequate protection against inhuman and degrading treatment. The measures in Article 3 should provide effective protection, in particular, of children and other vulnerable persons and include reasonable steps to prevent ill-treatment of which the authorities had or ought to have

[92] *Gillick v. West Norfolk and Wisbech AHA* [1985] 3 All ER 402.
[93] Article 6(2).
[94] *Herczgefalvy v. Austria* (1993) 15 437.
[95] *Costello-Roberts v. United* Kingdom(1995) 19 EHRR 112, *X and Y v. the Netherlands* 26 March 1985, Series A no. 91, para 21–27.
[96] *Z & others v. United Kingdom* Application no. 29392/95 10th May 2001.

had knowledge. The children of parents, who have a mental disorder and are not receiving care or treatment, resulting in severe neglect of the family, may claim a breach of Article 3, where the state had or ought to have had knowledge of the neglect. Treatment in an environment that is seriously inappropriate for children may also raise Article 3 concerns where the impact on the child is severe as occurred in *Nevmerzhitsky v. Ukraine.*[97] In that case, the inadequate medical treatment had a serious impact on the health of the applicant and was regarded as degrading treatment that violated Article 3.

Irish law and Article 3

There is no guarantee that children will be entitled to detention in an appropriate place that will ensure their protection from inhuman and degrading treatment. It is likely though that admission to an adult ward might not reach the level of severity to engage Article 3. Admission to adult wards is inappropriate for many reasons, such as the ethos of adult treatment units, lack of staff with child treatment skills, the lack of ready access to child psychiatrists, as well as the lack of an appropriate treatment environment, raising State obligations in this regard based on *Aerts v. Belgium.*[98] The lack of facilities for the treatment of children and their admission as voluntary patients to adult wards, as well as the inappropriate placement of behaviourally disturbed children, including juvenile offenders, in psychiatric care is highlighted annually in the Inspector of Mental Hospitals Reports. There are only two centres specialising in the admission of children for psychiatric care, with no services developed for 16 and 17 year olds, who are classified as children under the 2001 Act.[99] The Irish College of Psychiatrists have stated that the lack of specialised services for adolescents is having an impact on the ability of children's services to treat younger children, thereby creating waiting lists for all children.[100]

The UN Committee on the Rights of the Child, which monitors compliance with the Convention on the Rights of the Child, has expressed concern about the incidence of

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[97] Application no. 54825/00 5th April 2005.
[98] (2000) 29 EHRR 50.
[99] Department of Health & Children, *Working Group on Child and Adolescent Psychiatric Services,* 2nd Report, Dublin, 2003.
[100] Irish College of Psychiatrists, "Position Statement on Psychiatric Services for Adolescents" 2001.

teenage suicide and the widespread gap in adolescent services.[101] The lack of appropriate facilities has been highlighted in a number of reports, including a submission to the CPT.[102] Recommendation (2004) 10 advises against detention in adult wards.[103] The UN Committee on the Rights of the Child stated in 1998 that it was concerned about the lack of a national policy to ensure the rights of children with disabilities and the lack of adequate programmes and services addressing the mental health of children and their families. Amnesty International, concerned at Ireland's failure to comply with international obligations towards children with mental illness, commented in 2001 that significant advances have been made in the mental health care system, but that psychiatric services for children and adolescents remain underprovided in most areas of the country.[104]

The right to education must be safeguarded while in hospital. Athough this is not included in the 2001 Act, it is provided for in the Child Care Act 1991.[105] The Constitution affirms the right to free primary education with a cut off point at 18 years for children with mental disabilities as established by the Supreme Court in *Sinnott v. Ireland.*[106] This right is enshrined also in Article 2 of the First Protocol to the Convention and, while this right is not absolute, it has been interpreted by the Court as protecting a right to access effective education.[107] Further support for the right to education can be found in Recommendation (2004)10, which states that children with mental disorders should have a right to free education and to be reintegrated into the general school system as soon as possible. Where possible, they should be individually evaluated and receive an individualised educational or training programme.[108] This recommendation reflects Article 28 of the UN Convention on the Rights of the Child, which provides for a child's right to education, and that such education should be accessible and available to all children. Where children are

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[101] *Concluding Observations of the Committee on the Rights of the Child: Ireland,* 4/02/98 CRC/C/15.
[102] Children's Rights Alliance, *Submission to the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment,* 17th May 2002.
[103] Council of Europe, Committee of Ministers, *Recommendation (2004)10 on the protection of the human rights and dignity of persons with mental disorder,* Article 15.
[104] *Op. cit.,* 56 p60.
[105] Article 2 of the First Protocol to the Convention This is also required in many human rights documents particularly the U.N. Convention on the Rights of the Child.
[106] *Sinnott v. Minister for Education* [2001] 2 IR 545. Also Quinlivan & Keys "Official Indifference and Persistent Procrastination: An Analysis of Sinnott", (2002) 2(2) *Judicial Studies Institute Journal.*
[107] *Belgian Linguistic Case (No 2)* 1 EHRR 252.
[108] Council of Europe, Committee of Ministers, *Recommendation 2004 10 on the protection of the human rights and dignity of persons with mental disorder,* Article 29(5).

admitted to adult wards, the culture of such an environment may not ensure that education is a significant factor.

Conclusion

The 1945 Act has a statutory basis for the voluntary admission of children, i.e. those under 16 years, but the common law applies to their treatment in the absence of any guidance in the Act. There is a requirement in the 1945 Act that the admission would benefit the child, but this is not defined. The benefit requirement is not replicated in the 2001 Act for children, although it must be applied to the detention of adults.[109] The 2001 Act has statutory principles that apply to all admissions. These principles must influence any action taken in connection with admission and treatment. There is no express guidance on the voluntary admission of children in the 2001 Act, other than that applying to adults. The statements of the Court in *HL v. United Kingdom* and in *Storck v. Germany* should apply ***mutatis mutandis*** to children being admitted as voluntary patients to psychiatric care where they are subject to the level of control and supervision required for a deprivation of liberty. Unless safeguards are provided, Ireland will breach Article 5. The decision in *Storck* requires the state to provide supervision and control over detention by private individuals in contrast with the decision in *Nielsen.*[110]

