



SCOTTISH EXECUTIVE



**Making the Connections:
Human Rights and Mental Health
Edinburgh 5-8 March 2006**

Seminar Report

Charlotte MacDonald

Executive Summary	3
Day 1	5
Introduction – Alan Miller.....	5
Wales – Phil Fennell.....	6
Northern Ireland – Kevin McLaughlin.....	7
England – Camilla Parker.....	7
Scotland – Donny Lyons.....	8
Human rights and mental health care in Australia.....	10
The experience of Mental Health and Human Rights in the Egyptian Context.....	12
Human Rights and Mental Health Care in Europe.....	13
Mental Well Being and Human Rights: Indian Perspectives.....	15
A perspective from Nepal.....	15
Day 2	17
Visit to Redhall Walled Garden.....	17
Visit to Carstairs State Hospital.....	17
Workshop 1: Recovery: Raising Awareness and Expectations.....	18
Workshop 2: Individuals – Listening, involving and advocacy.....	19
Workshop 3: Communication and access to information.....	20
Day 3	22
Workshop 4: Consultation and development of legislation.....	22
Report back, discussion and future thinking.....	25
Annexes	27
1. Seminar Participants	27
2. Presentations	30
Phil Fennell – Convention Compliance, Public Safety, and the Social Inclusion of Mentally Disordered People.....	30
Dr Sev Ozdowski OAM – Human Rights and Mental Health in Australia.....	51
Gael Robertson – a perspective from Nepal.....	72
Simon Bradstreet – Recovery: Raising Awareness and Expectations.....	73
Graham Morgan – Individuals: Listening, Involving and Advocacy.....	74

Executive Summary

The seminar took place in Edinburgh in March 2006 against a background of new Scottish mental health legislation. The Mental Health (Care and Treatment) (Scotland) Act 2003 was implemented in October 2005 and is based explicitly on a set of Principles designed to uphold the human rights of people with mental health problems and learning disabilities. Participants from around the world heard about the legislative process in Scotland and visited mental health services.

Seminar presentations covered the experience of mental health services in diverse countries. Workshops examined different approaches to changing attitudes to mental health and there was lively discussion on the theme of connections between mental health and human rights. This brief summary seeks to distil the presentations and discussions by highlighting particular themes recurring throughout the 3 day event. A full report is also available. Participation in the legislative process by the people most directly affected is an effective way of ensuring that human rights are at the core of mental health law.

The Scottish experience has demonstrated the value of including service users and carers alongside professional and other groups in the legislative process. The new Scottish law is regarded as a model of progressive legislation for achieving a balance between human rights and public safety. Because the principles on which the Scottish law are based are made explicit, medical practitioners can be required to justify their treatment decisions in terms of the Principles. This is the outcome of a thoroughly participative process. But human rights do not happen on paper. Legislation alone cannot change the culture of services.

The stigma of mental illness is a major barrier to progress in human rights. Stigma may be generated by society, by family and caregivers and by the self. In some developing countries, the stigma of mental illness is so powerful that family members lock up their own relatives who are ill. Adequate resources and commitment to changing attitudes are needed.

Litigation is one way of highlighting systemic problems in mental health services

There has been some success in Eastern Europe in forcing changes to services through litigation but legal incapacity is a major barrier. Stigma also prevents people from taking their case to court. Information on case law is available but not widely disseminated.

Human rights legislation has to be backed up with adequate resources and political will.

Securing human rights requires investment in high quality services, medicines, training and education to change attitudes. The closure of institutions should lead to the transfer of resources to community-based services. This lesson was learned in Australia where mental health services were starved of funds for 12 years following deinstitutionalisation.

Mental health service users' experience of services throughout the world is generally negative in spite of the existence of international law, including the European Human Rights Act, and domestic legislation aimed at protecting the rights of people with mental illness. Evidence from the more developed countries showed that, even with legal safeguards and greater resources, services were slow to address human rights issues in mental health. A recent review in Australia revealed serious deficits in services for young people and low levels of spending on mental health compared with other countries. One participant argued that as long as compulsion is an option for dealing with mental health problems, the incentive to radically improve services is lacking.

Mental health should be a priority on the international Human Rights agenda

In some of the countries represented at the seminar, human rights for people with mental health problems are non-existent. Different reasons account for this in different countries. They include war, extreme poverty, conservative and religious attitudes and a tradition of neglect of human rights in totalitarian regimes.

Degrading and non-therapeutic conditions continue to exist in institutions. Legal incapacity is the main barrier to promoting human rights in many of the ex-Warsaw Pact countries of central and Eastern Europe. It is normal there for the directors of 'social care homes' to assume Guardianship of residents who have no recourse to independent advocacy or representation.

International action is needed to end discrimination against people with mental health problems

The international development agenda ignores mental health and its interconnections with physical health. People with mental health problems are discriminated against because of the gulf between facilities to treat mental illness and those to treat physical illness. They are also discriminated against by being subject to compulsion when they have mental capacity.

The inclusion of mental health issues in the draft UN Convention on Disability is a positive step towards protecting people with mental health problems from discrimination.

Day 1

The first day included papers from a wide range of countries represented at the seminar. It started with a panel made up of a speaker from each of the four countries of the UK. This was followed by papers on Australia, Egypt, Eastern Europe, India and Nepal. Presentations were followed by questions and discussion. In the afternoon, participants continued the discussions in workshops.

Introduction – Alan Miller

Mental health was the subject of the very first piece of legislation enacted by the Scottish Parliament after it was established in 1999. This was prompted by a challenge to the existing mental health law by a patient in Carstairs high security hospital who claimed that he could not be legally detained if no treatment were available for his condition. The Scottish legislative response to this challenge was to make it possible to detain people in such circumstances if they posed a risk to public safety.

The debate which ensued about the balance to be struck between public safety and human rights became the central focus of the Millan review of Mental Health Law. The cultural shift signalled by Millan was reflected in attempts to generate a new culture of human rights awareness in the regime at Carstairs in advance of any new legislation. The Millan review laid the basis for the Mental Health (Care and Treatment) (Scotland) Act 2003, which is regarded as a very progressive piece of legislation.

Against this background, it is clear that the connections between mental health and human rights are a live issue in Scotland and we are keen to share our experiences with other countries.

Wales – Phil Fennell

Unlike Scotland, Wales remains subject to Westminster legislation in the health and social care fields although it has devolved responsibility for implementing legislation.

There are three competing mental health policy agendas in England and Wales:

- The human rights agenda as enshrined in the 1998 European Human Rights Act
- The social inclusion/ anti-stigma agenda reflected in ‘soft law’ e.g. codes of practice, national service frameworks
- The public protection agenda enshrined in the 1983 Mental Health Act

User and carer organisations have over the last 10 years “battled for the soul of mental health legislation”, trying to put social inclusion and anti-stigma at the head of new legislation. But in England and Wales, the dominant thrust has come from concern about homicides by mentally disordered people. Service users and carers have felt that the language used in the two recent draft bills have portrayed them as a threat to society. Many feel that the Scottish legislation is more attractive.

Human Rights has tended to be viewed in the negative sense as the obligation of the state not to interfere unless certain criteria are met. This is contrasted with a positive interpretation of the law as in *Storck v Germany* where it was successfully argued that the state was obliged to intervene to protect an individual from interference in their private life by others [this was the case of a young girl who was placed by her father in a private hospital and compulsorily detained without any judicial process as required in Germany]. This case represents an important development in human rights law. It established that a patient is entitled to more than simply medication.

In Wales, the provision of psychology and psychotherapy lags behind that of England with waiting times of up to four years. The closure of institutions creates the need for adequate community-based support for patients and their carers. Without this support people can be condemned to a life of isolation and stigma.

Northern Ireland – Kevin McLaughlin

The Northern Ireland Human Rights Commission was formed against a background of the Good Friday agreement and the Northern Ireland Act of 1998. It is committed to measuring law, policy and practice against internationally accepted rules and principles of human rights.

In December 2003 the Commission published *Connecting Mental Health and Human Rights* by G Davidson, M McCallion and M Potter

(http://www.nihrc.org/documents/pubs/inr/mentalhealth_HR.pdf). The report's recommendations include:

- a definition of 'mental disorder' enshrined in law and consistent with Article 5 of the ECHR
- automatic review of detention within 28 days by a Mental Health Review Tribunal
- legislation to protect people with capacity from being treated against their will
- legislation to protect people with incapacity

Following a review of mental health and learning disability, the Commission has produced a draft report calling for a stronger role for mental health promotion within health administration. The report will be published shortly and is expected to produce recommendations covering human rights issues.

England – Camilla Parker

The 1998 Human Rights Act may have influenced mental health law but how much effect has it had on people's experience?

People with mental health problems do not make up an elite club – we may all join at any time. Mental illness and stress related conditions are the most common cause of sickness absence and the connection between long term unemployment and mental ill health is now recognised at policy level.

The Human Rights Act has brought positive change in terms of clarification on 'nearest relative', burden of proof and detention and increased judicial scrutiny. But many patients have limited access to justice. Dissemination of case law is essential.

Evidence that the HRA has brought cultural change is harder to come by. I wonder whether it has made any difference at all in the light of recent surveys on inpatient services. Mind's Ward Watch (2004) and the Healthcare Commission

(2005) produced quite disturbing findings. Concerns about care don't apply universally but there is evidence that the experience of using services is likely to be quite negative.

England's funding for tackling stigma and discrimination at national level is well below that of Scotland. Spending on the See Me campaign in Scotland is 13p per head of population whereas the English campaign 'Shift' will cost only 1.5p per head.

The development of community based services is necessary to implement the UN, EU and Council of Europe recommendations that flow from the Human Rights Act.

The principles for mental health legislation which come out of Human Rights instruments are not controversial but they challenge the reality of services. Human Rights should be a benchmark for assessing quality of care. People making decisions should be ready to justify those decisions in a human rights context.

People with mental health problems must be included in anti-discrimination measures for disabled people.

Scotland – Donny Lyons

Respecting the rights of the individual lies at the heart of The Mental Health (Care and Treatment) (Scotland) Act 2003.

The Act adopted a broad definition of mental disorder which excludes the misuse of drugs and alcohol. The inclusion of learning disabilities in the definition causes some distress. However the Act adds other criteria to be met before compulsion is allowed: there must be treatment available, if treatment is not provided there would be significant risk to the patient or others, the patient must have significantly impaired decision making powers, and compulsion must be necessary. Full details of the Act are available at www.mwcscot.org.uk

The new Mental Health Act strengthens patients' ability to challenge compulsory measures by providing safeguards to protect their interests. Under previous legislation, once a person was subject to compulsion they had few rights. An advance statement may be overridden at the discretion of the medical practitioner who is required to give reasons to the Mental Welfare Commission. The Commission is taking a close interest.

The new Act is intended to shift the balance of power in favour of patients and carers. It is based on a set of explicit Principles developed by the Millan Committee which are designed to protect the human rights of patients.

The anti-stigma campaign in Scotland 'See Me' has been well received with posters and TV advertisements dealing with issues such as self-harm and schizophrenia. Information on the campaign can be found at www.seemescotland.org.uk

The Adults with Incapacity (Scotland) Act 2000 is also based on human rights principles. It protects the interests of people with incapacity for whom the Mental Health Act is not relevant.

Questions and comments for the panel

The panel were asked what one thing they would change about the mental health scene in their country. Here are their replies:

- Change attitudes to people with mental health problems
- Recognition that the issue is one of health and not public order
- Make sure that the Home Office and the Department of Health (Westminster government) learn to talk to each other
- Improve the quality of inpatient accommodation
- Include mental health issues in disability anti-discrimination policies and practice

One participant questioned whether we need compulsion at all. People with mental health problems are treated differently from people with physical illnesses by being subject to compulsion. No one worries about the traumatic effects which compulsory care may have on people.

Human rights and mental health care in Australia **Sev Ozdowski**

www.humanrights.gov.au

Ratification of human rights treaties represents a commitment by governments to their own people. The role of the Australian Human Rights and Equal Opportunity Commission (HEROC) is to promote public debate and political accountability on how well Australian governments deliver on those commitments.

The Burdekin Inquiry (1993) found that the care and support provided by the Australian health care system contravened the basic human rights of mentally ill people. While institutions were being closed down, community services were not being adequately built up. The Inquiry contributed to the creation of the National Mental Health Strategy which for the first time gave the federal government a role in funding and giving a lead in mental health services. The Burdekin Inquiry also contributed to law reform initiatives and changing perceptions of mental illness. An evaluation found significant progress had been made in incorporating human rights standards in the mental health legislation of all Australian states and territories.

Despite the initial good response, reforms stalled and mental health budgets flattened over the years following Burdekin. HEROC Consultations in 1998 provided disturbing evidence about how little had changed in practice. Lack of community based services was the main issue. Community treatment orders often amount to nothing more than a fortnightly injection with inadequate case management and review. Also, NGOs have been concerned that people with mental health issues were having their benefits cut for failing to meet requirements such as attendance at job interviews.

National Inquiry into Children in Immigration Detention (CIDI)

The Convention on the Rights of the Child is the most widely adopted Convention in the history of the UN. It allows detention of children only as a last resort. However the Inquiry found that long term detention was leading to deterioration of mental health and that continuing to detain people who needed treatment amounted to “cruel, inhumane and degrading treatment” by the government.

As a result of the Inquiry, all children have now been removed from detention centres – a testimony to the strength of international human rights law and to the strength of Australian civil society. However, refugees who continue to suffer mental illness following their release from detention have reported that they had experienced major problems accessing mainstream mental health services.

“Not for Service” review (2004-5)

As a result of these persistent reports, as Disability Discrimination Commissioner, I decided to conduct national consultations to establish how accessible mental health services are to the general public. The national consultations clearly illustrated the major failure of the Australian mental health system and placed the issue of mental health services back on the national agenda.

Two general points emerged from the consultations which formed the review. Firstly, widespread use of common drugs such as cannabis, amphetamines, alcohol and ecstasy has contributed to an increased rate on mental illness among young people. Secondly, as well as the general lack of services, there was a huge shortage of services catering for young people. Specific findings cover the low level of spending on mental health compared with other countries, failure to deliver early intervention programmes for young people, failure to treat dual diagnosis involving drug addiction, lack of treatment facilities specific to children, inadequacies in emergency and acute services, lack of supported accommodation, neglect by medical services of the physical health of patients, use of prisons and the police to care for people with mental illness, stigma and discrimination, service provision in remote areas and lack of access for indigenous and non-English-speaking Australians.

The extent of the problem is clear and so is the solution. As a result of the national consultations things have started to change with some political leaders placing mental health reform high on their agenda. Both Federal and state budgets have been significantly increased. For example the Federal Government committed an additional A \$1.8 billion of new money to mental health over the next 4 years.

People with mental health problems do not make a powerful political lobby. Human rights instruments can help by setting standards and national human rights bodies can help to make the voices heard of people affected by mental illness. International monitoring bodies can also help governments with human rights issues. People with mental health problems need their human rights protected more than any other group of people.

Questions and comments

People with mental illness have not been involved enough in formulating human rights principles that impact on their daily life. There is a need for transparency. As institutions are closed and there is a lack of community resources, people will take desperate measures to get admitted to hospital.

Is there a case for taking mental health out of the care and treatment box and locating it in the human rights arena? The speaker agreed that a human rights approach to mental illness may bring positive outcomes. It gives proper standing and dignity to people with mental illness. But care needs to be taken - total

removal of the mental illness label may result in physical illness taking over the vast proportion of national health budget and may undermine availability of services for people with mental illness.

There is UN concern about human rights and mental health across the board, not just in one or two countries.

In Australia, nurses were not properly trained for working in the community after hospitals closed. Also funding was not ring-fenced.

The connection between criminology and psychiatry can be a problem in changing service delivery.

There is a need to pay more attention to psycho-social solutions.