In the 2001 Act, the District Court is involved in all compulsory admissions of children. There is no automatic right under the 2001 Act to legal representation for the child. This right may be provided under the Child Care Act 1991. There are concerns regarding the scope of the discretion open to the court with regard to the time-scale for the provision of expert reports and the continuing detention of the child in the meantime. The role of parents is minimal in this regard and they have no express rights associated with such hearings, such as access to copies of detention orders. Another concern is the lack of express provision for Garda involvement with the removal of a child to inpatient care. One of the most serious issues is the admission of a child, whether voluntary or compulsory, to adult wards in the absence of more

[109] Mental Health Act 2001 section 3(1)(b)(ii).
[110] *HL v. United Kingdom* (2004) 40 EHRR 32. Application no. 45508/99 5th October 2004 para 120, *Storck v. Germany* Application no. 61603/00 16th June 2005 and *Nielsen v Denmark* (1989) 11 EHRR 175.

appropriate services, raising similar issues to those in *Aerts*. There are gaps with regard to the provision of information, despite Article 5(2) and many human rights standards, particularly having regard to age and understanding. Some of these issues may engage Article 14 on the basis of the different treatment meted out to children, particularly the competent older child when compared with adults.

The right to self-determination regarding consent to treatment is not protected in either Act for the child with voluntary status. The common law will apply and parents or guardians will consent on the child's behalf with no other requirement. This seems to apply to all treatments available, thereby offering no safeguards, while the 2001 Act provides the court will be the safeguard in deciding for the child regarding ECT or psychosurgery. It is not clear if any second opinion will be included in this procedure and there is no recommendation that children will be treated by a child psychiatrist. This is an important issue given that there are only 20 specialist inpatient beds for children in Ireland and adult services are often used. The imposition of the three month stabilising period for medicine before consent or a second opinion applies. The lack of independence of this second opinion applies to children, as well as adults and, therefore, it is doubtful if the convincing necessity standard in Article 3 can be reached. The right to self-determination of those between 16 and 17 years is not considered, even though the statutory right to consent to general medical treatment applies at 16 years. This raises the question of unnecessary interference and a possible violation of Article 8 and the right to respect for private life, particularly with capable minors. It may also engage Article 14, unless there is objective and reasonable justification for the difference between medical and psychiatric treatment. However, the decision in *Storck* may lead to greater State involvement in the supervision of such treatment. These gaps may well reach the inhuman and degrading treatment standard in Article 3 when linked with an inappropriate hospital environment.

The 2001 Act requires a proper system of safeguards including: proper procedural safeguards, recognition of the compliant incapacitated child, appropriate and beneficial placement, representation for the child, protection of their his to privacy, and recognition that his capacity to consent grows with increasing maturity.

CONCLUSION

This thesis set out to examine the compatibility of Irish mental health law with the European Convention on Human Rights and considered the following rights: to liberty, to self-determination, to protection from inhuman and degrading treatment, to have access to court, to protection of life, to marry and children's rights. The findings on each of these rights are summarised and issues needing special attention are highlighted. The overall conclusion is that the 2001 Act should be fully implemented as a matter of urgency and further matters in relation to incapacitated patients also must be addressed.

Right to liberty

Chapter One considered the provisions of the 1945 and 2001 Acts as they apply to admission to psychiatric care in the light of the obligations arising under Articles 5(1) and 5(2) of the Convention. Chapter Two considered the right to review of detention in Irish law against the background of Article 5(4) to see if Ireland is meeting its obligations. Alternative review procedures were also examined and included a study of the use of habeas corpus in Ireland.

Deprivation of liberty under the 1945 Act can take place on the basis of social considerations, such as neglect, cruel treatment and perverted conduct contrary to the *Winterwerp* criteria and in breach of Article 5(1)(e).[1] Modern medical practice does not adhere to these criteria, thereby creating a gap between law and practice. There is a real risk of arbitrariness and unpredictability, where the rule of law does not apply in contravention of Convention requirements. It also creates difficulties for professionals attempting to match current practice with inadequate legislation.

The criteria for detention in the 2001 Act define mental disorder to include three categories: mental illness, severe dementia and significant intellectual disability, where failure to admit the person would lead to a serious deterioration or prevent appropriate

[1] *Winterwerp v. Netherlands* [1979] 2 EHRR 387.

treatment being given. The requirement of a "benefit" from the admission forces some consideration of the potential impact on the individual. The use of the words, "serious," "immediate," "significant" and "severe" throughout the criteria for detention indicate that a more exacting standard and higher level of proof will be required for any detention. As drafted, the criteria in the 2001 Act seem to comply with Article 5(1)(e).

Many of the procedures under the 1945 Act are vague, unforeseeable in their effect, have unlimited discretion and would not meet the "fair and proper procedure" requirement in the Convention. The broad range of applicants and the mixing of mandatory and non-mandatory words like "may" and "shall" in relation to the examination requirement in the 1945 Act, depending on which category of doctor is involved, leads to confusion.[2] The Irish courts have held that the failure to carry out any examination prior to making a recommendation for detention as in *Kiernan v. Harris, Kiernan & Midland Health Board,* or where an examination for such recommendation for detention was based partly on a telephone conversation as in *Melly v. Moran & North Western Health Board* does not comply with national law, resulting in lack of reasonable care.[3] Procedural differences under the 1945 Act between private and public patients raise many questions, some of which may engage Article 14. The Supreme Court, in *Gooden v. Waterford Regional Hospital,* referred to these as "unnecessary and invidious."[4] Such differences were highlighted in the decision in *Storck v. Germany,* which held that the state has positive obligations to ensure the interests of the patient deprived of his liberty are safeguarded in both the public and private area.[5]

The 2001 Act procedures are more clearly defined and exclude certain categories of applicant from the detention procedure.[6] The Act places a greater onus on the doctor in the examination for detention to provide objective medical evidence of mental disorder,

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[2] Mental Treatment Act 1945, Section 163(1)(b)(i).
[3] *Melly v. Moran & North Western Health Board,* Unreported Supreme Court, 28th May 1998, and *Kiernan v. Harris, Kiernan & Midland Health Board,* Unreported High Court, 12th May 1998.
[4] *Gooden v. Waterford Regional Hospital* [2001] IESC 6 21st February 2001 para 54.
[5] Application no 61603/00 16th June 2005.
[6] Mental Health Act 2001, section 2(1).

thereby complying with the *Winterwerp* criteria.[7] The person must be informed of the purpose of the examination, but there is no second opinion option prior to detention. The principles in the Act, however, may ensure some consideration of the individual's wishes.

There is no obligation in the 1945 Act to communicate promptly the factual and legal basis of the detention so that the patient can challenge the detention. The 2001 Act places significant emphasis on the provision of information to the patient, but does not include the substantive reasons for the detention as established in *Van der Leer v. Netherlands.*[8] The Act provides that the patient be given information about the detention and right to review within 24 hours of an admission or renewal order being made, complying with the "prompt" requirement. The information must be in writing, raising concerns about real compliance with Article 5(2) where there are literacy, language, or a representative is needed.

The 1945 Act formalises the admission of voluntary patients, but does not adequately consider the situation of the incapacitated voluntary patient. While the Act recognises that a patient may not be truly voluntary and mandates that such patient is either detained or discharged within 28 days, this clearly is not the practice. During this 28 day period, the patient is effectively under the control of the hospital. This seems disproportionate to the aim of safeguarding the patient. The current failure to comply with this statutory procedure amounts to a breach of national law and of the Convention. All of the factors required to establish a deprivation of liberty and necessitating safeguards were outlined in *HL v. United Kingdom* and *Storck v. Germany* and these rulings clearly have application to Ireland, raising possible breaches of Article 5.[9] Where such admissions meet the requirements to establish a deprivation of liberty, the Irish State has a positive obligation to ensure there are safeguards in place. These safeguards include the presentation to a competent authority of objective medical evidence of a true mental disorder, which is of a kind or degree justifying detention and regular rights to review of detention. The 2001

[7] *Winterwerp v. Netherlands* [1979] 2 EHRR 387.
[8] (1990) 12 EHRR 567.
[9] (2004) 40 EHRR 32. Application no. 45508/99 5th October 2004, para 9, Application no.61603/00 16th June 2005.

Act does not have any formal admission requirements for voluntary patients or specific safeguards, but has a 24 hour holding power. The key question is whether those who are compliant and incapacitated will be treated as if truly voluntary, even when under the total control of the hospital staff, raising the same issues as apply to the 1945 Act.

The 1945 Act is clearly in breach of Article 5(4) by failing to have any independent review mechanism available, despite the extensive and unlimited detention periods. Habeas corpus is the only option to challenge the legality of the detention and, as a result, occupies a position of fundamental importance, which the Irish State has relied on discharge its responsibilities under Article 5(4).[10] It is well established that both judicial review and habeas corpus are not adequate remedies to test the legality of the detention since they go to the lawfulness in a less substantive sense than is required by the Convention and are commonly used to challenge procedural irregularity, not medical evidence.[11] However, habeas corpus can be used as an effective check against arbitrariness for emergency measures, provided the measures are of short duration.

The results of an empirical study into the use of habeas corpus by psychiatric patients established the low rate of applications for habeas corpus from patients in psychiatric hospitals, compared with applications from prisoners.[12] Reasons for the low rate may include, the lack of information as to the rights available to people in detention, the lack of a rights culture in psychiatric hospitals, the lack of rights based mental health legislation with no access to information regarding the rights available in the 1945 Act. Judicial review is restrictive in Ireland and reliance on both these provisions means that the safeguards of the 1945 Act do not conform to Article 5(4).

The 2001 Act partially complies with Article 5(4) by providing a right to review by a tribunal of the initial decision to detain and of each decision to extend an order, but

[10] *Croke v Ireland* Application No. 33267/96.
[11] Fennell P., "Doctor Knows Best Therapeutic Detention under Common Law, The Mental Health Act and the European Convention," (1998) 7 *Med. L. Rev.* p 349.
[12] There were 111 applications from psychiatric detainees from 1923-1999 and 113 from prisoners from 1998-1999.

excluding wards of court is a breach of Article 5(4).[13] There is a right to legal representation before the tribunal, but there is no statutory right to an independent medical report for the hearing. The initial review will take place within 21 days of detention and at each extension to a detention order. The statutory time scales will provide for a speedy review provided the system is adequately resourced.[14] Unlike the Mental Health Act 1983, the tribunal has no statutory power to make a conditional discharge, defer a discharge or direct that a patient's disorder be reclassified. In the right of appeal to the Circuit Court against the tribunal decision the burden of proof will rest with the individual that he no longer has a mental disorder. This is almost certainly in breach of Article 5(4), having regard to the decision in *Reid v. United Kingdom.*[15]

The right to self determination

Chapter Three considered the nature of the right to respect for private life, family life, home and correspondence under Article 8 and the enforcement of these rights in Irish law. The main focus of the chapter was on private life, with particular emphasis on the right of self-determination in relation to consent to treatment, including seclusion and advance directives.

The Irish Courts held, in *In re a Ward of Court(Withdrawal of medical treatment),* that the constitutional rights of every person, the well and infirm, include the right to privacy, autonomy and self-determination, part of which is the right to refuse treatment.[16] Where patients are unable to consent, the common law doctrine of necessity provides a defence for doctors acting in their best interests.[17] Where an individual is incapable of managing himself or his affairs, he may be made a ward of court and loses all self-determination

[13] Mental Health Act 2001, section 18. Wards are not entitled any other system of regular review of their detention.
[14] *Ibid,* section 18(2).
[15] *Hutchinson Reid v. United Kingdom* (2003) 37 EHRR 9.
[16] *In re a Ward* [1995] 2 ILRM 401 p404.
[17] *Bolam v. Friern Hospital Management Committee* [1957] 2 All ER 118 *Dunne v. National Maternity Hospital* [1989] IR 91.

rights.[18] Serious medical treatment decisions are then made by the President of the High Court and minor decisions made by the "committee," subject to the principle that in an emergency a doctor is entitled to take urgent action to preserve life and health.[19] This system is extreme and disproportionate to the aims of the protective jurisdiction and is likely to breach Article 8 in its private life aspects. The Power of Attorney Act 1997 provides for an enduring power of attorney that does not include medical treatment decisions by the attorney.