The experience of Mental Health and Human Rights in the Egyptian Context **Dina Al-Shafie**

Mental health care in Egypt depends on whether one is rich or poor and whether one comes from a religiously conservative background or a liberal one. The practice of psychiatry itself is also influenced by religion leading to prejudice and misdiagnoses.

There are some advantages and many disadvantages for mental health patients compared with those in developed countries. People are not expected to deal with high technology in their daily lives in the same way and close-knit families can provide good support. Egypt is large enough to provide care anonymously which means it is popular with Gulf Arabs seeking mental health treatment.

On the other hand, mental illness is stigmatising in families and in society as a whole. People may be locked up by their families rather than taken for treatment. But promiscuity in women is judged to be even worse and can lead to women being put in a mental hospital. Families seek to conceal mental illness by resorting to traditional healers or religious sheikhs.

The Egyptian Corporation for Women's Rights is campaigning against abuses. In Egypt, certain mental health problems such as drug abuse are not tolerated and there are strong taboos around HIV/AIDS and homosexuality.

Cairo has the largest metropolitan refugee population in the world. Refugees suffer discrimination and abuse and do not have basic rights to education or health care.

Questions and comments

In the UK, the same issues of discrimination arise for refugees and for people with drug addiction who need mental health care.

The cultural/religious factors apply also in Jordan. It can be mistaken to stress the positive of close family relations since it can give institutions an excuse not to act. Societies are in transition and social support becomes less reliable. On the positive side, there is a strong stigma attached to suicide in Islam.

In multi-cultural societies, barriers in mental health care exist when professionals are all from a single cultural group.

Human Rights and Mental Health Care in Europe

Oliver Lewis

Mental Disability Advocacy Centre (MDAC) is based in Budapest and covers Central and Eastern Europe. Mental health services in the 'transition' countries of the EU are influenced by the low effectiveness of civil society and the tragic history of psychiatry in the Soviet Union.

The right to health should include freedoms but consent to treatment is the biggest joke in mental health law across the world. Patients have the right to agree but not to disagree. This is illustrated by a photograph of a nurse dispensing pills at the entrance to a hospital cafeteria – getting a meal is conditional on accepting medication.

Inhuman and degrading conditions exist in hospitals. For example, patients can be found living in voluntary slavery in psychiatric hospitals; restraints and seclusion are illustrated by caged beds in the Czech Republic.

The numbers of people needing services are not known. Far more people with mental health problems are in the social care system than in the health care system and are not counted.

The term 'social care home' is a euphemism as such homes tend to be large, remote and abusive. They perpetuate lifelong social exclusion. The system of appointing the care home Director as Guardian means that patients are 'nobody'.

High doses of medication are used. There is no right to privacy and routines are regimented – this point is illustrated by a framed and glassed in notice setting out the weekly timetable of activities. Care homes lack any kind of family atmosphere or culture of rehabilitation.

The use of ‘legal incapacity’ is the main barrier to sorting out many of these issues. In contrast to the UK, lawyers in Central and Eastern Europe do not represent patients or seek to safeguard their human rights.

So why litigate? Under the European Commission for Human Rights a person has the right to litigate but there are many access to justice hurdles:

- Lawyer must gain access to the institution
- Service user must be aware of their rights
- Communication can be difficult
- Medication can be disabling
- Institutions can seek retribution
- Legal aid may not be available
- Judicial capacity may be lacking

Nevertheless, mental health is becoming part of the human rights mainstream in Europe.

Questions and comments

It is entirely possible for litigation to be successful in individual cases. There have been successes, for example in Estonia re. Guardianship and in Russia where states were forced to provide services for parents of children with intellectual disabilities.

Litigation is one tool in the toolbox but it cannot solve many problems alone. Human rights cases are a way of highlighting systemic issues. They are not anti-psychiatry in general but aimed at resolving individual cases.

It is sometimes argued that human rights is a luxury for countries with low levels of development. However, no country has been forced to sign the ECHR. Resources may be limited but they can be reallocated, as happened in Slovenia, where one social care home was closed and all of the staff were redeployed.



Mental Well Being and Human Rights: Indian Perspectives

Amita Dhanda

The definition of mental well-being differs depending on who defines it: service users or providers, the family or society at large, or police or other authorities. Social, economic and cultural factors have an impact on mental well-being.

In India, the legislative perspective is passive and paternalistic. Mental well-being is seen as something to be provided rather than strived for. This approach would not score very high on the Human Rights agenda.

The adjudicative perspective aims to remove deficits which impede well-being by improving conditions in psychiatric institutions, ordering the closure of faith healing centres and, in some cases, ordering services to be closed.

But too much focus on physical facilities means that human rights get squeezed out. The individual's voice is not heard and this is supported by Indian law based on the premise of incapacity.

If mental well-being is a human right then can its presence or absence be determined by another? Indian law should allow for mental well-being to be defined by the self. The incapacity regime which causes dependency should be changed to a more interdependent view which recognises that all of us need support to a greater or lesser extent.

A perspective from Nepal

Gael Robertson

Nepal is a nation in trauma the result of a 10 year long violent insurgency. The human rights situation in Nepal is one of the worst in the world. Currently, Nepal has the highest number of disappearances. The Maoist insurgents and the State are both committing atrocities. In the past 10 years 13,000 people have been killed. Men, women and children are suffering. Mental health is neglected. Human rights are neglected.

In Nepal mentally ill people are stigmatised and excluded. A national mental health policy was agreed in 1995, and has as one of its objectives "to protect the fundamental rights of the mentally ill in Nepal". The rights of mentally ill people in Nepal remain unaddressed. To date there is no law to protect the rights of a person with a mental illness. But there is some legal provision, established in 1963, concerning the States responsibility for a mentally ill person. This responsibility is primarily jail. The few mental health services available are urban based with a medical focus. People in rural Nepal (most of the country) have no access to mental health services. Over the years human rights organisations in Nepal have failed to address economic social or cultural rights.

The international development agenda ignores mental health. Mental health is excluded from the millennium development goals (MDGs). The MDGs drive the funding of development activities. A further gap exists between the human rights framework and the MDGs. The MDGs focus on quantity rather on process, they are unable to address the complexity and interconnectedness of peoples lives. While, international development advocates rights based approaches it has steered the international development agenda in a direction that violates the International Covenant on Economic, Social and Cultural Rights through the failure to “recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”.

Mental health is a development issue. The result of the violent armed conflict in Nepal has worsened the mental health and human rights situation in the country. On top of this, the situation of inadequate mental health and social services as well as the lack of legal provision to ensure the rights of people with a mental illness remain. Action is needed. In a country like Nepal mental health must become a development issue to ensure that a connection is made between human rights and mental health. First, international development needs to embrace that physical and mental health go hand in hand as a human right.

Day 2

The second day of the seminar started with visits to service settings. One group of participants visited Redhall Walled Garden, which is run by the Scottish Association for Mental Health. A second group visited Carstairs State Hospital which provides care and treatment in conditions of special security. Reports from the visits and from the workshops on day 1 were presented in the afternoon.

Visit to Redhall Walled Garden

The service provides a supportive environment for people with or recovering from severe and enduring mental health problems.

The group were very impressed with the evidence they saw of healing processes through activities and especially gardening. The people they met explained that they shared a common goal of welfare and health and found the experience of the service very positive.

People who attend either refer themselves or are referred from health services. Funding comes from the health service and there is a waiting list for places.

One member of the group commented that people at the garden were not paid for the work they were doing and that this ran counter to the idea of promoting independence. Another member of the group disagreed, pointing out that 'we are all dependent on each other' and that for many people experiencing mental illness, having reduced opportunities might not be a source of dissatisfaction.

Visit to Carstairs State Hospital

The group were subjected to heavy security on entering the complex and were then given a guided tour of the outsides of all of the buildings. They also received a presentation from a lawyer on the Human Rights orientation of the regime at Carstairs. They were not able to meet any patients or view any of the facilities. When they asked why this was the case they were told that while some patients might welcome the contact, others would not.

There are 600 staff and 240 patients of whom 8 are female. Referral is through the prisons, the courts and the health service. The average length of stay of current patients is 44.5 years with a range of 3 months to 33 years. There is a severe shortage of medium secure facilities in the health service in Scotland and this has an effect on the use of places at Carstairs.

Members of the group were disappointed by the visit and felt it was strange to allow a visit and then not to permit access to any buildings or patients. They also

had the impression that the regime was paying more attention to human rights than to what they are doing with the patients.

Workshop 1: Recovery: Raising Awareness and Expectations
Presentation by Simon Bradstreet

“The concept of recovery from illness is a fundamental human rights issue. If people are seen as helpless, they are not allowed to take charge of decisions and cannot even stand for their own rights.”

Eric Rosenthal, Executive Director, Mental Disability Rights International

Long term outcome studies and personal narratives show us that people can and do recover from long-term mental health problems and mental illness. We are starting to learn more about the role and importance of promoting a more hopeful outlook, building on people’s strengths and capacities and creating an expectation of recovery.

The presentation covered:

- The work of the Scottish Recovery Network (one part of the Scottish Executive’s National Programme for Improving Mental Health and Well being) and the wider Scottish policy context.
- How we understand and interpret recovery in this context.
- Some learning about the key elements and themes of recovery.
- Suggestion and ideas for getting recovery thinking into practice in mental health services and out with them.

We need to be aware of recovery not as a short shift but as a process in which there may be little reverses but the general trend is towards recovery.

People who experience long term mental health problems have the right to be involved in decisions about their own health and well being, the right to play an active and meaningful part in their community, the right to challenge pessimistic and stigmatising messages. In short the right to recover.

Feedback and discussion

Recovery is a process which may be influenced by many aspects of care ranging from attitudes of care professionals, the institutional environment, experience of stigma, having a say in the kinds of treatments used, and the role of service user groups.

Stigma operates at many levels e.g. through unhelpful media reporting and the withholding of insurance on the basis of mental illness.

Some measures to promote recovery were discussed. Professional training of staff to aid recovery should include people such as pharmacists and receptionists. Service user groups should be represented on NGO advisory groups. Choice over drug treatments should be available.

Recovery will represent a very different journey for different people. People have different goals. Some people may be too frightened to believe in any hope of recovery.

Workshop 2: Individuals – Listening, involving and advocacy **Presentation by Graham Morgan**

The Highland users' group (HUG) was established 10 years ago as a self-advocacy organisation of users of mental health services who live in the Scottish Highlands. It has 360 members. It is supported by one full time and 2 part time workers who have themselves experienced mental illness. It is a project of Highland Community Care Forum.

HUG produces 6 reports a year on the issues that its members find important. Examples vary from employment to medication to complaints and recovery. These act as policy documents when giving voice to members' views.

Workers and members speak at conferences, committees and other meetings in order that their voice can be heard. These meetings happen at a local, regional and national level.

HUG's reports and activities have resulted in tangible changes occurring and have been used across the Highlands, Scotland and beyond. Half of its activity involves its members speaking out and being involved in challenging stigma and discrimination. This happens in the following ways: working with young people, providing mental health awareness training, working with the media, creating DVDs of personal testimony, producing newsletters and arts magazines that give voice to members shared experiences, operating a website (hug.uk.net) and producing publicity materials on a mental health theme.

HUG has been successful in changing attitudes to mental health issues. For members, involvement is seen as being positive and safe.

Feedback and discussion

Membership of HUG is restricted to people who have experienced mental health problems. There is no objective test of this – it is up to the individual to decide if they are eligible. People with dementia are not admitted.

Story-telling is one of the most powerful tools for changing policies. Understanding the social context is also an important element for changing attitudes – this should be part of training for doctors. Organisations wanting to develop their mental health services must listen to service users.

HUG has achieved success through being very proactive. It provides advocacy for individuals and also for achieving systemic change. It works to raise community awareness and participation by service users in civic society.

Workshop 3: Communication and access to information **Presentation by Sandra McDougall**

Participation and empowerment require meaningful involvement in decisions and control of treatment, better understanding of illness and a focus on recovery. In Scotland efforts are being made to encourage proactive information-giving.

The legislative framework in Scotland includes the Data Protection Act 1998 which allows people to access personal information held about themselves, the Mental Health (Care and Treatment) (Scotland Act) 2003 which lays down the duty to provide certain information as well as the guiding principle of participation, and the Adults with Incapacity (Scotland) Act 2000 which is based on the guiding principle of taking the adult's wishes and feelings into account.

Policy in Scotland tries to balance the right to effective treatment with the right to privacy. A Mental Health Information Strategy has been drafted which would allow anonymised information from electronic patient records to be used for service planning and evaluation. These issues are currently under discussion on the context of the latest review of health services in Scotland – the Kerr report. Increased investment is planned for the development of the eHealth system based on a single patient record.

Detailed questions were raised about the Adults with Incapacity. This legislation provides mainly for people with dementia and people with learning disabilities.

Feedback and discussion

Information provided to patients promotes participation, but with the 'get out' that it can be withheld if considered harmful. Information provided to the public promotes anti-stigma and mental health awareness. The campaign in Scotland has been successful with young people.

Stigma comes from society, from care-givers and from the self.

In some countries, information is restricted by law and patients can only obtain it through the courts. But even where the law does allow information to be passed to patients, doctors are not in the habit of disclosing. It is important to involve user groups in debate about information giving and privacy.

The psychiatrist should be the main source of information for individual patients and they should spend a lot of time on this.

Denmark has provision for patient libraries staffed by trained librarians. Expert input from psychiatrist is available at information evenings.

Day 3

On the third day of the seminar participants attended a final workshop on the development of recent mental health legislation in Scotland. This was followed by a wide ranging discussion developing some of the issues raised during the seminar.

Workshop 4: Consultation and development of legislation **Presentations by Adam Ingram MSP and Colin McKay**

The two presenters each lead a separate workshop covering the same topic. Adam Ingram's workshop is reported here.

The Mental Health (Care and Treatment) (Scotland) Act 2003 was introduced after a lengthy legislative process involving intensive consultation with individuals and organisations. It is regarded as an international exemplar for the protection of rights and addressing of needs in relation to mental health.

The credit for the enlightened approach is due to the Millan Committee which established the case for reform on the basis of consultation with service users and carers. Millan specified the 10 key principles, which after lengthy debate, have been incorporated into the Act. The breadth and depth of consultation and the broad consensus achieved in the mental health community made the process of drafting the legislation easier.

There was concern that the Executive was taking too long over the drafting. The first draft gave rise to hundreds of amendments and NGOs were dismayed at the extent of omissions. In view of the tight deadline for completing the legislative process, 64 organisations came together to form the 'Let's Get it Right' campaign led by the Scottish Association for Mental Health. This campaign was decisive.

My aim as chair of the cross-party group was to maintain the consensus built by Millan. The group acted as a clearing house for amendments and ensured that for all amendments an MSP was assigned to speak to it in Committee.

The final version of the Bill contained essential elements of Millan which had been absent from the earlier draft. The Principles were restored; the right to advocacy and carers' rights to information were clearly stated.

The legislative process took barely 6 months but implementation took 2.5 years. It is too early yet to say how successful the Act has been.

Comments and discussion

Feedback from the first 6 months?

The key to success is providing the necessary resources. There is a need to build up training and recruitment - there is a significant demand on psychiatrists' time to attend Tribunals. The Mental Welfare Commission will provide regular monitoring reports.

Role of cross party group?

The original impetus for the group came from the concerns of carers.

The experience in England.

Two draft bills were produced bearing no relation to the report of the Richardson Committee which had contained similar principles to Millan. 'Stakeholders' were ignored and the main agenda was public safety.

Devolution and change?

Devolution changed the legal framework and has brought a more enlightened approach to compulsion. Physical changes to the environment have still to be worked through. There is an acute shortage of medium secure units to allow people to be discharged from Carstairs, but no agreement about where new units should be located. The number of acute beds has been cut. There has also been a significant increase in compulsory orders over the last 4-5 years. The reason for this is unclear. There have been repeated claims that people seeking help voluntarily are being turned away, only to be detained compulsorily when their health deteriorates.

Monitoring the new law?

The Mental Welfare Commission has a role prescribed in the Act. This is an independent body, funded by the Scottish Executive, whose main role is to safeguard the interests of people with a mental illness, learning disability or other mental disorder. Commissioners include service users and carers. The Executive has also funded a research programme dedicated to evaluating the effect of the Act and a study of the impact of the Tribunal system on professional resources is about to be commissioned.

Implementation and resources.

In Scotland Health Boards have discretion over how they spend their budget. This makes it difficult to give effect to clinical priorities established by the Executive. Mental health suffers from the 'Cinderella syndrome'. The closure of hospitals is an ongoing process but there is a need for more resources and not just a shift from hospital to community. The right sort of acute beds are desperately needed for people who need peace and quiet in a therapeutic environment.

Legislation as a reflection of a society's priorities.

The Scottish Act reflects a bit of a culture change, also evident in the anti-stigma campaign. The Act's Principles are the key to the cultural shift but in themselves are only words. Over time, service users knowing their rights together with training and recruitment will generate a new culture within services.

The State Hospital, visited by seminar members the day before, did not convey the image of a progressive, humanising service. Doubts were expressed about the therapeutic value of an environment with such a diverse group of patients. Also the length of the average stay was too long and the geographic location too remote.

The Scottish experience provides a model for consultative legislation. Service user groups involved in consultations from the Millan Committee through to the legislative process felt that it was a very good experience.

Feedback from workshops – comments from participants

The level of consultation accompanying the legislation in Scotland was impressive and could only lead to greater credibility and acceptability for the new provisions.

The inclusion of principles of dignity, reciprocity, least restrictive setting etc is very important in modern mental health legislation. Although principles are not legally binding, clinicians have to be able to demonstrate that they have taken account of them.

Some participants felt there was an over-emphasis on the process of legislation in the presentations and felt they had learned little about what real changes had been made and where the pressure points lie in the new regime.

Involvement in consultation inevitably falls to concerned stakeholders. The Westminster government claimed that evidence supplied in consultations over their mental health Bill was skewed because it did not represent the general public. But it is unrealistic to expect people to be involved in legislation which does not affect them.

The detail of the law in Scotland attempts to give effect to the Principles. It is a condition of compulsion that the person's judgement is significantly impaired by reason of their mental disorder. This brings mental health law closer to the law that affects everyone. In the future we may have incapacity legislation for everyone and no separate mental health law.



Report back, discussion and future thinking

Mary Redshaw (chair)

The seminar closed with a session designed to pull together the threads of the discussions and consider some specific questions. What has been learned at the seminar and what can be implemented? How should the international agenda change? Participants summed up their thoughts in some messages for the international agenda, national governments and the British Council.

The main problem internationally was seen as the gulf between facilities to treat physical and mental illness. Compulsion is necessary because psychiatric hospitals are very rarely places anyone would chose to stay voluntarily. This is true of developed countries. In developing countries there is the added problem of mental illness being swept under the carpet – the account from Egypt earlier in the seminar represented a totally different world.

Should compulsion ever be seen as legitimate? The existence of compulsory powers removes the incentive to make mental health services acceptable to service users and carers.

How important is the role of legal services? Support for NGOs is needed so they can provide legal services and advocacy as well as input to consultation and legislative processes. There is a well established body of case law (e.g. Mental Health Law Reports in the UK) but not so widely known about. However people are not usually willing to expose themselves in court because of the stigma of mental illness.

Messages for international campaigning activities:

- International indicators to be used as lobbying tool
- Inter-country networking of user groups
- Expansion of anti-stigma campaigns internationally
- Make use of international mental health day in October

Messages for national governments

- Promote joint working between health and social care systems
- Focus on lifestyle issues which make life harder for people with mental health problems, such as family disintegration and technological change
- Ensure that people with mental health problems have the same rights as other people
- Ensure that people with mental health problems are protected against discrimination in the same way as other disabled people

Messages for the British Council

- Support comparative research on human rights across different countries
- Support anti-stigma campaigns in different countries using similar themes and slogans
- Disseminate information about participative law making
- Provide access to resources on independent advocacy
- Publish expenditure on mental health services internationally so that comparisons can be made.

Implementing lessons from the seminar

- Continuing to keep in touch with each other
 - Sharing information
 - Understanding differences and similarities across countries
-

Annexes

1. Seminar Participants

Country	Name	Job title and Institution
Australia	Dr Sev OZDOWSKI	Former Australian Human Rights Commissioner and Disability Discrimination Commissioner
Chile	Dr Alberto MINOLETTI	Head of Mental Health Department
Colombia	Dr Fernando Jiovani ARIAS	Director, Fundacion dos Mundos
Denmark	Mr Kim RATTENBORG	Local President, SIND – Aarhus
Egypt	Dr Dina Al-SHAFIE	Director of Psychosocial Services, African and Middle East Refugee Assistance
England	Ms Camilla PARKER	Mental Health and Human Rights Consultant
Estonia	Mrs Mari AMOS	Adviser, Office of the Chancellor of Justice
Estonia	Ms Eve PILT	Legal Director, Estonian Patients Advocacy Association
Hungary	Miss Eszter CSERNUS	HIV/AIDS & Patients' Rights Programme Director, Hungarian Civil Liberties Union (HCLU)
Hungary	Mr Oliver LEWIS	Legal Consultant
Hungary	Mária Bucholczné SZOMBATHY	Graduate psychologist and senior lecturer at Semmelweis University, Mental Health Institute

India	Dr Amita DHANDA	Legal research and law teacher, NALSAR, Hyderabad
Jordan	Professor Salwa AL-EBISAT	Dean, Faculty of Nursing, The Hashemite University
Jordan	Dr Mohammed AL-HABASHNEH	Psychiatrist, The Jordanian Society for the Protection from Family Violence
Nepal	Ms Gael ROBERTSON	Independent social development practitioner in community health, human rights and conflict.
Northern Ireland	Ms Billie HUGHES	Clinical Services Manager, South and East Belfast Trust
Northern Ireland	Mr Kevin McLAUGHLIN	Northern Ireland Human Rights Commission
Pakistan	Mr Arshad WAHEED	Director, Institute of Social Policy, Islamabad
Portugal	Dr Antonio LEUSCHNER	Chief Executive Officer, Hospital de Magalhães Lemos
Portugal	Ms Fátima JORGE-MONTEIRO	President of the Board Federação Nacional das Entidades de Reabilitação de Doentes Mentais (FNERDM)
Russia	Mr Igor KOLMAKOV	Consultant, Open Health Institute, St Petersburg
Russia	Ms Natalia EDOKIMOVA	Chairperson, Committee on Social Problems, Legislative Committee of St Petersburg
Scotland	Dr Donald LYONS	Director, Mental Welfare Commission for Scotland
Scotland	Simon BRADSTREET	Network Director with the Scottish Recovery Network
Scotland	Mr Graham MORGAN	Advocacy project manager,

		Highland Users Group
Scotland	Ms Sandra McDOUGALL	Legal Officer, Scottish Association for Mental Health
Scotland	Ms Fiona MYERS	Senior Policy Researcher, Scottish Development Centre for Mental Health
Scotland	Ms Fiona TYRELL	Mental Health Division, Scottish Executive Health Department
Ukraine	Mrs Raisa KRAVCHENKO	Executive Director, All-Ukrainian NGO Coalition for People with Intellectual Disabilities
Ukraine	Dr Andriy SHEVTSOV	Deputy Director, Governmental Fund for Social Protection of Disabled People
Wales	Mrs Ruth COOMBS	Policy Manager, Mind Cymru
Wales	Professor Phil FENNELL	Professor in Law in Cardiff Law School, University of Wales, College of Cardiff
British Council	Farah KABIR	Consultant Participative Democracy, British Council
	Mary REDSHAW	Consultant, Law and Human Rights, British Council
	Helena SHARP	Deputy Director Commonwealth, British Council
	Alison ST. CLAIR-FORD	Event Manager
	Christine WILSON	Governance Co-ordinator, British Council Scotland

2. Presentations

Phil Fennell – Convention Compliance, Public Safety, and the Social Inclusion of Mentally Disordered People

There are three parallel agenda in mental health law and policy: public safety; respect for Convention rights; and social inclusion, which entails protection against discrimination and combating stigma. Since the 1990s successive Governments have pursued a public safety agenda in relation to mental health services responding to concerns about homicides by mentally disordered people. Although these fears have been exaggerated, they have had a disproportionate impact on mental health law and policy and produce tensions between the agendas of public safety and social inclusion.¹ The Government has followed its immediate predecessors in pursuing a legislative agenda of increased control over mentally disordered people in the community whilst at the same time, through the National Service Frameworks for England and Wales, promoting policies of social inclusion, combating stigma, and user and carer involvement.² Although Convention compliance has been a major issue in mental health law since the 1981 decision of the Strasbourg Court in *X v United Kingdom*, since October 2000 it has been a direct issue in the courts, and has also come to be a major focus of ethical debate about law reform.

The first part of this paper considers the impact of the HRA 1998 in the courts, and the application of Articles 3, 5 and 8, in relation to psychiatric detention, treatment without consent and seclusion. The second part looks at its effect on the discourse of law reform. Here a key theme is the way Convention compliance has been used by the Government to justify measures that will lead to a broadening of the scope of compulsory powers and a reduction in rights.

Detention on grounds of unsoundness of mind

Article 5(1)(e) of the Convention reflects the attitudes of the 1950s, authorising detention on grounds of unsoundness of mind, alcoholism, addiction to drugs, or vagrancy, provided that detention takes place in accordance with a procedure prescribed by law. Although the Convention cannot by any stretch of the imagination be seen as an enlightened statement of the rights of persons of unsound mind, the Strasbourg Court has striven to build additional safeguards through its jurisprudence. The Council of Europe has issued the Bioethics Convention 1997 and the 2004 Recommendation setting out principles for the treatment of people with mental disorder, although the United Kingdom

¹ P Fennell, 'Reforming the Mental Health Act 1983: "Joined Up Compulsion"' 2001 *Journal of Mental Health Law*, 5-20.

² Department of Health, *National Service Framework for Mental Health: Modern Standards and Service Models (2000)*, Welsh Assembly Government, *Strategy Document for Adult Mental Health Services in Wales: Equity, Empowerment, Effectiveness, Efficiency (2001)*.

Government has avoided becoming a party to either. In 1979 in *Winterwerp v the Netherlands*³ the Court laid down three important substantive and procedural requirements for lawful detentions of persons of unsound mind:

- (1) Except in emergencies, the individual must reliably be shown to be suffering from a true mental disorder on the basis of objective expertise.
- (2) The mental disorder must be of a kind or degree justifying confinement.
- (3) Those carrying out the detention must satisfy themselves at intervals that the criteria for detention continue to be met.⁴

Winterwerp established that detention must be a proportionate response to the patient's circumstances.⁵

These requirements are met in the detention procedures under the Mental Health Act 1983 (MHA 1983) Admission is by administrative process, based on professional expertise and checks and balances. Only an Approved Social Worker ASW (with specialised mental health training) or the patient's nearest relative may apply for detention, supported by two medical recommendations, one from a person with psychiatric expertise. The ASW presents objective medical evidence of a true mental disorder of a kind or degree warranting detention to a competent authority, the hospital managers. The competent authority has the duty to review the detention at reasonable intervals and to discharge if the criteria are not met. An application may only be made if the treatment cannot be provided without detention, reflecting the principle of proportionality. Nothing in Article 5 or the case law requires admission to be authorised by a court or tribunal, so the current admission procedures are Convention compliant.⁶

However, English law's long-standing non-application of the statutory procedures to mentally incapacitated patients presented a potential problem. Since the MHA 1959 English mental health legislation has provided that the existence of the statutory procedures should not prevent a person being admitted 'informally', meaning that the person is admitted without using statutory powers of detention. Informal admission applies to patients with sufficient mental capacity actively and validly to consent to admission, and also people who are incapable of consenting to admission but who are not actively resisting it. This approach assumes that there can be no detention unless the person is actively protesting against or resisting confinement. The crucial factor is not consent but absence of dissent, the key indicia of dissent being physical resistance to admission, and persistent attempts to leave. Detention was to be reserved for the minority of patients who

³ *Winterwerp* Series A No. 33, p. 16, para 37.

⁴ *Winterwerp v The Netherlands*, above; *X v UK*, Series A Judgments and Decisions No. 46, and *Van der Leer v the Netherlands* (1990)12 EHRR 567.

⁵ *Litwa v Poland* (2000) 63 BMLR 199

⁶ *HL v United Kingdom* 5 October 2004.

were resisting hospital treatment,⁷ as it was thought unseemly and stigmatising to detain compliant mentally incapacitated people such as elderly patients with dementia or people with profound intellectual disabilities, when often a major reason for their admission to hospital is that there is nowhere else where they can be looked after. This allowed large numbers of compliant incapacitated patients to be admitted without the procedural safeguards available to detained patients, under a statutory permission, that nothing in the Mental Health Act prevents a person from *being admitted* informally.⁸

Only in 1989, in *In re F*⁹, did the House of Lords enunciate the common law doctrine of necessity, conferring a power on doctors to give treatment without consent that is necessary in a mentally incapacitated patient's best interests. In 1999, before the HRA 1998 came into force, the doctrine of necessity was extended by the House of Lords in *R v Bournewood Community and Mental Health NHS Trust, ex parte L (Secretary of State for Health and others intervening)*¹⁰ to confer a power on a doctor to restrain and detain a mentally incapacitated adult if it was necessary in his or her best interests. In *Bournewood*, L had been admitted to hospital on the authority of the psychiatrist in charge of his treatment after he had become disturbed in a day centre. He was kept in hospital, and his long term carers were told that it would not be in his clinical interests to visit him. The doctor instructed ward staff that if L tried to leave he should be formally detained. The House of Lords ruled by a 3-2 majority that L had not been detained. They also ruled unanimously that, even if he had been, there was a power at common law to restrain and detain a mentally incapacitated person in their best interests.

In *HL v United Kingdom* the Strasbourg Court held that Article 5(1)(e) had been breached in the *Bournewood* case. The court held that where a compliant incapacitated patient is subjected to a strict level of control over residence, treatment, movement and access to carers she is deprived of liberty. Whatever the position under English law, removal to the hospital, and retention there without access to carers, amounted to a deprivation of liberty under the Convention, and had to be carried out in accordance with a procedure prescribed by law, under Article 5(1)(e). The Court refused to treat compliant incapacitated patients on a par with capable patients who were consenting, affirming that:

The right to liberty in a democratic society is too important for a person to lose the benefit 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.

⁷ For a full discussion of this history see P. Fennell, 'Doctor knows best? Therapeutic Detention Under Common Law, the Mental Health Act and the European Convention' (1998) Vol 6 *Medical Law Review* 322-353.

⁸ Mental Health Act 1983, s 131.

⁹ [1990] 2 AC 1.

¹⁰ [1998] 3 All E.R. 289.

The law authorising detention must be sufficiently precise to allow the citizen to foresee, to a degree that is reasonable in the circumstances, the consequences which a given action might entail. The *Winterwerp* criteria must also be met. There have to be rules specifying a procedure to admit and detain compliant incapacitated persons, indicating who can propose admission, specifying the purpose (assessment or treatment), grounds and medical evidence needed to justify detention, specifying time limits and providing for regular review. A nominated representative should be able to make 'certain objections and applications' available under the 1983 Act, especially important for legally incapacitated patients with limited communication abilities.

Under the Convention the common law doctrine of necessity may be used to justify an emergency detention, but not a prolonged deprivation of liberty, because there is no procedure to exercise the common law power. Conferring such a power on a doctor without procedural safeguards risks arbitrary deprivation of liberty based on medical misjudgement.