The 1945 Act contains no safeguards for consent to treatment which is imposed on the basis of the common law, regardless of patient capacity. There are no safeguards when treatment is being given to a resisting patient. Voluntary patients should be able to give legally effective consent to treatment and there is nothing in the Act or common law to suggest otherwise. Those who are admitted voluntarily, but who lack capacity, are treated without any particular consideration of their status or incapacity. These provisions do not provide adequate safeguards to comply with Article 8.

The 2001 Act principles support the right to self-determination, requiring respect for the dignity, bodily integrity, privacy and autonomy of the individual.[20] Safeguards for consent apply only to those who are formally detained and not to voluntary incapacitated patients. These require that the consultant is satisfied regarding the patient's "capacity to understand," which may not mean actual understanding.[21] The second opinion safeguard, where the patient refuses ECT treatment or medicine, is not required to be independent of the service and can be requested by the patient's psychiatrist. These omissions are significant in relation to the imposition of treatment on a mentally competent resisting adult. There is no requirement that reasons are given for the decision to override the self-determination of a mentally competent adult and no right of appeal lies against the second opinion other than judicial review. Patients can be given medicine forcibly for a three

[18] Lunacy Regulation (Ireland) Act 1871 and in the Courts (Supplemental Provisions) Act 1961. The procedure is set out in Order 67 of The Rules of the Superior Courts 1986.
[19] *JM v. St.Vincent's Hospital* [2003] 1 IR 321. Lunacy Regulation (Ireland) Act 1871 (1871 Act) . *In re an Application by the Midland Health Board* [1988] ILRM 251.
[20] Mental Health Act 2001, section 4(3).
[21] Jones R., *Mental Health Act Manual* (9th ed.), Thomson, London, 2004, p 298.

month period before the second opinion safeguard applies. When different medications are used, there is no guidance on when the time begins. This constitutes an interference with private life under Article 8(1) and can only be justified under Article 8(2) if it can convincingly shown to be necessary for health and safety. In *Storck v. Germany,* the Court held that even a minor interference with the right to bodily integrity can breach Article 8.[22]

The protection of the confidentiality of patient information can arise when the needs of the patient and carer have to be balanced and, while governed by the common law, there is no reference to confidentiality in the 1945 Act, but the 2001 Act requires respect for the right to privacy.[23] Any information given without consent will have to stand the necessity test, have a legitimate aim and be proportionate to the achievement of that aim in order to comply with Article 8(2). Similarly, rights to privacy of the home or correspondence are not specifically protected in the legislation and the intrusion by staff into the homes of patients in community facilities and the lack of privacy in such places or with correspondence might well engage Article 8, unless it is justifiable as pursuing a legitimate aim and is proportionate to that aim.

Protection against inhuman and degrading treatment

Chapter Four considered the impact of Article 3 and the safeguards in Irish law to prevent torture, inhuman and degrading treatment. The main issues addressed were whether the conditions of detention could reach the minimum level of severity to come within the scope of Article 3, whether medical treatment could amount to inhuman and degrading treatment and whether the side-effects of medication or the failure to treat could amount to a breach of Article 3.

Government reports highlight the seriously inadequate physical conditions in facilities, ranging from patients having to slop-out, to unsafe observation areas and overcrowding,

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[22] *Storck v Germany* Application no.61603/00 16th June 2005 para 144.
[23] Mental Health Act 2001, section 4(3).

as well as poor attention to the general health needs of patients, in contrast with private hospital accommodation. The lack of appropriate facilities for children, including those with an intellectual disability, most of whom have voluntary status, could be severe enough to engage Article 3 where it results in inhuman and degrading treatment. The 2001 Act proposes a more rigorous inspection system than the 1945 Act to ensure that minimum physical standards and staffing needs are met in all mental health centres as a condition for registration of the centres.[24] Inadequate or non-existent community services and a high readmission rate to in-patient facilities with loss of liberty represents a serious impact on peoples' lives and, where this is not regarded as sufficiently severe to engage Article 3, it would very likely be a breach of Article 8 and the right to respect for private and family life. The denial of appropriate treatment to a severely ill patient could be serious enough to engage Article 3.[25] The 2001 Act requires that a treatment plan is in place for all in-patients.[26]

The practice of seclusion and restraint is not subject to any formal safeguards or access to review of the practice in either the 1945 or the 2001 Acts. The lack of formal safeguards, or independent monitoring and review of seclusion, or an independent second opinion before it commences, is also a cause of concern, having regard to the decision of the English Court of Appeal in *Munjaz*.[27]

Medical treatment could involve a breach of Article 3 if the side-effects are sufficiently serious.[28] If the medication is therapeutically justified, the possibility of establishing a breach of Article 3 is more remote, unless there was an equally effective alternative that produced less serious side-effects.[29] The Inspector's reports have highlighted the wide range and diversity of drug prescribing, along with the lack of guidance for appropriate

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[24] Mental Health Act 2001, section 64.
[25] *D v United Kingdom* (1997)24 EHRR 423.
[26] Mental Health Act 2001, section 66(2)(g).
[27] *R (on application of Munjaz)* v. *Mersey Care National Health Service Trust & Others* [2003] EWCA Civ 1036, [2005] UKHL 58.
[28] *Grare v. France* (1992) 15 EHRR CD 100.
[29] Jones R., *Mental Health Act Manual,* (9th ed.), Thomson, London, 2004, p778.

and effective prescribing.[30] Referring to sudden deaths, the Inspector has commented on the need for greater care in examination and getting informed consent to treatment. Polypharmacy is widespread and individuals are not given information on the medication and possible side-effects, raising the question of informed consent for those who were treated and the possibility of degrading treatment under Article 3.[31]

Civil rights and obligations

Chapter Five considered the nature of civil rights and obligations under Article 6 and the obligation to have speedy access to a fair hearing and right to representation and concentrated on the legal provisions affecting access to the courts. The access restrictions to take civil action under the 1945 and the 2001 Acts were examined for compliance with Article 6.