Reviewing the lawfulness of detention

Article 5(4) entitles detainees to take proceedings by which the lawfulness of detention must be decided speedily by a court and release ordered if it is not lawful. In *X v United Kingdom*¹¹, the Strasbourg Court held that the court must be able to review the applicability of the *Winterwerp* criteria.¹² If they are not met, the court must have the power to direct the patient's discharge. Review of the 'lawfulness' of detention must be carried out in light of domestic legal requirements, the Convention, and the principle of proportionality. Article 5(4) review is carried out jointly by the High Court and by Mental Health Review Tribunals (MHRTs). The High Court reviews the formal legality of decisions to detain and renew detention via judicial review and habeas corpus. Review of the continued applicability of the *Winterwerp* criteria is done by MHRTs, which have the power to direct discharge. A number of aspects of the MHRTs' functioning were ripe for challenge.

The burden of proof

Most obvious was the burden of proof on the applicant to satisfy the MHRT of the absence of detainable mental disorder or the absence of risk to the patient's health or safety or to the protection of other people.¹³ In a series of cases decided prior to the coming into force of the HRA 1998 the courts emphasised the importance of the reverse burden of proof¹⁴, departing from Lord Atkin's

¹¹ (1981) 4 EHRR 188.

¹² *Ibid*, at 189. See also *Hutchison Reid v United Kingdom* 30 January 2003.

¹³ This applied to patients detained for treatment for up to six months renewable under s 3 of the 1983 Act.

¹⁴ *Perkins v Bath DHA; R v Wessex MHRT ex p Wiltshire CC* (1989) 4 BMLR 145. *R v Merseyside MHRT ex p K* [1990] 1 All ER 694; (1989) 4 BMLR 60.

statement in *Liversidge v Anderson* that ‘One of the pillars of liberty is that in English law every imprisonment is prima facie unlawful and that it is for the person directing the imprisonment to justify his act.’¹⁵ This was justified because the MHRT’s jurisdiction was to review, not to make the original decision to detain. A tribunal was only required to direct discharge ‘if satisfied of a negative, because the tribunal is not intended to duplicate the role of the medical officer, whose diagnosis stands until the tribunal is satisfied that it is wrong.’¹⁶

The burden of proof was the subject of the first declaration of incompatibility between the MHA 1983 and Convention rights with the decision in *R (H) v Mental Health Review Tribunal North and East London Region and Secretary of State for Health* where Lord Phillips MR held it ‘contrary to the Convention compulsorily to detain a patient unless it can be shown that the patient is suffering from a mental disorder that warrants detention.’¹⁷ The burden of proof has now been changed by remedial order¹⁸ and the tribunal is required to discharge a patient if not satisfied that the patient is then suffering from detainable mental disorder of the requisite nature or degree.¹⁹ The Strasbourg Court agreed in *Hutchison Reid v. the United Kingdom*²⁰, holding that it was ‘implicit’ in the Convention case law that it was for the authorities to prove that an individual satisfies the conditions for compulsory detention, rather than the converse, ... [since] detention could only be lawful under Article 5(1)(e) if it could ‘reliably be shown that he or she suffers from a mental disorder sufficiently serious to warrant detention.’²¹

These decisions establish a clear improvement in the due process rights of patients, and remove the Kafkaesque task of establishing the absence or mental disorder of a nature or degree and risk in the face of psychiatric evidence to the contrary. They mark the introduction into the MHRTs of common law procedural safeguards appropriate to cases of deprivation of liberty. They can be said to uphold the non-discrimination, social inclusion agenda

- *Speedy Review*

To comply with Article 5(4) ‘speedy’ review must be available, and it has been a long-standing concern that MHRTs have not been convened speedily enough. In 1984 the Council on Tribunals noted that already patients were waiting too long for a hearing. In 1988, the Council Annual Report described delays of between 12 and 19 weeks for non-offender patients. In the late 1990s the MHRTs introduced new arrangements were introduced to manage case loads, culminating in the conduct of hearings without tribunal clerks but with Tribunal

¹⁵ *Liversidge v Anderson* [1942] A.C. 206 at 245 (dissenting).

¹⁶ *R v Canons Park MHRT* [1994] 2 All ER 659.

¹⁷ [2001] 3 WLR 512.

¹⁸ Mental Health Act 1983 (Remedial) Order 2001 S.I. 2001 No 3712.

¹⁹ In *Lyons v. the Scottish Ministers* 17 January 2002, First Division of the Court of Session Scottish Ministers had also accepted that the Convention required them to bear the burden of proof and had argued that section 64 of the Scottish legislation should be read to give this effect.

²⁰ Judgment of 30 January 2003.

²¹ *Ibid.*, at para. 70

assistants employed by an agency. In *R (on the application of C) v the Mental Health Review Tribunal London and South West Region*²² listing all cases for a date precisely eight weeks after the application was held to be a breach of Article 5(4), since some cases could be brought on in less than eight weeks, whilst others might legitimately take longer.

In *R (on the application of KB and Others) v Mental Health Review Tribunal*²³ Stanley Burnton J held that the right of seven applicants to a speedy hearing under Article 5(4) had been breached and that the evidence before him indicated the basic responsibility for the delays experienced by patients was that of central Government rather than tribunal chairmen or staff. The disposal of cases speedily has placed the tribunal under tremendous pressure to manage cases speedily, resulting in clerks being replaced by tribunal assistants recruited through an agency, and in some cases tribunals sitting without a clerk. At the same time, the tribunal's case load has increased steadily from a figure of 3,868 applications, and 2,009 hearings in 1983 to the current level of in excess of 22,000 applications to tribunals for discharge per annum, 11,000 of which result in hearings.²⁴ Effective enforcement of the speediness requirement is clearly crucial to any system of review and to the psychological well-being of patients awaiting review, but when tribunals sit without professional clerks there must be risks to the quality of justice.

The Effects of Tribunal Decisions

MHRTs have the power of discharge, but an Approved Social Worker (ASW) has a duty to apply for the admission of a patient 'where he is satisfied that such an application ought to be made and is of the opinion that it ought to be made by him.'²⁵ Although a MHRT decision to discharge makes further detention under that authority unlawful, it does not necessarily prevent a fresh application being made for detention or guardianship. Allowing unfettered discretion to 're-section' a patient creates the possibility of professionals countermanning a tribunal decision that had gone against them, in effect an appeal from a judicial body to 'mental health professionals' who have in all probability been parties to the hearing. The courts have had to steer a careful path between fettering the discretion of the 'mental health professionals' to manage a perceived risk to the patient or others, and undermining the authority of the tribunal, which is the competent court for the purposes of reviewing the lawfulness of detention under Article 5(4).

In *ex parte von Brandenburg*²⁶ the House of Lords established that mental health professionals need not establish a 'change in circumstance' since the tribunal

²² (CA) [2002] 1 WLR.

²³ [2002] EWHC 639.

²⁴ Submission of the Mental Health Review Tribunal Chairmen for England and Wales to the Joint Parliamentary Scrutiny Committee on the Mental Health Bill, para. 1.

²⁵ Mental Health Act 1983, s 13.

²⁶ [2003] UKHL 58.

decision before being able to re-section. The ASW must have formed the reasonable and bona fide opinion that he has information not known to the tribunal which puts a significantly different complexion on the case as compared with what was before the tribunal. In the overwhelming majority of cases where re-sectioning is in prospect, there will have been a material change of circumstance, but the courts do not wish to place this restraint on discretion to intervene where there is risk to the patient's health or safety or the protection of others.

The other circumstance where re-detention following discharge by the tribunal has been considered, is where the hospital authorities think the tribunal has erred in law. In 2002 the Court of Appeal held that to countenance as lawful re-sectioning on the ground that the tribunal was believed to have erred in law would be to permit the professionals and their legal advisers to determine whether a decision by a court to discharge a detained person should have effect, and would contravene Article 5(4). The hospital authorities should instead apply for a stay of the tribunal's decision, pending an application for judicial review.²⁷ If there are material facts not known to the tribunal, the ASW may re-section, but not if the contention is that the tribunal erred in law. The guiding principles in these cases have been to uphold the authority of the MHRT as the competent court as required by Article 5(4), whilst effectively managing risk by ensuring, as the courts in all these cases have repeatedly asserted, that nothing affected the ability of the professionals to re-section a patient if he does or threatens to do something that imperils or might imperil his health or safety, or that of members of the public. An important consequence is that the High Court now has power, through the jurisdiction to grant a stay, to allow applications for judicial review by the detaining authority against discharge decisions where those responsible for implementing the decision consider discharge to be too risky. These are important developments. The tribunal has acquired another court-like feature, in that speedy procedures are now available to the detaining authority to seek review of the tribunal decision to discharge.

Positive Duties under Article 5

The issue in *R v Secretary of State for the Home Department and another ex parte IH*²⁸ was the extent to which, in addition to creating negative rights not to be arbitrarily detained, Article 5 creates positive rights to treatment in the least restrictive setting. *Stanley Johnson v United Kingdom*²⁹ had established that where a court reviewing the lawfulness of detention finds that a person is no longer suffering from mental disorder, it is not under an obligation to discharge immediately, but may order discharge subject to the provision of after-care

²⁷ *R (on the application of H) v Ashworth Hospital and Others R (on the application of Ashworth Hospital Authority) v Mental Health Review Tribunal for West Midlands and the North West Region and London Borough of Hammersmith and Fulham and Ealing Hammersmith and Hounslow Health Authority* [2002] EWCA Civ 923.

²⁸ [2003] UKHL 59.

²⁹ (1997) 27 EHRR 296.

support. If this happens, the court must have the power to ensure that discharge is not unreasonably delayed. The scope of the duties of the court and the after-care authorities under *Johnson* was the key issue in *IH*. Resolving it, the House of Lords reaffirmed the fundamental principle of English law that, regardless of whether psychiatrists are public authorities for the purposes of the HRA 1998, a doctor cannot be ordered to do anything against his clinical judgment of the best interests of the patient.³⁰ Neither a tribunal nor a health authority could order a doctor to take on the care of a patient if the doctor, in his or her clinical judgment, considered that care could not safely be provided.

In *IH* Lord Bingham maintained a narrow approach to the ruling in *Johnson v United Kingdom*³¹ limiting the scope of the duty to ensure that discharge is not unreasonably delayed to cases where the patient is no longer suffering from mental disorder, the '*Johnson* type of case'. In *IH* the second *Winterwerp* criterion was no longer met, because there was still mental disorder but no longer of a kind or degree justifying detention, as long as adequate placement and supervision in the community could be arranged. Hence, the Court of Appeal and the House of Lords in *IH* agreed that, where the basis of discharge is nature or degree of the illness rather than its absence, 'If a health authority was unable, despite the exercise of all reasonable endeavours, to procure for a patient the level of care and treatment in the community that a tribunal considered to be a prerequisite to the discharge of the patient from hospital, the continued detention of the patient in hospital would not violate the right to liberty under Article 5.' Patients will rarely be pronounced 'cured' by psychiatrists or tribunals, so the effect of the ruling is to limit significantly the impact of *Johnson*, and the extent to which Article 5 is capable of imposing positive duties on state authorities to provide after-care to facilitate discharge.

In the U.S.A. the Supreme Court dealt with a similar issue in *Olmstead Commissioner, Georgia Department Of Human Resources, v. LC*.³² The Court held that under the Americans with Disabilities Act states are required to provide persons with mental disabilities with community-based treatment rather than placement in institutions. This duty applies where (1) the state's treatment professionals have determined that community placement is appropriate; (2) the transfer from institutional care to a less restrictive setting is not opposed by the affected individual; and (3) the community placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others with mental disabilities.

³⁰ A principle which has since been modified by Munby J in *R (Burke) v General Medical Council* [2004] EWHC 1879.

³¹ An approach first adopted by introduced by Lord Phillips of Worth Matravers M.R., in paras [32]-[36] of his judgment in *R(K) v Camden and Islington Health Authority* [2001] EWCA Civ 240, [2002] QB 198..

³² 527 U.S. 581; 119 S. Ct. 2176.

In the United Kingdom, in the Strasbourg Court, and in the U.S.A. the courts are showing commitment to the idea of a right to treatment in the least restrictive setting, a potential positive obligation in relation to Article 5(1)(e) detentions. However, this is subject to the significant limitation that it must accord with the clinical judgment of the health professionals, and will no doubt be subject to the availability of resources, as *Olmstead* makes clear in the U.S.A. The *IH* case, like *Olmstead*, shows how the powers of competent courts under Article 5(4) are subject to the important limitation of the clinical judgment of the doctor who will be treating the patient in the community, and his or her view of whether the risk posed by the patient to self or to others can safely be managed in the community. *IH* subjects *Johnson* to strict limits in the interests of risk management.

Since the ruling in *HL v United Kingdom*, the European Court of Human Rights has delivered a further important ruling in *Storck v Germany*³³ which contains important statements not only about the right to protection against arbitrary detention under Article 5 and but also concerning the right to physical integrity as an aspect of respect for private life under Article 8. The applicant had been admitted at age 15 to a children and young person's unit and spent seven months there in 1974-5. From July 1977 to April 1979 placed in a locked ward at a private psychiatric clinic (Dr Heine's Clinic), without any judicial order, as required by German law. She was brought back in March 1979 by police after she escaped. The private clinic was not entitled under German law to receive detained patients.

The Court held that there was a positive obligation for the state to take measures to protect the right to liberty under Article 5 and the right to personal integrity under Article 8 against infringements by private persons, and that both Article 5 and Article 8 had been infringed.

Treatment without Consent and the Convention

In *Herczegfalvy v Austria* Article 3 was not breached because 'The established principles of medicine were in principle decisive in such cases; as a general rule, a measure which is a therapeutic necessity cannot be inhuman and degrading.' Nevertheless, the Court emphasised that the 'position of vulnerability and powerlessness' of people detained on grounds of mental disorder called for vigilance on the part of the Court and the national authorities to satisfy themselves that medical necessity had been convincingly shown to exist. *Herczegfalvy* also claimed under Article 8 that the various treatments given to him, including large doses of neuroleptic medication, infringed his right to respect for private life, which afforded him the right of self-determination. The court rejected his claim, attaching 'decisive weight to the lack of specific information capable of disproving the government's opinion that the hospital authorities were entitled to regard the applicant's psychiatric illness as rendering him entirely incapable of taking decisions for himself.' In other words there was no evidence that he had the necessary capacity to be entitled to refuse treatment.

³³ Judgment of 16 June 2005.

The inference from this is that had *Herczegfalvy* possessed the necessary capacity he would have been entitled to refuse treatment as part of his right of self-determination. Then if doctors wished to impose treatment on him they would have to find a justification under Article 8(2), 'in accordance with law' and only if necessary in a democratic society for health, or to protect the rights and freedoms of others.

There are various other statements regarding treatment without consent in Council of Europe instruments. To escape criticism by the European Committee for the Prevention of Torture a member state has to ensure under the CPT Standards that treatment without consent is based on law and only relates to strictly defined exceptional circumstances.³⁴ Article 6 and 7 of the Bioethics Convention³⁵ provide that treatment of incapable patients may take place with the authority of their representative or a treatment proxy provided for by law, and treatment without consent of people with serious mental illness should be made subject to supervisory and appeal procedures, and should be based on the likelihood of serious harm to health. Although the UK has not ratified the Bioethics Convention, following the Strasbourg Court's approach in *Glass v United Kingdom*³⁶ these provisions should be taken to be a guide to the likely interpretation of Article 8 of the ECHR.

Finally, Article 12 of Council of Europe Recommendation (2004) 10 concerning the protection of the human rights and dignity of persons with mental disorder, (again not ratified by the United Kingdom), provides that treatment of a mentally disordered person must be with consent if the patient is capable, and must be authorised by a representative, authority, person or body provided for by law. Treatment in emergencies may be carried out without such authority only when medically necessary to avoid serious harm to the health of the individual concerned, or to protect the safety of others.