Under Irish law, a statutory restriction on the right of access to court would not be unconstitutional where there were objective reasons for the restriction and where it was not of itself unduly oppressive.[32] Under Article 6(1) while there is a margin of appreciation enjoyed by contracting states, the limitations applied must not restrict or reduce the access left to the individual to such an extent that the very essence of the right is impaired.[33] In addition, the limitation will not be compatible with Article 6(1) if it does not pursue a legitimate aim and if there is not a reasonable relationship of proportionality between the means employed and the aim sought to be achieved.[34]

The 1945 Act contains a restriction (section 260) on taking civil action in connection with detention and, because it is regarded as a curtailment of the constitutional right of every individual to have access to court, such legislation must be strictly construed in the sense

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[30] Department of Health and Children, *Report of the Inspector of Mental Hospitals for year ending 2003,* Government Publications, Dublin, 2004.
[31] Schizophrenia Ireland *A Question of Choice Service Users Experience of Medication and Treatment* (Dublin 2002) Amnesty International, *Mental Illness The Neglected Quarter,* Dublin, 2003.
[32] *Murphy v Greene* [1990] 2 IR 566.
[33] *Ashingdane v United Kingdom* (1984) 7 EHRR 528 para 57.
[34] *Ibid.*

that it must not be availed of, except where it is essential to do so.[35] Leave to take civil action will be granted by the High Court if there are substantial grounds for alleging bad faith or want of reasonable care. The Irish courts have stated that that the standard of reasonable care under the Act may be quite different from such standard in ordinary medical practice.[36] Only four cases have succeeded in being granted leave based on lack of reasonable care: where there was a failure to carry out any examination or offer a second opinion, where the recommendation for the detention was out of date, where telephone conversations were held not to form part of the actual examination for the recommendation for detention and for failure to diagnose.[37]

In a constitutional challenge to the section in *Blehein v. Minister for Health & Children, Ireland & Attorney General,* the plaintiff argued successfully that section 260 was a legislated breach of the separation of powers and independence of the judicial function. The High Court held that this restriction constituted an impermissible interference by the legislature in the judicial domain, contrary to the Constitution, and that the legislature was not entitled to limit access to the High Court on specific grounds as contained in section 260.[38] This means that the High Court will grant leave where it is satisfied that there are substantial grounds for doing so, thereby making it easier for mental health patients to take civil action and for accessing court. Under the 2001 Act, the burden of proof has been reduced to reasonable grounds creating a more favourable situation for the applicant. Applying the decision in *Blehein* to the 2001 Act means that the High Court can grant leave if satisfied that no reasonable grounds exist that the proceedings are vexatious or frivolous. The burden will remain on the applicant to show the application is reasonable and it is likely that this aspect will meet Article 6 requirements on access to court. The failure to exclude public authorities from the section is disproportionate to the aim of protecting individuals involved in the detention. Neither Act has any express provision for legal aid in taking civil actions and, having regard to the reasoning in *Airey*

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[35] *B. v. Gallagher* [1995] 2 ILRM 433, *Murphy v Greene* [1990] 2 IR 566.
[36] *Murphy v Greene* [1990] 2 IR 566 per McCarthy J p192.
[37] *Kiernan v. Harris, Midland Health Board & Ors* [1998] IEHC *71 Melly v. Moran & North Western Health Board* 12th May 1998 *Bailey v. Gallagher* Unreported Supreme Court 28th May 1998, In *Manweiler v. Bourke & HSE Eastern Region* Unreported High Court, March 2005, Unreported Supreme Court, September 2005.
[38] *Blehein v. Minister for Health & Children, Ireland & Attorney General* [2004] IEHC 374 p5.

v. Ireland, the right of access to court must be effective.[39] The failure to provide a comprehensive civil legal aid system directly impacts on effective access to court and, taking into account the particular vulnerability and powerlessness of persons with mental disorders, this potentially transgresses the very essence test by destroying access resulting in a breach of Article 6.

Chapter Six considered the ward of court system as it applies to the removal of legal capacity to manage one's person or property. At the opposite extreme is the enduring power of attorney as an example of an advance directive in anticipation of incapacity, which was considered as were the Law Reform Commission proposals for a comprehensive system for the protection of vulnerable adults.[40]

The removal of legal capacity for decision making under the ward of court system by the High Court, which protects and manages the property and person of legally incapacitated individuals, is extreme and automatically divests the individual totally of decision-making capacity through a court procedure and usually lasts for life.[41] The consequences are so severe that the procedure is avoided where possible and this results in many informal and arbitrary interventions in managing the property of the individual in the absence of a less extreme measure. The Lunacy Regulation (Ireland) Act 1871 does not deal with specific issues related to welfare, such as the withholding of medical treatment, although the right to protection in wardship is not limited to the protection of property.[42] The High Court relies on either the *parens patriae* principle or the inherent jurisdiction under the Constitution to make these decisions.

The criteria for entering wardship require that the person must be of "unsound mind" and must also be "incapable of managing his person or property." The assessment is open to a broad interpretation of incapacity and the term "unsound mind" is not defined. It is left to the discretion of medical experts, even though a specialist assessment is not required.

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[39] *Airey v. Ireland* (1979) 2 EHRR 505.
[40] Law Reform Commission, *Law and the Elderly* (LRC CP-23 2003) recommends the abolition of the system and replacement with a whole new system.
[41] The ward may be permitted to make a will.
[42] *In re D (Midland Health Board Wardship application)* [1987] IR 449.

These factors, along with the failure to take account of the ward's or carer's wishes, may well transgress the proportionality requirement in Article 6. The capacity assessment for entry to wardship is a general one, rather than issue specific, and where the criteria are satisfied autonomy is removed. This would seem to be disproportionate to the aim of protecting the property or welfare of the individual and not in keeping with functional approach and the least restrictive alternative or proportionality principle. There is no statutory requirement to have a legal representation, though in practice this is ensured. The ward may be able to make a will if the High Court confirms that he has testamentary capacity to do so based on medical evidence and the opinion of his solicitor.

The legislation imposes a mandatory duty on medical and legal visitors to visit the ward, but this is not done due to lack of resources. Clearly, this is a breach of statutory requirements, perhaps causing people to remain in wardship longer than necessary. The wards who are in psychiatric detention have no specific rights under either the 1945 or 2001 Acts, particularly with regard to review of detention. This is in breach of Article 5(4) and also raises Article 14 issues, unless the difference in treatment can be justified. The length of time to complete a wardship application is regarded as too long at a minimum of three months and may not comply with the speedy requirement in Article 6. There is no automatic review of continuing wardship and the presumption of continuing incapacity is no longer acceptable, but there is no guidance on the level of capacity necessary for discharge from wardship. This is obviously an arbitrary approach to continuing incapacity and may not be justifiable as being proportionate to the aim of the protective jurisdiction.