The United Kingdom has reserved its right not to comply with the Council recommendation, as explained by the Minister of Health Rosie Winterton when she said:

[B]ecause we are in the process of revising important aspects of legislation in England and Wales on mental health and mental capacity, we were not in a position to identify definitively whether there were specific points in the Recommendation on which we might wish to reserve our right not to comply. We therefore said, at this stage, the United Kingdom wished to reserve its right not to comply with the provisions of the Recommendation generally.³⁷

³⁴ The CPT Standards, Chapter VI, para. 41.

³⁵ The Convention for the Protection of the Human Rights and Dignity of the Human being with regard to the application of Biology and Medicine (the Bioethics Convention) opened for signature in 1997. 31 other member states have signed.

³⁶ Judgment of 9 March 2004

³⁷ Hansard HC Debs 20 October 2004, col 796W.

Article 8 of the ECHR requires compulsory treatment to be carried out 'in accordance with law.' This means that the law must be sufficiently clear to be predictable in its effects, so that patients will know the circumstances in which they may be treated without consent, and the grounds on which such treatment must be based (protection of own health or that of others). The patient must be able to tell which of the Article 8(2) grounds is relied upon.

The MHA 1983 allows for the compulsory treatment of patients liable to be detained under the Act. A detained patient may be given ECT or medicine for mental disorder without their consent. This applies whether they are incapable of consenting to the treatment or capable but refusing it. If the patient is incapable or is refusing ECT, the treatment may only be given with the approval of a second opinion doctor appointed by the Mental Health Act Commission. The same procedure applies to medicines for mental disorder, but the patient may be required to accept medication for mental disorder for three months before becoming entitled to a second opinion. These are the 'supervisory procedures' where patients are to be treated without consent for mental disorder.

Since 2000 challenges have been brought under Article 3 and Article 8 against the regime of powers to treat compulsorily under Part IV of the 1983 Act. The English courts have accepted that treatment without consent can breach Article 3 if it is not a therapeutic necessity and reaches a minimum level of severity causing physical or recognised psychiatric injury.³⁸ The test for a second opinion doctor to approve treatment is whether the treatment should be given, having regard to the likelihood it will alleviate or prevent deterioration in the patient's condition. Following the introduction of the 1983 Act, a circular was issued stating that second opinion doctors approving treatment without consent should not ask themselves whether the proposed treatment is one they would recommend, but instead ask whether the treatment is one which other responsible psychiatrists would support, in other words the *Bolam* test. Since the HRA 1998 it has been made clear that second opinion doctors authorising treatment without consent must apply the test of therapeutic necessity rather than the *Bolam* test in deciding whether treatment without consent should be given. If a second opinion doctor authorises treatment without consent, written reasons must be given why the infringement of the right of respect for privacy is necessary to meet one of the goals in Article 8(2), which include health and the protection of the rights and freedoms of others.³⁹ There has been a steady move towards establishing the facets of quasi-judicial procedure, a right to be heard, a right to reasons, and tighter criteria to authorise treatment, including a rejection of the *Bolam* test.

³⁸ *R (on the application of Wilkinson) v Broadmoor Special Hospital Authority* [2002] 1 WLR 419, *R (on the Application of N) v Dr M and others* [2002] EWCA 1789 [2003] 1 WLR 562. *R (on the application of PS) v Responsible Medical Officer and Another* [2003] EWHC 2335.

³⁹ *R (Wooder) v Fegetter and Mental Health Act Commission* [2002] EWCA Civ 554

The next logical step in the test cases is to place further substantive limits on the power to treat without consent, by seeking to establish that treatment should only be able to be imposed without consent on an incapable person on grounds of necessity, and that the test of necessity to prevent serious harm to health or serious harm to other people be applied in deciding whether treatment without consent ought to be authorised. These developments will have to be achieved by the process of arguing that what is currently 'soft law' under the Bioethics Convention and the Mental Disorder Recommendation 2004 ought to be used, as in *Glass*, as indicators of a developing European framework of human rights for mentally disordered people and therefore as aids to the construction of the Convention.

In *Storck v Germany*⁴⁰ the Strasbourg Court held that there was a positive obligation for the state to take measures to protect the right to liberty under Article 5 and the right to personal integrity under Article 8 against infringements by private persons, and that both Article 5 and Article 8 had been infringed. The Court stated that 'Insofar as the applicant argued that she had been medically treated against her will while detained, the court reiterates 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*.'⁴¹

This statement suggests that the crucial factor in identifying a breach of Article 8 is the fact that the intervention is carried out against the individual's will, in other words that there is some resistance. However, in *HL v United Kingdom* the Strasbourg Court refused to treat compliant incapacitated patients as on a par with capable patients who were consenting. Reaffirming the importance of the right to liberty, the court said this:

The right to liberty in a democratic society is too important for a person to lose the benefit 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.⁴²

The Court emphatically rejected the argument that a compliant incapacitated patient should be treated on the same basis as a capable consenting patient in relation to deprivations of liberty under Article 5. The same principle must apply to interferences with physical integrity. It is too important to be lost simply because a person has given themselves up to the intervention, especially if they lack capacity to consent.

Seclusion and Restraint

⁴⁰ Judgment of 16 June 2005.

⁴¹ *Ibid.*, para 143.

⁴² *HL v United Kingdom*

In *Keenan v United Kingdom* the Court observed that where a person has been deprived of his liberty 'recourse to physical force which has not been made strictly necessary by his own conduct diminishes human dignity and is in principle an infringement of the right set forth in Article 3.' Mark Keenan, a mentally ill prisoner, had been placed in solitary confinement when he became disturbed and subsequently killed himself in seclusion. The court held that he had been punished in circumstances breaching Article 3 and there had also been breach of his Article 13 right to a remedy that would have quashed that punishment before it had been executed or come to an end.

No provisions in the MHA 1983 expressly justify seclusion. It is, however, subject to guidance under the MHA Code of Practice, defined as 'the supervised confinement of a patient in a room, which may be locked to protect others from significant harm. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others.' The Code requires that seclusion should only be used as a last resort and for the shortest period possible, reflecting common law necessity and the Convention principle of proportionality. It should never be used as a punishment or threat, as part of a treatment programme, because of shortage of staff, or where there is a risk of suicide or self harm.⁴³

In *Munjaz v. Mersey Care National Health Service Trust and S v. Airedale National Health Service Trust* the applicants challenged their seclusion in breach of the MHA Code of Practice.⁴⁴ The case establishes that legal powers to seclude exist under the 1983 Act and outlines the impact of Articles 3 and 8 of the Convention on those powers. The effects had not reached the level of severity necessary to engage Article 3. However, there was a potential breach of Article 8, under *Raininen v Finland* where it was held that respect for privacy under Article 8(1) includes the physical and moral integrity of the individual, and extends to deprivations of liberty', 'affording a protection in relation to conditions of detention that do not reach the level of severity required by Article 3.'

The Court of Appeal upheld both challenges to seclusion, holding that Ashworth were only entitled to depart from the Code with good reason, and that Airedale were not justified in keeping S in seclusion from the time when it ceased to be a necessary and proportionate response to the risk he presented to others. The Court of Appeal held that Convention rights obliged them to afford a status and weight to the Code consistent with the state's obligation to avoid ill-treatment of patients detained by or on the authority of the state. Seclusion would infringe Article 8 unless justified under Article 8(2) to protect health or the rights and freedoms of others. Since the justifications under the 1983 Act were very broad, the Code of Practice had an important role to play in securing that they had the necessary degree of predictability and transparency to comply with Article 8(2). Moreover, the need for frequent review of the continued need for seclusion is

⁴³ Mental Health Act Code of Practice (1998), para. 19.16.

⁴⁴ [2003] EWCA Civ 1036.

necessary in order to comply with the requirements of Article 13 as specified in *Keenan*.

If a hospital's policy or actions are in unlawful breach of the Code, legal remedies are available by way of judicial review according to traditional principles and under the Human Rights Act 1998, to declare and if necessary remedy any illegality and to award damages. The Court of Appeal decision in *Munjaz* establishes a lawful base for seclusion. It also seeks to meet the requirements of Article 13 by affording judicial remedies and requiring review of seclusion by nursing and medical staff whereby it may be brought to an end if no longer necessary. The House of Lords has since reversed the decision of the Court of Appeal, holding that hospitals are bound to follow the Guidance in the Code on seclusion but may depart from it if they have cogent reasons for doing so.⁴⁵ Both the Court of Appeal and the House of Lords held that seclusion potentially engages Article 8. Therefore it must be necessary, proportionate and must be carried out in accordance with law. This implies a certain level of transparency and predictability. The Court of Appeal and the House of Lords considered that this could be achieved by the Code of Practice. The Mental Health Act Commission has argued strongly that seclusion should be subject to legal regulation rather than left to the Code.⁴⁶ The ruling in *Storck v Germany* establishes that states are under a positive obligation to provide effective supervision and review of decisions to treat without consent, and this would most certainly include decisions to seclude.

Finally, it will be necessary to consider the way in which the principle in *HL v United Kingdom* applies to Article 8. If the right to liberty is too important in a democratic society to be lost merely because someone gives him or herself up to detention, so too must be the right of self-determination under Article 8(1), leading to the conclusion that treatment and seclusion without consent of compliant mentally incapacitated patients should be carried out in accordance with law and in a proportionate manner, according to ascertainable criteria.

The 1998 Act has undoubtedly strengthened the procedural rights of psychiatric service users under the 1983 Act in important ways. There has been a steady process of juridification of decisions to admit to hospital, to treat without consent, and to seclude. Patients' lawyers have sought to pursue a strategy of upholding what may be called the negative rights, not to be arbitrarily detained, not to be compulsorily treated unless treatment is clinically necessary, not to be secluded unless the safeguards in the MHA Code are observed. There have been

⁴⁵ [2005] UKHL 58.

⁴⁶ 'Regulations under the next Act should ensure that the definition of seclusion extends to all incidents of isolation and solitary confinement so that neither confusion nor obfuscation of definitions deprives patients of safeguards established for its use.' Mental Health Act Commission Eleventh Biennial Report 2003-2005 *In Place of Fear* (2006) TSO, 312. See also the Joint Committee on Human Rights, *Deaths in Custody: Third Report of Session 2004-2005* HL Paper 15-1, HC 137-1 para 245.

significant successes with this approach. At the same they have ensured that there is an effective legal framework for risk management, reaffirming the power to detain, to treat without consent and to seclude in a Convention compliant manner. Where their strategy has been to seek to extend patient's positive rights to treatment, support, and facilities which will enable them to be cared for in the least restrictive environment, it has been visited with much more limited success.

Human Rights and the Discourse of Law Reform

A protracted process of mental health law reform is drawing to a close. At the time of writing, Parliament is debating the Capacity Bill, a framework for decisions about the care and treatment of people who lack mental capacity resulting from a disturbance or disability of mind. A Draft Mental Health Bill is currently undergoing Pre-Parliamentary scrutiny by a Joint Parliamentary Scrutiny Committee. This will provide for the compulsory treatment of people who suffer from mental disorder, and who pose a risk to their health or safety or to other persons. The Mental Health Bill pursues an agenda of managing the potential risk posed by mentally disordered people in the community, whether to themselves or to others. Its two principle policy goals are to provide for the indeterminate detention of people with personality disorders, who pose a risk to other people, and to provide greater controls to ensure that mentally disordered patients in the community comply with medication regimes. This will be done by expanding the definition of mental disorder to offer increased possibilities to detain people with personality disorders and drug and alcohol problems by abolishing the so-called 'treatability test' for detention, and by increasing the legal controls which may be imposed on patients in the community, allowing for them to be taken and conveyed to a place where they will be required to accept medication, and requiring them to desist from any specified conduct.

The 2004 Bill defines mental disorder as an impairment or disturbance in the functioning of mind or brain resulting from any disorder or disability of the mind or brain, and in contrast to the Mental Health Act 1983 does not exclude people from being treated as mentally disordered by reason *only* of sexual deviancy, addiction to alcohol or drugs. People with these behaviours are not currently liable to be detained under the Act unless they have some accompanying mental disorder. The Convention concept of unsoundness of mind poses no obstacle to a broad definition of mental disorder. Since Article 5(1)(e) provides for the detention of alcoholics and drug addicts, the removal of the exclusion in respect of these groups will not contravene the Convention.

There are five conditions of compulsion in the Bill.⁴⁷ First the patient must be suffering from a true mental disorder from an international diagnostic manual such as the DSM IV or the ICD 10. Secondly, the mental disorder must be of a kind or degree warranting medical treatment. This is a much lower threshold than is required for compulsory admission under the 1983 Act or under Article 5, where the mental disorder must be of a kind or degree warranting confinement.

⁴⁷ Mental Health Bill 2004, cl. 9.

The 2004 Bill is intended to provide a single gateway to compulsory treatment in the community or in hospital, hence the lowering of this threshold. The third criterion, the risk criterion, requires that treatment must be necessary for the protection of the patient from suicide or severe self-harm, or serious neglect by him of his health or safety, or for the protection of others. This raises the threshold of compulsion higher than the 1983 Act test of necessary in the interests of the patient's own health or safety or for the protection of others, but only in relation to admissions in the person's own interests, not to those which are in the interests of others.

The fourth criterion is that medical treatment cannot lawfully be provided to the patient without him being subject to the provisions of this Act. The other ways of lawfully providing the treatment would be first if the patient consents to it, or second if the patient lacks capacity and is not resisting, and could therefore be treated under common law necessity. This latter avenue has now been closed off, other than in emergencies, by the ruling in *HL v United Kingdom*. This fourth criterion does not apply if the patient is at substantial risk of causing serious harm to others. Every patient who is subject to assessment for the use of compulsory powers will have to be assessed as to whether they pose a substantial risk of serious harm to others. If so it will be possible to detain them even if they consent to admission, and also to dis-apply principles in the Code of Practice, most notably the principle of proportionality, that detention may not be used if there is a less restrictive alternative. This is contrary to the principles established consistently by the Strasbourg Court in Article 5⁴⁸ and in Article 8⁴⁹ cases that proportionality applies to all deprivations of liberty and interventions with privacy. It is pointless to dis-apply proportionality, because if a patient is high risk, detention will be a proportionate response.

The major effect of this provision is that the Government can be seen to be affording fewer protections to patients who are at substantial risk of causing serious harm to others. Its possibly unintended effect will be to reinforce any connection in the public mind between mental ill health and dangerous behaviour. This sits uneasily with Standard One of the National Service Framework for Adult Mental Health Services which states that health and social services should: promote mental health for all, working with individuals and communities to combat discrimination against individuals and groups with mental health problems, and promote their social inclusion.⁵⁰

⁴⁸ *Litwa v Poland*, no. 26629/95 (Sect. 2), ECHR 2000-III.

⁴⁹ *Pretty v United Kingdom* 66 BMLR 147.

⁵⁰ *A National Service Framework for Mental Health: Modern Standards & Service Models* Department of Health; September 1999, accessible at www.doh.gov.uk/pub/docs/doh/mhmain.pdf

The fifth criterion is that appropriate medical treatment is available, taking into account the nature or degree of his mental disorder and all other circumstances. This is the replacement of the so-called 'treatability' test in the 1983 Act, and is a key part of the Government's public safety agenda. Treatment does not have to alleviate or prevent deterioration in the patient's condition (the 1983 Act test for admission of people with psychopathic disorder or mental impairment). Under the Bill appropriate treatment must be available which is appropriate. This could include psychotherapy or counselling which is available, even if the patient is not co-operating with it. The treatability test is seen by many as a bulwark against the use of mental health legislation for preventive detention. The Government has drawn support for its abolition from *Karl Anderson and others v. The Scottish Ministers and the Advocate General for Scotland*.⁵¹ There the Privy Council held that it was a matter for domestic law whether a person deprived of his liberty on grounds of unsoundness of mind in circumstances which meet the *Winterwerp*⁵² criteria should also receive treatment for his mental disorder as a condition of his detention. So too was the place of his detention, so long as it is a place suitable for the detention of persons of unsound mind. The fact that a person's mental disorder is not susceptible to treatment does not mean that, in Convention terms, his continued detention in a hospital is arbitrary or disproportionate.