The Power of Attorney Act 1996 provides for an enduring power of attorney permitting a measure of control by an adult in anticipation of future incapacity. This power is limited to property and finance and personal care decisions that specifically exclude health care decisions.[43] While the High Court has general supervisory powers in relation to enduring

[43] Powers of Attorney Act 1996 Section 4(1), the definition of personal care includes, where the donor should live and with whom, whom the donor should see and not see, the training and rehabilitation the donor should get, the donor's diet and dress, the right to inspect the donor's papers and housing, social welfare and other benefits for donor.[43]

powers of attorney, there are concerns about the lack of supervision of attorneys. Although some safeguards exist, these are not adequate to ensure that those appointed act in the best interests of the incapacitated person. Some of these issues are the subject of current law reform.

The Law Reform Commission (LRC) recognises the need for change in relation to decision making and vulnerable adults.[44] These reforms propose to replace the wardship system with a comprehensive structure that will assess capacity, enhance and enable decision-making capacity and provide proxy decision-making where necessary. The LRC propose that the law on capacity should reflect capacity, rather than incapacity, ensuring that it would be enabling, not restrictive, in nature and, therefore, compliant with constitutional and human rights standards.

Right to life

Chapter Seven considered the positive obligations on the State under Article 2 that arise in relation to the protection against unlawful killing by agents of the state[45] and the protection against unlawful killing by non-state agents, such as other patients or prison in-mates.[46] The obligation also requires protection against suicide in particular circumstances where the risk is known to the state[47] and protection of the public against the known risk from a mentally disordered person.[48] These obligations increase in relation to people with mental disorder in detention. Obligations arise in relation to the investigation of such deaths and to ensure family involvement in inquiries. Hospitals are obliged to establish an effective judicial system for ascertaining the cause of a death in hospital and any liability on the part of the medical practitioners concerned.[49] In the

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[44] Law Reform Commission Consultation Paper, *The Law and the Elderly* (LRC CP 23–2003).
Law Reform Commission Consultation Paper, *Vulnerable Adults and the Law: Capacity,* (LRC CP 37-2005).
[45] *McCann v. United Kingdom* 31 EHRR 97.
[46] *Edwards v. United Kingdom* (2002) 35 EHRR 19.
[47] *Keenan v. United Kingdom* (2001) 33 EHRR 38 para 92.
[48] *Osman v. United Kingdom* (2000) 29 EHRR 245 para 56.
[49] *Erikson v. Italy* 29 (2000) EHRR CD 152 p7.

context of prisoners, the authorities are under a duty to protect vulnerable mental health patients.

The 1945 Act mandates that a report on the death of any patient in a mental institution be given to the coroner within twelve hours of the death.[50] There is no obligation to hold an inquest if the coroner is satisfied the death is due to natural causes. There is also an obligation on the hospital to inform the inspector of mental hospitals about the death.[51] There is no express provision in the Coroner's Act 1962 requiring the family of the deceased to be in attendance at the inquest, but the rules of constitutional justice require that the family be given the opportunity to be present at the inquest.[52] Drug prescribing and hospital deaths has been highlighted in reports from the Inspector, who emphasised the need for caution by having thorough examination and review of medication and side-effects and avoiding polypharmacy.[53] The protection of patients from the fatal side effects of prescribed medication may engage Article 2 where their physical vulnerability is a known factor. The 2001 Act does not have specific obligations, like the 1945 Act, to report deaths to the Department of Health and Children or to the Mental Health Commission.

The General Prisons (Ireland) Act 1877 provides that the coroner must allow sufficient time for the attendance of the "nearest relative" at an inquest.[54] These provisions are in keeping with the obligations under Article 2 and provide that the family do not have to initiate the involvement.[55] There is a mandatory requirement to have an inquest into the death of every prisoner.[56] The word "prison" is interpreted widely and includes the death of a person in Garda custody. In practice, such deaths are normally reported to the coroner and a post-mortem and inquest will always be held. There is some evidence that

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[50] Mental Treatment Act 1945, section 268.
[51] *Ibid,* section 272(e).
[52] *State (McKeown) v. Scully* [1984] ILRM 133.
[53] Department of Health and Children, *Report of the Inspector of Mental Hospitals for year ending 2001*, Government Publications, Dublin, 2002, p12.
[54] General Prisons(Ireland) Act 1877, section 56.
[55] *Edwards v. United Kingdom* (2002) 35 EHRR 5 para 69.
[56] General Prisons(Ireland) Act 1877, section 56.

not all such deaths are actually reported, which would raise Article 2 obligations.[57] The obligation requires the state to account for any injuries suffered and this involves an even greater obligation when the person dies.

In the recent Barr Inquiry, the test applied in an inquest into the shooting dead of a man who had a history of depression by Gardai was whether the killings were "reasonably justified," which is a lower and less stringent standard than the "absolutely necessary" standard in Article 2.[58] There is considerable doubt as to whether the actions of the Gardai could have met the Article 2 test of "absolutely necessary" or that the actions were proportionate to the actual threat involved.[59] It remains with the final report to ascertain whether the Article 2 test is satisfied in the case.

Right to marry

Chapter Eight considered the right to marry under Article 12, which raises two important issues: the restrictions imposed on people who have a mental disorder, and consideration of the limitations on people exercising reproductive rights that include a right to a sexual relationship and a right not to be sterilised. Article 12 overlaps with Article 8 in these private and family life areas. The rights guaranteed in national law must recognise the right to marry and found a family in principle and this right is confined to legally formalised heterosexual relationships.[60] Any restrictions on the right must be for a legitimate purpose, must be proportionate to the aim of the restriction and must not impair the very essence of the right.[61] A narrow margin of appreciation is granted to national authorities in matters involving intimate aspects of private life, such as the right to sexual relationship, to marry and found a family.[62]

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[57] Browne, "Inaccurate Garda records on deaths in custody", The Village Magazine, 8th -14th July 2005 p5.
[58] Irish Council for Civil Liberties, *Submission to Joint Oireachtas Committee on Justice, Equality, Defence and Womens' Rights on the Garda Investigation of the Shooting of Mr. John Carthy at Abbeylara on 20th April, 2000* 30th November, 2000.
[59] As of February 2006 the final report has not been published.
[60] *Rees v. United Kingdom* (1987) 9 EHRR 56. *Hamer v United Kingdom* (1982) 4 EHRR 139.
[61] *Cossey v. United Kingdom* (1990) 13 EHRR 622.
[62] *Norris v. Ireland* (1989) 13 EHRR 186, *Dudgeon v. United Kingdom* (1982) 4 EHRR 149.

The Constitution recognises the right to marry and the right to procreate, but it can be limited in specific circumstances. The equality provision of the Constitution expressly permits the State to have due regard to difference in capacity and social function. The loss of capacity does not result in the reduction of personal rights, including the right to privacy and self-determination.[63] The common law understanding of the nature of marriage is not pitched at a high level. The appropriate test to be applied is whether the person had the capacity to marry and to understand the nature of the marriage contract, and was mentally capable of understanding the duties and responsibilities that normally attached to marriage.

There is a statutory prohibition on wards of court entering marriage. Article 6(1) requires that any limitations on this civil right be proportionate to the aim of protecting incapacitated people and the restrictions must not be such that the very essence of the right to marry is impaired. Some people who are wards of court might be able to understand the nature of the marriage contract. The Law Reform Commission has recommended that the statute be repealed due to being over inclusive and may well breach Article 12 as destroying the very essence of the right to marry.

A related right to sexual relations and to found a family are important aspects of Articles 8 and 12 rights. A sexual relationship with a person who is "mentally impaired" is a crime, unless they are married to one another, subject to a defence of not knowing of the impairment. The definition of mental impairment is unsatisfactory as it is based on the ability to lead an independent life. The effect is that, apart from marriage, a sexual relationship between two mentally impaired people may constitute a criminal offence, as there is no defence of consent where both are presumed to give real consent. These barriers may be disproportionate to the aim of protecting against exploitation and may transgress Article 8 rights to privacy in sexual relationships, unless the restrictions can be justified.

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[63] *In re a Ward (Withdrawal of Treatment)* [1995] 2 ILRM 401.

Compulsory sterilisation or abortion are interferences with the right to found a family in Article 12, and Article 8 could well be engaged in this regard in relation to the right to respect for private and family life.[64] The focus for justification in cases of non-consensual sterilisation should be on the rights and interests of the individual, rather than on broader issues, like "benefit to society," in order to comply with Article 12. Generally, in other jurisdictions, a distinction is drawn between therapeutic and non-therapeutic sterilisation, with leave of the courts being necessary for non-therapeutic sterilisation for a mentally disabled person.

Children

Chapter Nine considered the admission and treatment of children and necessitated a separate chapter due to the application of additional statutes to children and also the dominant role of parental authority.[65] The admission and treatment of children with mental disorders and the minimalist approach by the 1945 and 2001 Acts to safeguarding both their Article 5 rights and their Article 8 privacy rights, as well as exposing them to the possibility of inhuman and degrading treatment under Article 3, were considered. By virtue of the powerful protections that the family in Ireland as a unit receives, there is a near-automatic presumption that parents' rights cannot generally be interfered with by the courts where the risks are minimal.[66] The children of parents, who have a mental disorder and are not receiving care or treatment resulting in severe neglect of the family or even mental disorder in the children, may engage Article 3 where the state had or ought to have had knowledge of the neglect.

Parental involvement is limited to making voluntary admission applications under both Acts. Under the 2001 Act, a detention order can only be made by the court where the parents refuse to consent to an examination or cannot be found. The District Court can, exceptionally, make an order for detention without a medical report, but there is no

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[64] *In re D (Application by the Midland Health Board)* [1988] ILRM 251.
[65] *Nielsen v. Denmark*, (1988) 11 EHRR 175.
[66] Martin F., "Parental Rights to withhold consent to medical treatment for their child: A conflict of Rights", (2001) 7 *ILT* p114-119 at 117.

specific time scale in the legislation for its provision or the period a child (under 18 years) might be in detention pending a final determination. Where there is no "objective medical expertise" confirming mental disorder, unless there is an emergency, this could engage Article 5(1). There is no statutory right to legal representation for the child, contrary to international human rights law.[67] The 2001 Act does not make provision for children who are detained to choose to be voluntary, in contrast to adults and in keeping with the least restrictive alternative. The rights applying to adults with regard to information do not apply to children, even taking account of age and understanding. Parents will have to be given the opportunity to be involved in the decision-making process to avoid a breach of their Article 8 rights, unless exclusion can be justified under Article 8(2). Similarly, there is no provision in the Act to give parents copies of court orders or to give them to the capable child.

The place in which children are admitted and treated is significant where it fails to satisfy the relationship of proportionality between the grounds of permitted deprivation of liberty relied on and the place and conditions of detention.[68] Adult wards with no specialist facilities, where there is no clear benefit to the child so as to satisfy the proportionality requirement, may well breach the child's Article 3 rights to be protected from inhuman and degrading treatment or, if not, could breach Article 8 and the child's right to respect for privacy.[69] In the 2001 Act, the District Court, in making a detention order, is not required to take "benefit" into account. In relation to adult detention, "benefit" must be considered and such difference in application, without objective or reasonable justification, could well engage Article 14.

Children, despite being voluntary patients, are often not given choices in admission and treatment and the Court stated that the right to liberty is too important for a person to lose the benefit of the Convention because he has been compliant in admission, especially

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[67] Council of Europe, Committee of Ministers, *Recommendation (2004) 10 on the protection of the human rights and dignity of persons with mental disorder*, Article 29(3).
[68] *Aerts v. Belguim* (2000) 29 EHRR 50. See also, Department of Health and Children, *Report of the Inspector of Mental Hospitals for year ending 2003,* Government Publications, Dublin, 2004, referred to the increasing number of children in adults wards, some as young as 11 years.
[69] *Op. cit.*, 67 Article 29(4).

when he does not have the capacity to consent to what is proposed, nor can those in this situation be treated the same as consenting capable adults. Children can only be admitted as voluntary patients under the 1945 Act with the consent of their parents.[70] Parents can give written notice of their intention to remove the child and they are then at liberty to do so, subject to the provisions of the Child Care Act 1991 where there is a risk to the child. The child has no express rights in terms of leaving hospital or refusing treatment, she is effectively under the control of the hospital staff and is *de facto* detained.