This view has since been reinforced by the decision in *Reid v United Kingdom* that 'No ... requirement [that the mental disorder be amenable to medical treatment] was imposed by Article 5 (1)(e) of the Convention.' The Court held that '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 other persons'.⁵³ Both the House of Lords and the Strasbourg Court gave strong support to the public safety agenda, and left no obstacle in the way of weakening the treatability test.

Under the Bill patients may have resident (detained) or non-resident status. Residents are required to accept treatment in hospital. Non-residents may be required to live at a specified place, to grant mental health professionals access to them, and to attend a specified place at a specified time for the purpose of treatment. These powers were available in respect of patients subject to guardianship and subject to supervised discharge under the 1983 Act. The Mental Health (Patients in the Community) Act 1995 added a power to take the patient and convey him to the place where he is required to attend for treatment. Once at that place, the patient could only be forced to accept the treatment, in the words of the Code of Practice, if it was 'an emergency covered by the common law.' The treating psychiatrist was then entitled to assess the patient for possible re-admission to hospital.

⁵¹ 15 October 2001

⁵² (1979) 2 E.H.R.R. 387.

⁵³ *Hutchson Reid v United Kingdom*, para 51.

The 2004 Bill allows for the imposition of a fourth condition that the patient does not engage in specified conduct,⁵⁴ reversing the 'essential powers' approach of the 1983 Act which confined community powers within narrower limits needed for the delivery of care and treatment. Added to the list of potential conditions is the requirement that the patient desist from any conduct specified. This is reminiscent of anti-social behaviour orders, but much more wide ranging, reflecting a return to the breadth of powers conferred by the Mental Deficiency Act 1913 and the Mental Health Act 1959 where the guardian had all the powers of a father over a child under 14. The second extension is that once the patient has attended at the required place for treatment, or has been taken and conveyed there having failed to attend voluntarily, s/he may be treated as a 'compulsory patient' whose consent is not required for treatment described in a care plan which is in force or has been approved by the tribunal.⁵⁵ In other words reasonable force may be used to treat non-resident patients without consent, but only once they have been taken to the hospital or clinic which they are required to attend for treatment. The Bill will undoubtedly widen the scope of compulsory powers, both in terms of the population eligible for compulsion and in terms of the powers available to treat compulsorily. The safeguards against wrongful or over zealous use of these powers therefore become all-important

Safeguards

Under the 1983 Act, a person with a mental disorder of a nature or degree warranting detention can be detained if necessary for their health *or* safety *or* for the protection of others. Dangerousness is not a prerequisite of detention. As a counterweight to this strong paternalism the 1983 Act gives substantive rights to the patient's 'nearest relative' to be consulted and to object to compulsory admission. The nearest relative may request the discharge of a detained patient and the authorities must discharge the patient unless the patient is likely to act in a manner dangerous to self or others. The family can take responsibility for their family member's health needs, but not if the patient is dangerous to self or others, where the state has the power to take over and provide care under detention. Even then the nearest relative retains rights to question the need for detention before the detaining authority and to seek discharge from the Mental Health Review Tribunal.

These rights are taken away in the 2004 Draft Bill. The nearest relative gives way to the nominated person, who is not appointed until after compulsory powers have been imposed. The patient can nominate this person, who will not have any rights in the substantive sense merely the right to express the patient's wishes and feelings to the authorities, and a right to apply to the Mental Health Tribunal for discharge from compulsion or transfer from detention to non-resident status. The mental health professionals will have to consider the patient's wishes and feelings and the views of the nominated person, but will not be bound by them.

⁵⁴ Mental Health Bill 2004, cls. 15(4), 26(5), and cl 46(7).

⁵⁵ *Ibid.*, cls 80, 198-200.

In *JT v United Kingdom*⁵⁶, the United Kingdom was held to be in breach of the right to respect for privacy under Article 8 because JT did not have a power to apply to court for displacement of her mother who was unsuitable to act as her nearest relative. The Commission stated that the absence of any possibility to apply to the County Court to change the applicant's nearest relative rendered the interference of her rights under Article 8(1) of the European Convention disproportionate to the aims pursued. The judgment of the European Court noted that a friendly settlement was reached between JT and the UK government, whereby the government undertook to introduce reform proposals to (1) enable a patient to make an application to the court to have his nearest relative replaced where the patient objected on reasonable grounds to a particular individual acting in that capacity, and (2) prevent certain persons from acting as the nearest relative of the patient. Three years later the Government had still not acted, and a declaration of incompatibility was granted in *R. (on the application of M) v. Secretary of State for Health*.⁵⁷ Convention compliance requires that the patient be entitled to apply on reasonable grounds to the court to displace their nearest relative, and disqualifying those who have abused the patient in the past. The Government's response is to throw the baby out with the bathwater, and to remove the possibility for carers and family members to act as effective protectors of the rights of their mentally disordered family member prior to detention, especially important if that person lacks mental capacity.

The Mental Health Tribunal

The key regulatory body under the Bill will be the Mental Health Tribunal (MHT). Patients will be subject to compulsory assessment and treatment for up to 28 days on the authority of determinations by an Approved Mental Health Professional (AMHP) and two doctors. Any compulsory treatment beyond 28 days will require the authority of the Mental Health Tribunal by treatment order or further assessment order. In making these orders, the tribunal will determine whether a patient should be a resident (detained) or non-resident patient. The tribunal will also approve the care plan indicating what treatment may be given to the patient under the order, and will be required to impose conditions which address the risk by reference to which the patient is subject to compulsion. This fundamentally changes the tribunal's role. It is to become the detaining authority, not simply the body that reviews lawfulness of detention. It will take over the functions currently performed by second opinion doctors under the 1983 Act, and will authorise Electro Convulsive Therapy (ECT) for adult patients subject to compulsion who lack capacity to consent or refuse treatment, and for all children under 16. The MHT would exercise functions under both Article 5(1)(e) to authorise detention and under Article 8 to authorise and review treatment. The tribunal will continue to exercise functions under Article 5(4) jurisdiction to review the lawfulness of detention, following applications by the patient or the nominated person.

⁵⁶ (2000) 30 E.H.R.R CD 77.

⁵⁷ [2003] E.W.H.C. 1094.

The fact that a judicial body will authorise both the imposition of compulsory powers and compulsory treatment is seen as the acme of human rights protection. However, it is necessary to question this assumption. The current system of compulsory admission is based on checks and balances, where the ASW has a discretion to make an application, and the nearest relative has rights to be consulted, to object to the initial use of compulsion, and to discharge a patient who is not dangerous to self or to others. Under the Bill, if the mental health professionals determine that the conditions are met, the patient automatically becomes subject to compulsory assessment. The patient's carer has a qualified right to be consulted, but no right to object. Once the person is subject to compulsory assessment, they or their nominated person may appeal to the MHT. If, on such an appeal, the Mental Health Tribunal is satisfied that the new broad conditions of compulsion are met, they must make a treatment order or continue the assessment order. If not, they must discharge. Issues of burden of proof are studiously avoided.

It will be difficult for a patient who has been obliged to take medication in the community to convince the tribunal that compulsory treatment is not necessary to prevent serious self-neglect by him of his health. Currently the issue is more straightforward, whether the patient should be discharged from liability to detention in hospital. The conditions under the Bill are so broad that once a person has been subject to compulsion, it will be very difficult for them to achieve discharge. In *Karl Anderson v Scottish Ministers*, the Privy Council referred to the 'lobster-pot' effect but the Bill's procedures might more accurately be described as a 'dragnet' in that the process of initial compulsion has much fewer safeguards for patients and their families, and once in the system of compulsion, it will be hard to achieve discharge.

It is not necessary to have the MHT authorise compulsion to achieve Convention compliance. It is questionable whether the new framework provides more effective safeguards for patients' rights, given the breadth of the powers of compulsion and the removal of the nearest relative's rights. It is also questionable whether the Bill justifies the Government's confidence in its compatibility with Convention rights,⁵⁸ considering the dis-application of proportionality to patients at substantial risk of causing serious harm to others. With the exception of the procedures in relation to ECT, there are issues concerning the existence of a sufficiently predictable procedure to impose treatment without consent on a capable patient. Perhaps most difficult is the issue of achieving compliance with *HL v United Kingdom*. Estimates of the numbers of compliant incapacitated patients vary between 20,000 and 40,000. If all these have to be subject to a procedure prescribed by law, this will be difficult to achieve when the procedures for deprivation of liberty in both the Capacity Bill and the Mental Health Bill involve authorisation by judicial bodies, the Court of Protection or the MHT.

⁵⁸ DoH, *Improving Mental Health Law: Towards a new Mental Health Act* TSO 2004, para 1.4.

Conclusion

At meetings discussing the 2002 Draft Mental Health Bill (substantially the same as the 2004 Draft), Departmental officials spoke of a 'new human rights agenda', based on the idea that the community should have strong rights to protection against potential depredations visited upon them by mentally disordered people. The rights of the community should be weighed in the balance against those of individual psychiatric patients, and in certain cases should trump those individual rights. The new human rights agenda involves reading up the state's positive duty under Article 2 to uphold the public's right to life under *Osman v United Kingdom*. *Osman* establishes that Article 2 is breached if the authorities 'knew or ought to have known at the time of the existence of a real and immediate risk to the life of identified individual or individuals from the criminal acts of a third party, and failed to take action within the scope of their powers which, judged reasonably, might have been expected to avoid that risk.'⁵⁹

The new human rights agenda reads down the individual Article 5 and Article 8 rights of psychiatric patients to protection against arbitrary detention and against arbitrary compulsory treatment. The Government has aimed for the minimum level of restraint on compulsory powers consonant with Convention compliance, and have avoided ratifying the Council of Europe Conventions and recommendations that seek to uphold the dignity of mentally disordered people. The 2004 Bill opts for the widest possible definition of mental disorder, further weakening of the treatability test, removal of nearest relatives' rights, and reduction of the rights of patients who are at substantial risk of causing serious harm to others. The main burden of legitimising this expansion of compulsory powers is on the MHT, and may prove too great. The 'new human rights agenda' privileges public safety concerns, and leads to reduction of protection for service users and their families. This concept of Convention compliance will result in increased stigmatisation and social exclusion of mentally disordered people, and the pre-eminence of public safety will eclipse the social inclusion agenda in the National Service Frameworks.

⁵⁹ (1998) 29 EHRR 245 at 305.

Dr Sev Ozdowski OAM – Human Rights and Mental Health in Australia

Acknowledgments

Thank you for the opportunity to speak today.

My best congratulations to the organisers: Christine Wilson, Farah Kabir and Alison St. Clair-Ford - it takes plenty of effort and good planning to organise such an important international seminar.

Allow me also to acknowledge:

- the Seminar chair
- my fellow speakers
- all other distinguished guests who have worked to champion the rights of people affected by mental illness.

Introductory Comments

I have been asked to speak briefly about Australian experience in the area of human rights and mental health. So I propose to give you a *tour de horizon* of Australian developments in this area over the last 10 years or so.

I understand that this seminar has a very practical focus as it aims to:

- raise awareness amongst policy makers regarding policies and legislation, and
- initiate dialogue for both practitioners and advocates.

Let us start with few introductory comments.

Prevalence of mental illness

Allow me first to call to mind the human scale of the issues we are talking about.

In 1998 the Australian Bureau of Statistics (ABS) estimated 2,383,000 adults, out of some 20 million Australians, had a mental disorder. This included 1,300,000 people with anxiety disorders; 778,000 with depression or other affective disorders; and 1,041,000 with substance use disorders. (Adding these numbers gives more than the total number of individuals affected because some people had more than one mental disorder.)

The rate of mental disorders was highest in the 18 to 24 year old age group with a staggering rate of 27%. The ABS did not have as clear a set of figures for mental health problems in children and adolescents as for adults. But it did indicate 20% of adolescents had significant mental health problems.

A study by Robyn Vines *et al.* published in the Medical Journal of Australia (MJA) in July 2004 asserts that *'About 25% of Australians report at least one mental disorder in any 12-month period, and between 19% and 40% presenting to general practitioners have mental health difficulties.'*

The Australian figures are not that different from mental health statistics recorded here in the United Kingdom or in any other parts of the world. So if one could paraphrase a quotation: *'The statistics on sanity are that one out of every five people this year will experience some form of mental illness. Think of your four best friends. If they're okay, then it's you.'*

Mental illness associated with disadvantage and poverty

In all countries I surveyed, including Australia and the United Kingdom, mental disability is associated with disadvantage and poverty.

People with mental illness and their families have much smaller incomes, participate less often in the workforce and are more often unemployed. They face difficulties with accessing education, housing, transport, communication, health and social services and so on. Many people with mental or psychiatric disability suffer daily violence, intimidation and denial of their basic civil rights in addition to economic disadvantage. Further more many of them suffer stigma and type-casting. In fact they are one of the most marginalised groups in our society.

Government responsibility

In modern society a significant part of the cost of medical care and the social services required by people with mental health problems is a government responsibility. The government is also responsible to ensure that people with mental illness are not discriminated against and can meaningfully and equitably participate in community life when they are well.

But when one looks at these statistics it is remarkable that for so long people with mental disabilities were pushed to the margins, or not taken into consideration at all in major social decisions. They were pushed to the margins because their special needs were overlooked or given lower priority in budgetary allocations for mental health services and infrastructure.

People with mental illness also were failed because often no adequate regulatory regimes or effective implementation mechanisms were put in place. Lack of proper regulation and laws deny people with mental disability their human rights and equal standing in society.

To sum up, mental illness is now the biggest social issue that is confronting contemporary society. This clearly constitutes a significant challenge to contemporary policy makers and to those who advocate for people with mental disability.

Mental health and positive rights

The role of government in relation to human rights is not limited, however, to refraining from arbitrary or illegal actions which infringe upon human rights - actions such as wrongful detention or illegal deportation, to pick a couple of examples out of the air.

People also look to governments to take positive actions to secure human rights. Those actions can require the application of very substantial resources. One cannot have the basic rights to a fair trial and equal protection of the law without investing in independent judges, impartial and uncorrupted prosecutors and police as well as other features of a justice system. Equally, you cannot have the right to the highest attainable standard of mental health without investing in the medical and community facilities to ensure that people who need it have access to treatment and support.

Mental health is a human rights issue

Introduction

It is very appropriate to be having a conference that highlights mental health as a human rights issue. And today I am addressing you not as an expert on mental health, but as a human rights expert. Thus, I will emphasise the human rights dimensions of mental health issues.

Australia does not have the US style Bill of Rights; it also does not have a document similar to the *British Human Rights Act* (1998); neither is it a party to the *European Convention for the Prevention of Human Rights and Fundamental Freedoms* (1950).

Protection of rights of people with mental illness in Australia depends on:

- relevant standards set up in international conventions acceded to by Australia;
- Australia's domestic laws, including common law, elected legislatures, independent courts, free media and the broader civil society including mental health advocacy NGOs; and
- a range of official watchdogs, including the Human Rights and Equal Opportunity Commission (HREOC or the Commission).

International human rights law

As early as in 1948 Australia signed and then ratified the ***Universal Declaration on Human Rights***. Article 25 of that Declaration refers to '*the right to medical care and other necessary social services as part of a right to an adequate standard of living.*' The Universal Declaration is not a binding treaty. But it is accepted around the world as a common standard for governments to strive towards and, in the case at least of more prosperous countries like Australia, a standard that people should feel entitled to expect.