The statements of the Court in *HL v. United Kingdom* and in *Storck v. Germany* apply when children are subject to the extreme control necessary to establish a deprivation of liberty and require the state to provide supervision and control over detention by private individuals which would apply to parental action. These decisions confirm state obligations to provide effective review and supervision of all such admissions to ensure Articles 5 and 8 are not violated.[71] The Court, in *Storck,* referred to the obligation on the state to secure to its citizens their right to physical integrity under Article 8 of the Convention. The Court may have had in mind a wider application than psychiatric facilities to include residential centres, where children with intellectual disability are found to be deprived of their liberty without authorisation. The common law applies to consent to treatment for voluntary admission with parents giving proxy consent. Human rights standards require that the opinion of the minor be taken into consideration as an increasingly determinative factor in proportion to age and maturity, although commentators have recognised that Article 8 rights to self determination do not feature in case law.[72]

Children have no self determination rights regarding treatment under either the 1945 or the 2001 Acts. The 2001 Act has no requirement for any children to be consulted in relation to any matter, including consent to treatment. When children are detained, medication can be given to the child for three months without any reference to a second

[70] Mental Treatment Act 1945, section 191(3).
[71] *HL v. United Kingdom* (2004) 40 EHRR 32. Application no. 45508/99 5th October 2004 para 120, *Storck v. Germany* Application no. 61603/00 16th June 2005 and *Nielsen v Denmark* (1989) 11 EHRR 175.
[72] Article 12 of the Convention on the Rights of the Child and Article 6 of the Convention on Human Rights and Biomedicine Human rights

opinion safeguard until three months have elapsed. This second opinion does not guarantee independence, nor is there any requirement that it might be authorised in the first instance by a child psychiatrist, with a second opinion from another child psychiatrist. This provides a lower standard of protection than applies to adults, who at least are asked to consent. It is arguable that the "stabilising period" of three months is excessive, particularly where severe medications are used. The decision to use force may involve a balance between continuing treatment, which is forcibly opposed, and deciding not to continue with it. The court must approve psychosurgery and ECT, but there is no detail on what reports are required by the court in an area where independent opinions and representation are essential. The Act fails to consider the capacity of a 16 year old, yet common law decisions and statutes permit consent at this age and most 16-18 years are competent to consent.[73] This is also out of step with human rights standards that the opinion of the minor should be taken into consideration as an increasingly determining factor in proportion to his or her age and degree of maturity.[74] As a result of this sparsely drafted law, it is likely that there will be unwarranted interference with the Article 8 rights of children, unless such interference are convincingly shown to be necessary.[75] The treatment of older children under the Act is particularly vulnerable to a breach of Article 8, taking into account both the decision in *Storck* and the requirement of proportionality.

Other aspects of Article 8 rights, such as confidentiality, not specifically included in the Act, may be raised where conflicts arise and the older child does not want information disclosed to family, even when he is living with them. The information should be limited to what is necessary for the particular task in order to comply with Article 8(2).

Conclusion

The findings of this thesis clarify the areas of mental health law that breach Convention requirements in both Acts and highlight the areas of the 2001 Act that need special

[73] *Gillick v. West Norfolk and Wisbech AHA* [1985] 3 All ER 402, Non. Fatal Offences Against the Person Act 1997, section 23.
[74] Convention on Human Rights and Biomedicine Article 6(2).
[75] *Herczgefalvy v. Austria* (1993) 15 EHRR 437.

attention as a priority. It is clear that the 1945 Act is in breach of the Convention to a significant extent and seems not to meet the requirements on several important grounds, such as non-compliance with *Winterwerp* and failure to respect rights of self-determination for all patients. The findings show the urgent need to introduce the 2001 Act under which many of these compliance problems will be resolved. However, many other aspects of the Act will continue to breach the Convention, such as, the exclusion of wards from the right to review and the total failure of the 2001 Act to recognise the incapacitated voluntary patient. Significant work will have to be done to ensure that the vague provisions in the Act are clarified sufficiently to comply with the Convention. The rights of children need specific attention in almost all aspects under the Convention due to the failure to have even the most minimal protections in the Act. Even if Ireland does achieve compliance with the Convention, it still is only a minimum standard that confines itself mainly to civil and political rights.

The 2001 Act provides for a review of its operation in 2007, so that the deficiencies with regard to the Convention can be addressed and necessary amendments made to the Act.[76] The issue of capacity and the failure to recognise the incapacitated voluntary patient need to be addressed and safeguards introduced to apply to all aspects of their care and treatment. The safeguards should include regular monitoring of treatment with an element of independent representation. The rights of children and appropriate procedures and safeguards need to be introduced as a priority because currently, there are no effective safeguards to protect Convention rights. These should include independent second opinions, the involvement of child psychiatrists and a re-examination of the lack of safeguards for medicine for three months to apply to both adults and children. The impact of drug treatment practices like polypharmacy and powerful neuroleptics on adults and children, is recognised. Greater accountability is needed for outcomes of such practices, particularly where the person dies. Clear breaches of the Convention by the 2001 Act need to be addressed such as exclusions of categories from review mechanisms and the requirement to shift the burden of proof in the Circuit Court appeals from tribunal decisions.

[76] Mental Health Act, section 75.

The final question remains as to why it has taken so long to have law reform in this area. There are many reasons for this delay, the lack of a service-user movement to drive reform, a paternalistic state approach to mental health care and little recognition of human rights obligations, perhaps foremost among them. The Irish government has managed to avoid contentious proceedings by agreeing to the introduction of the 2001 Act. This Act is now partially in force, but key parts have not been implemented. Ultimately, if these parts are not introduced, the chances are that there will be further applications to Strasbourg or to the Irish courts to enforce the legislation and conform with human rights obligations.

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