Then, Australia signed and ratified a range of important human rights treaties, which explicitly recognise the right of everyone to the highest possible mental health care. For example:

- the ***International Covenant on Economic Social and Cultural Rights***, Article 12, states: *'The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.'*
- ***The Convention on the Rights of the Child***, Article 24, states: *'States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.'*

It also adopted ***the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*** (United Nations General Assembly, 1991) which reinforce the rights enshrined in the International Covenants and provide valuable guidance as to how those rights ought to apply to people with mental illness, namely:

- Principle 8(1) makes clear that people with mental illness have the right to the same standard of health care as other ill persons.
- Principle 14 states that mental health facilities should have the same level of resources as any other health facility.
- Additionally, Principle 7 emphasises the right to be treated and cared for as far as possible in the community.

Currently Australia is actively working with UN on a new convention dealing with human rights of people living with disability. The convention will cover human rights of people with mental disability as well.

Domestic implementation of international HR treaties

Although the Australian Government was closely involved in the negotiation of the human rights treaties and then ratified them, the fact is that the treaties and international declarations of principles do not implement themselves as they are not self-executing in Australia. To implement them, Australian Parliament needs to create domestic laws.

Supporters and opponents alike of the role of the United Nations in human rights often speak as if the main point of international human rights law is as a commitment to the international community. But really the point of the Australian government subscribing to human rights treaties and supporting international declarations on human rights issues is as a commitment to the people of Australia. Delivering on that commitment and keeping faith with the people requires accountability.

One way which Australia and other countries have tried to promote accountability on human rights issues is by establishing domestic anti-discrimination legislation and human rights commissions.

In 1992 Australia enacted the ***Disability Discrimination Act*** 1992, which contains a broad definition of disability which includes mental disability. It prohibits discrimination on the basis of '*physical, intellectual, psychiatric, sensory, neurological and learning disabilities*'. Australia also has a relatively generous welfare system with medical and social services for people with mental illness.

However, it is important to stress that protection of human rights is not only the task of relevant legislation or even a human rights commission. Protection of human rights is everybody's business. All parts of the political and legal system and indeed organisations beyond that in the private and community sector, also have to play their part if human rights of the mentally ill are to be realities.

The Australian Human Rights and Equal Opportunity Commission

The Australian Human Rights and Equal Opportunity Commission (HREOC) is a national independent statutory authority established by the *Human Rights and Equal Opportunity Commission Act* (HREOCA) in 1986. The Federal Attorney General is the Minister responsible in Parliament for the Commission.

The Commission is administered by the President, who is the Chief Executive Officer. He is assisted by the Human Rights, Race, Sex, Disability and Aboriginal and Torres Strait Islander Social Justice Commissioners. Under the legislation administered by the Commission, HREOC has responsibilities for inquiring into alleged infringements under five anti-discrimination laws – including the Disability Discrimination Act 1992 as well as inquiring into alleged infringements of human rights under HREOCA.

Furthermore, the Commission jurisdiction is defined by reference to international human rights instruments appended to the HREOC Act. Its role is not to be the mental health expert but to promote public debate and political accountability on how well Australian governments deliver on these commitments made to Australian people through ratification of international human rights treaties. For more see: www.humanrights.gov.au

HREOC activities in the area of mental health

HREOC has a proud record of long standing involvement with mental health issues. One of the things HREOC has done successfully over the years is to provide forums for the voices of people who are disadvantaged and have difficulty being included and heard.

This brings me to the subject of the Burdekin Inquiry of 1993 and to my current work in the area of mental health.

Burdekin Inquiry

Background

Back in 1993 the Commission released the report of its National Inquiry into the Human Rights of People with a Mental Illness. It is widely known as the Burdekin report, in honour of the massive contribution by my predecessor Commissioner Brian Burdekin. This report was based on a national inquiry carried out over several years, including hearings conducted around Australia, hundreds of submissions and on extensive research.

At that time the mental health system had begun to move away from institutionalisation to care predominantly occurring in the community. This approach remains supported by all the experts and by all major organisations in the mental health sector.

In summary form, the Inquiry found that the care and support provided by the Australian health care system at that time contravened the basic human rights of our mentally ill and that while institutions were being closed down, community support was not being adequately built up.

Findings

In particular the 1993 Inquiry has found that:

- although the movement towards community care and mainstreaming of mental health services had reduced the stigma associated with psychiatric care, in general the money saved by deinstitutionalization had not been redirected into mental health and related services in the community.
- Health services and other services which would enable people with a mental illness to live effectively in the community were found to be seriously under funded or in some areas just not available at all. Thus, people affected by mental illness were suffering from widespread systemic discrimination and were consistently denied their human rights and services to which they were entitled.
- Governments were found to be relying increasingly on NGOs to provide services but were treating NGOs as peripheral in the allocation of funds.
- Accommodation for people with a mental illness was found to be particularly inadequate, with government housing support programs either excluding people with mental illnesses or failing to address their specific needs. The absence of suitable supported accommodation was the single biggest obstacle to recovery and effective rehabilitation.
- In the employment area, people affected by a mental illness were found to be disadvantaged by negative attitudes, a lack of awareness of means of accommodating employees with a psychiatric disability, and by inadequate vocational and rehabilitation services.
- Families and carers were found to be badly overstretched and insufficiently supported.

- Mental health services for children and young people were found to be seriously under developed. There were also recommendations for improvements in services for women. As well as recommendations on culturally appropriate services for Aboriginal and Torres Strait Islander people and people from non-English speaking backgrounds.
- Mental health professionals and allied staff working both in institutions and the community were found to require education and training in the delivery of community based services. And needs for improved education and training were identified throughout the sector.
- Mentally ill people detained by the criminal justice system were frequently denied effective health care and human rights protection. Procedures for detecting and treating mental illness and disorder in the Australian criminal justice system were found inadequate in all jurisdictions.
- Laws regulating mental health services were found to be badly in need of reform. On one hand, laws failed to recognise sufficiently the principle of applying the “least restrictive alternative” and gave wide discretionary powers of detention without sufficient provision for review of decisions for detention or compulsory treatment. Yet on the other hand, there was inadequate provision for treatment as a voluntary patient, much less a recognised legal right to access treatment. Furthermore laws providing safeguards regarding hospital treatment generally failed to extend to community treatment.

Implementation of the Burdekin report

The federal and state/territory governments of Australia did make major responses to the Burdekin Inquiry. In particular, the Inquiry clearly contributed to the development of the first National Mental Health Strategy which reflects a human rights approach to mental health.

The Strategy was a welcome and overdue acknowledgement of the role of the federal government in mental health. In fact, the federal government allocated funds for the first time specifically for mental health services, and became involved in providing some leadership in the area through a collaborative National Mental Health Strategy, rather than just leaving it all to the states. Federal initiatives in response to the Inquiry Report included \$200 million over 4 years for services either directly targeted at, or providing substantial benefit to, people affected by mental illness.

The states and territories also increased their funding in response to the 1993 HREOC report.

There were also substantial law reform initiatives. A particular issue in the criminal justice area highlighted by HREOC’s inquiry was the position of people found unfit to plead because of their mental condition. A person who could not be tried would generally be subject to indeterminate detention “at the governor’s pleasure.” The inquiry described this as a clear breach of human rights. It meant

that a person with a mental illness might well serve a longer period of imprisonment than if he or she had been convicted, and without any opportunity to have the charge tested.

Furthermore, it can be said confidently that the 1993 Inquiry had contributed to changing perceptions of mental illness. It did highlight issues affecting people with a mental illness as human rights issues rather than being purely medical issues. Its views and recommendations have been widely adopted by governments at least at the level of principle.

An evaluation of Australian mental health legislation was conducted then for the Australian Health Ministers Advisory Council, by reference to a “rights analysis instrument” based on international standards. This evaluation had shown that there had been significant progress. Every state and territory had amended or was amending its mental health legislation to move away from an emphasis on detention to a model based on human rights.

However, the same evaluation showed that no Australian jurisdiction had achieved full compliance with the United Nations Principles for Protection of Persons with Mental Illness and for the Improvement of Mental Health Care.

Post Burdekin years

Despite the initial positive response to the 1993 Inquiry, there was clear understanding among the mental health advocates that there is a great distance still to travel before we could be satisfied that we are responding adequately to the human rights of people who have or have had mental illness.

Over the next few years however the mental health reforms stalled and mental health budgets flattened, or even went into decline in some places and the situation of people with mental illness became even more difficult. In fact, small scale post-Burdekin monitoring by HREOC has indicated continuing concerns. These relate both to the level of resources and to implementation of HREOC recommendations about co-ordination of services and program design and eligibility.

The most substantial follow ups to the 1993 mental health report were HREOC’s 1998 consultations in response to concerns regarding community treatment orders. These consultations only dealt with a small sample of the issues covered by the national inquiry report, but they indicated that implementation of the report remains far from complete. In fact, they provided disturbing evidence about how little has changed in practice.

Consultations suggested that the right of people with mental illness to live, work and participate in the community to the full extent of their capabilities is still being compromised by the lack of available community based services and care options.

Particular criticism was made of community treatment orders. HEROC was told that:

- community treatment orders often amount to nothing more than a fortnightly injection at a local medical clinic or a community mental health service.
- mental health consumers are often subject to a community treatment order without receiving adequate case management, review or follow-up.
- mental health consumers subject to community treatment orders do not have access to, or support in accessing, an appropriate range of services that meet their needs for leisure, recreation, education, training, work, accommodation or employment.
- community based services are often non-existent or fragmented.

More recently non-government organisations have been expressing particular concern regarding income support arrangements – on the basis that people who fail to attend job interviews or meet other requirements because of mental health issues are being “breached.” Failing to meet these requirements meant being cut off from income support for weeks or left to survive on drastically reduced benefits.

By the year 2000 it appeared that despite the advances in legislation and in policy at the level of rhetoric, the reality for people with a mental illness and their carers continued to be denial of human rights in practice. It appeared clear that most of the Burdekin recommendations about the support needed by people with a mental illness still needed attention.

CIDI inquiry

In December 2000, when I was appointed as the Human Rights Commissioner, the Australian mandatory immigration system had become one of the most important human rights concerns. In November 2001 I announced that the Commission would hold a National Inquiry into Children in Immigration Detention (CIDI).

And here it is important to stress again the role of the international human rights law in this enterprise. The conduct of CIDI inquiry by HREOC was only possible because Australia adopted the *Convention on the Rights of the Child* (CROC) in 1989 and because CROC has been incorporated into the HREOC mandate. The Convention indeed provided a very powerful tool and formed the backbone to the CIDI report to Parliament on children in immigration detention, titled: “*A last resort?*” (for more see: www.hreoc.gov.au/human_rights/children_detention_report/report/index.htm).

In fact, CROC’s standard setting influence is almost universal. At this time, CROC is the most widely adopted Convention in the history of the United Nations and it formally establishes in international law a range of clearly defined

children's right to special protection and care. One of the basic principles of the convention is that *"the best interest of the child"* should be a primary consideration in all decisions that affect them. In the case of unauthorised immigration, CROC allows detention of children only in exceptional circumstances *"as a matter of last resort"* and *"for the shortest appropriate period of time."*

Although CROC covers almost everything from education to health, both physical and mental, to the right to play and the right to family unity, Article 24(1) of CROC requires ensuring that all children in Australia enjoy: *"the highest attainable standard"* of physical and mental health that Australia can offer. Or as it is stated in the formal treaty language: *"States Parties recognise the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services."* (Art. 24 (1)).

During the CIDI inquiry it became painfully obvious that long-term detention is associated in some cases with serious deterioration of mental health. However, the most serious finding of the detention inquiry was the failure of the Department of Immigration and Multicultural and Indigenous Affairs (DIMIA) to implement the recommendations from mental health professionals that certain children and families with mental health problems cannot be treated in detention and that they should be released for appropriate treatment.

The recommendation read as follows: *the Government's 'failure to implement repeated recommendations by mental health professionals to remove children with their parents from detention amounted to "cruel, inhumane and degrading treatment."*

Although the CIDI report was criticised by the Minister of Immigration as backward looking and harsh on DIMIA when it was released, soon after its release the government started removing all children and parents from detention and before the end of my term as the Human Rights Commissioner all children were out of the detention centres. The fact that children with their parents were allowed out of immigration detention centres is a testimony both to the strength of international law concerning human rights standards and to the strength of Australian civil society.

In fact, by now the CIDI report looks rather prophetic in the light of the revelations of the treatment of two mentally ill women, namely Cornelia Rau and Vivian Solon-Alvares, by DIMIA and other areas of government. Cornelia Rau, permanent resident of Australia since her childhood, was kept in prison and then in Baxter detention centre by a DIMIA mistake for some 10 months and Vivian Solon-Alvares, an Australian citizen, was wrongfully deported to her mother country the Philippines.

But let me briefly give you one “inhumane treatment” case study from the report to add a little flesh to the dry bones of that 'finding' and I refer now to the case of a 13 year old child who had been seriously mentally ill since May 2002.

This boy had regularly self-harmed. In February 2003 a psychiatrist examining the boy wrote the following: *‘When I asked if there was anything I could do to help him, he told me that I could bring a razor or knife so that he could cut himself more effectively than with the plastic knives that are available.’*

The most disturbing fact is that there had been approximately 20 recommendations from mental health professionals saying that he should be released from detention with his family. Some said that removal from detention was a matter of urgency.

When finally released, (after 3 years detention, and 2 years after mental illness diagnosis) as refugees, following a Refugee Review Tribunal finding, into the Adelaide community, all members of the family were severely mentally traumatized; prescribed heavy, daily medication, too ill to work and requiring extensive community support and assistance.

Some time after the CIDI report was tabled in Parliament, I visited the family of the 13 year old boy in Adelaide and I found that the boy and his father still suffer from mental health problems and do have major problems in accessing mainstream mental health services. I followed this up with some other refugees and their advocates to see what assistance they were able to get in the broader community and found that again the mental health system was failing them. Being very concerned about what I had seen and heard, I subsequently spoke with our top mental health bureaucrats and asked for an explanation of the current shortages.

There was no satisfactory explanation received. It became clear, that the mental health system of Australia was not delivering on the promise of the Burdekin reforms, at least as far as refugees were concerned. It was time to take another look at the performance of mental health services in Australia.

Human Rights and Mental Health “Not for service” Report

Background

From the time I commenced as Human Rights Commissioner in 2000, I was receiving report after report indicating a situation of ongoing crisis in access to effective mental health services. Ever increasing concerns were also being communicated to me by community members and NGOs.

I was reluctant to commence yet another inquiry in this area and add to the pile of reports and impose on the limited resources of HREOC (HREOC lost some 40% of its budget in 1996). For some time people working in the mental health sector

were saying that they actually did not want another inquiry because it would just put pressure on the people and organisations struggling to provide services and supports with inadequate resources.

As time went by I became more and more concerned about the obvious failures of mental health services and formed a view that HREOC need again to undertake major work in this area to:

- refocus debate on mental health as a human right; and
- draw public and political attention to the failures of the mental health system as a means of promoting accountability and remedies where abuses or neglect of human rights were found.

Or in other words, the purpose of this national review of human rights and mental health issues was not to produce another report, but to put the issue of the lack of mental services on the national agenda. To achieve this, the involvement of the Australian civil society was needed. In particular the review needed public opinion makers, media, church leaders and many others to publicise the issues associated with mental health shortages to be effective. The review needed cooperation of the whole civil society working together with HREOC for a change.

So, when in 2004 I, as the Human Rights Commissioner joined forces with the Mental Health Council of Australia (MHCA) and the Brain and Mind Research Institute to conduct a national review of human rights and mental health, our common purpose was, rather than to talk about inadequate services and outcomes, to put the focus where it belongs, on governments and bureaucracies which were still not giving enough priority to mental health issues - and on a community and political culture which allows them not to.

Methodology

The primary mechanisms used to collect data for this review included:

- written submissions
- consultations
- open community forums, and
- two community surveys

In addition, the Human Rights Commissioner wrote to all state and territory governments seeking information about the levels of community need and the effectiveness of mental health services. A draft report was provided to all governments for their comment.

Consultations and community forums

To start with, MHCA and HREOC issued an invitation to all those interested in mental health issues to provide written submissions. In response, some 360 submissions covering a wide range of issues were received by the review.

The consultations were conducted all over Australia: Perth, Brisbane, Sydney, Canberra, Bunbury in WA, Rockhampton and Broken Hill – to name but some of our destinations - and invited mental health experts to share their mental health experiences with the review. And it will come as no surprise to most of you here, that the review team was overwhelmed by the number of experts participating and the quality of their submissions.

Then between July and October 2004 the review conducted 20 open community forums in each State and Territory. Approximately 1,200 people came to participate in the forums including consumers, carers, general members of the community, clinicians, advocates, service providers (e.g. mental health, general health, accommodation providers), emergency personnel (e.g. police), academics and administrators.

We also conducted individual meetings with specific community, professional and non-government groups as well as meetings with various members of State and Federal governments.

The volume of input we received to the review from all these sources was overwhelming, as shown by the fact that the “*Not for service*” report is nearly as large as the original Burdekin report.

The findings – key points

The story that unfolded is not a pretty one. It is true to say that there is a long way to go before Australia’s mentally ill can truly enjoy the highest attainable standard of mental health as the human rights treaties require.

The people consulted make two general points.

First, that there is increasing evidence that widespread use of common drugs such as cannabis, amphetamines, alcohol and ecstasy had been contributing to an increased rate of mental illness among young people. In addition, that they were making those young people even more disturbed when they finally present for care.

And second, that in the treatment of mental illness the state government services were failing in the delivery of proper care. Not only was there a general lack of services, but there was also a huge shortage of services that cater specifically to young people who need help. It was often a tragic tale of medical neglect and community indifference. Those with a mental illness were still being blamed for being sick. And this kind of thinking affects those who care after the ill in every State and Territory. And, tragically, it affects the young more than we would like to admit.

Below there is a list of specific findings made by the review:

Inadequate resources

Resources provided were simply inadequate to match the level of needs and ensure access to treatment and services when they were needed. Australia currently spends only about 7% of its health budget on mental health. By comparison, other first world economies are spending between 10-14% of their health budgets on mental health. New Zealand now spends twice as much per capita compared with this country.

This call from the grassroots for more resources is backed up by the governments' own assessments. The evaluation of the Second National Mental Health Plan published by the Department of Health and Ageing in March 2003, stated that: *"While the aims of the Second Plan have been an appropriate guide to change, what has been lacking is effective implementation. The failures have not been due to lack of clear and appropriate directions, but rather to failures in investment and commitment."* A shorter and plainer way of saying that is to say that governments have not sufficiently matched their words with dollars.

The review was also told of a pattern of underspending and lack of investment in mental health.

Furthermore, accountability for money allocated to mental health services was seriously lacking. And even when resources were provided in name, there was no serious accountability for how that money was spent. For example, the West Australian Government withdrew \$4 million dollars provided under the National Mental Health Plan from mental health services and reallocated the money into general health. The reason? Different priorities.

Absence of early intervention

The most frequently mentioned gap in mental health services was the absence of early intervention and other specialist services for young people. We know that approximately 75 percent of mental illness first occurs in people aged between 15 and 24 years old. One in four people in that age group will suffer a mental illness in any 12 month period. Yet when the illness emerges many of these young people are denied basic treatment and care – they are simply told to go home and sort themselves out and only to come back when they are really ill.

This is despite the fact that Australia leads the way in development of early intervention programs for the mentally ill. A group of Australian clinicians led by Professor Pat McGorry in Melbourne has developed world-leading programs for young people in the early phases of psychotic and other severe mental illnesses. These programs are now being rolled out nationally in the United Kingdom and underpin major initiatives in Scandinavia, Europe and the USA. However, these same programs are still not being delivered routinely in Australia.

Lack of prevention and early intervention will mean the high cost of the treatment, in the future.

Lack of services for dual diagnosis

Many people with mental health problems have a range of other health and care needs.

As I have mentioned earlier, in Australia, there is increasing evidence that widespread use of common drugs such as cannabis, amphetamines, alcohol and ecstasy is contributing both to an increased rate of mental illness among young people as well as making those young people more severely disturbed when they finally do present for care. This also increases the likelihood that police or corrective services will become involved as well as increases the likelihood that involuntary hospitalization will eventually be required. In such cases, the chances of medical neglect or other obvious human rights abuses increase. International evidence now clearly shows the link between cannabis abuse and onset of psychotic illnesses such as schizophrenia. It appears that the earlier the adolescent is exposed to such drugs the higher the chance of developing a mental illness.

Furthermore current research suggests that up to half of the cases of alcohol and drug abuse that we now see in our young people are secondary to earlier mental health problems that have gone undetected or untreated.

Despite the increasing evidence of links between drug use and mental illness Australia still lacks adequate mental health facilities to cope where a person has both drug addiction and mental illness at the same time – or other forms of dual diagnosis. This is especially the case for those youth who are dependent on alcohol or drugs. Medical policy dictates that drug addiction be treated first, before the mental illness is tackled. But the reality is that they are often interconnected. So they are left in limbo, with the likely result being anything from preventable suicide, permanent brain disease, destroyed families to huge economic and social costs for society as a whole. And the failure to treat a dual diagnosis may lead to at least 20 years of life expectancy being lost.

Children in adult facilities

In all states I received reports of children and young people being admitted to inappropriate adult facilities.

Poor emergency services

Emergency services are overburdened and often inaccessible. To illustrate I will give you two examples:

First, in Western Australia I was told about a twenty year old man who reported to hospital suffering from an episode. The hospital's clinical response was to chemically induce sleep for 20 hours, because there was no psychiatrist available.

Second, a Sydney hospital clearly took the “lock ‘em up and throw away the key” mentality a step too far recently. It locked a mental patient and his two accompanying young police officers together in a room, and refused to let them go until a doctor arrived several hours later. The constables remained ‘locked up’ with the patient, even after their police sergeant made a direct request to hospital officials for their immediate release.

Poor acute care services

Acute care services are too often simply missing, especially in regional Australia. Deinstitutionalisation did not mean that all acute beds are to be closed.

Evidence was provided that in a number of cases the lack of acute care services resulted in preventable death.

In fact, suicide rates in teenagers and young adults remain historically high. We were told a great many stories of preventable suicides of young people. Let me tell you two of them:

A Central Coast teenager was admitted to a psychiatric unit because of attempted suicide. He was prescribed Valium and released the next day with no follow up. He died hours later after throwing himself in front of a moving train. The coroner found that he was inadequately assessed and discharged too early, because an on-going shortage of beds in the unit.

In Canberra we were told about a young man with a history of depression, and openly suicidal, who jumped from a sixth floor balcony only two days after being refused admission to the psychiatric unit following a second suicide attempt.

Inadequate accommodation

Going back to the original objectives of the National Mental Health Strategy in 1992, all governments committed to:

- Reducing the size or closing existing psychiatric hospitals and at the same time providing sufficient alternative acute hospital, accommodation and community-based services; and
- Increasing the number and range of community-based supported accommodation services and ensuring a range that provides a level of support appropriate to the needs of the consumer.

It is obvious that governments really got on with the closure of the psychiatric institutions. However, one of the biggest problems, it seems, is that they have not followed through with their commitment to build a strong system of community based care. One which includes adequate supported accommodation as the lack of appropriate supported accommodation for people with a mental illness has been a very strong theme coming through our community forums. The problem of course becomes much more acute in rural areas.

As an example of how bad the situation is, in the submission from St Bartholomew's House in Western Australia, which has been providing accommodation and support for people experiencing homelessness for 40 years, it was stated that even though staff try to provide a quality service, the lack of resources, a staff ratio of 1:54, poor education of staff and the number of people requiring care limits the capacity to deliver safe quality care.

We have also received submissions from family carers that report being advised by hospital staff that they should try and organize accommodation for their sick son in a backpackers hostel or if that failed then living in his car should be considered as an option. In the absence of appropriate supported accommodation, many people end up sleeping on the street or worse, in jail cells.

The experts in the field have advised the review that safe and stable accommodation is a vital element in someone's recovery. Without it, people have little hope of getting well or staying out of hospital.

Use of prisons to provide mental care

Not only are Australia's mentally ill being turned away from the health services that they need, they often end up in gaols instead. When in prisons they may face especial difficulties getting access to help. The earlier mentioned case of wrongfully detained Cornelia Rau provides a good illustration – her acute mental illness went undiagnosed during her imprisonment.

One can further claim that on the basis of the data collected through community forums and submissions there did appear to be a broader trend towards a "law and order" type response toward mental illness. We received many reports of the high percentage of people in our prisons with a mental illness. We were told that even in the community, it is the police who are often left to respond when someone is in the midst of a mental health crisis. This approach is so different to the approach taken to people suffering from physical illness. People having a heart attack, for example, are not left to be dealt with by the police.

Physical health care

The review staff was told on numerous occasions that the physical health of people with mental illness is considerably worse than the average. This was explained by the fact that a GP would tend to focus on mental health issues and neglect undertaking physical health check-ups. Communication problems were also blamed for the situation.

Community services unable to cope

The evidence suggested that community supports were seriously overburdened and unable to cope with the existing demand. Further, the carers of people with mental health problems were frequently ignored by services.

The issue of community resources, or lack of them, also had particular application for young people still within the family environment. And I refer here to the issue of the young person's "carer or carers" being removed from the home due to their own mental illness. In these cases, that young person, and typically in these scenarios we are talking about more than one child, may be left in the home with insufficient community support mechanisms to ensure they are properly attended to, while their carer is receiving treatment for their mental illness.

Stigma and discrimination

There is still fear and intolerance of people with mental health problems. Those with a mental illness were still being blamed for being sick. Also carers of people with mental illness can experience much of the same stigma as the people they support.

This stigma is reflected in discrimination against people with mental illness in their daily life. People with mental illness are denied job opportunities, access to accommodation and health services and so on.

Rural and remote areas – double disadvantage

While people living in capital cities had many difficulties in accessing the mental health care and support that they needed, those problems were exacerbated in rural and remote areas. Let me give two examples of the additional problems facing people in rural areas.

First, distances between available services and the people who need them have meant there is an over-reliance on treatment by phone - which is completely inadequate for many people with a mental illness.

Second, we heard that there were sometimes extremely long journeys for people needing acute care under conditions which were entirely inappropriate. For example GP's may be required to over-sedate someone so that they can be transported by air. Or people who need medical assistance, not punishment, may be required to travel long distances under police escort – which is demeaning for the patient, distressing for families, and an unwelcome diversion of police from the jobs they are trained to do.

Having read some UK literature, for example policy papers produced by the Sainsbury Centre for Mental Health, one could form an opinion that Australian problems are not unique in the world. In fact many governments around the world are desperately searching for ways of promoting mental wellbeing among all the people they serve.

Limited accessibility for Indigenous and ethnic Australians

There were also significant and unacceptable inequities in access to mental health services and in the reported outcome of services for Indigenous and non-English speaking background Australians. The Indigenous disadvantage in access was often aggravated by residence in remote locations. Both groups were denied access because of their cultural and linguistic characteristics and lack of culturally and linguistically sensitive services.

For more see: www.hreoc.gov.au/human_rights/mental_illness/index.html

Conclusion

People with mental illness are still denied their rights

Although it is acknowledged that some initial improvements were made post Burdekin inquiry, it needs to be said that what we found while conducting the review in 2004-05 was all too disturbingly close to the findings of the 1993 report. In fact the review has documented a mass of suffering and a mass lack of services and treatments which takes opportunities away from people with mental illness and imposes a severe burden on the economy.

In fact, to be perfectly honest, the review brought no surprises. The neglect of mental health services was going on for some time. All the concerns that were reported in evidence to the review had been in fact well known for a considerable period of time. The failure of adequate funding for mental health services, the failure by governments to address the issue and the resulting human right breaches and the suffering of people with mental health problems and their carers were all well known for a number of years.

As one submission to the 'Not for Service' review put it in simple terms: *'The dream of closing psychiatric institutions and moving towards community-based care has turned into a nightmare. Community care is under-resourced and integrated services are lacking. Too many people are denied treatment and slip through the gaps.'*

Furthermore, when one adds the stigma and stereotypes that surround the mentally ill to this already explosive cocktail the extent of this bleak picture can be seen. Truly, all this gives flesh to the pattern of neglect which has been described by the phrase: "Out of hospital, out of mind."

The fact that young people with mental health issues were missing out on access to mental health and other services was of particular concern because it was taking future opportunities away from them. As somebody told us in Victoria: *"It is better to build a fence at the top of the cliff, than to provide an ambulance at the bottom."*

There is a light at the end of the tunnel

The extent of the problem is clear and so is the solution. Governments need to provide leadership; they need to work together instead of apportioning blame; they need to provide more resources for mental health services and supports, and more accountability for how the money is spent.

And since the review was initiated and its evidence started to gain media attention things have started to change. The good news is that we are starting to get statements from political leaders who are placing mental health reform high on their agenda. First it was the Western Australian government which has returned to the mental health budget the \$4 million transferred to the general health budget. The newest State Premier, Mr. Iemma in New South Wales said in his inaugural speech that mental health would be one of his top priorities and followed it with money. Money for mental health was also found in other states and territories.

The Federal government, first in the election context, committed an additional \$110m to mental health. After the “*Not for service*” report was launched by the Minister for Health the hon. Tony Abbott, the Federal government took Australia wide leadership and put the mental health issue on the agenda of the February meeting of the Council of Australian Governments (COAG). All COAG leaders committed to development of a new national mental health plan and committed significant resources to address the problems identified by the report “*Not for service.*” Only time will show whether the current initiatives will bring permanent improvements or if they are temporary in their nature as the post Burdekin improvements were.

Human rights laws and watchdogs can make a difference

The final point that needs to be made is that people with mental health problems do not constitute a powerful political lobby able to look after their own interest. In fact they are quite low in the pecking order when it comes to determining budget priorities or having their voices heard. They need the help of others to secure a decent life. And here is where human rights are of significance.

First, the international human rights instruments set world wide mental health standards of appropriate care. These standards provide a very useful implementation guide to the national governments. The current draft disability convention, when adopted by the UN, will expend these standards enormously.

Then, in many countries there are national human rights institutions like the Australian HREOC charged with monitoring of the international human rights standards by national governments. These institutions can make a big difference

for the mentally ill. It is not because I expect governments to take instructions from a Human Rights Commissioner or to regard the Commission as the experts on everything, but because I think that on issues of access to mental health services around Australia, HREOC has helped to make the voices of people affected by mental illness heard - directly, or as family members providing care and support. The HREOC review has put the issue of mental health back on the national agenda.

Finally, there is a role for the international human rights treaties monitoring bodies to assist national governments with human rights issues. And one could hope that the new UN Human Rights Council will have enhanced interest in mental health issues.

Just as the example of the UN role allows me to finish with an opinion expressed recently by the UN Committee on the Rights of the Child reviewing a Member State's (not Australia) report on its compliance with CRC: *"The Committee joins the State Party in expressing concern at the long waiting list and delayed access to mental health services and professionals for children which are due to an insufficient number of psychologists and psychiatrists. The Committee encourages the State Party to explore ways of providing children with more timely access to mental health services and to address in particular the shortage of psychiatrists and psychologists."*

I am suggesting today that the comment I have just quoted, which was incidentally addressed to Norway, would certainly resonate strongly in many states with regard to timely access for young people to mental health services.

The people with mental health issues need their human rights protected more than any other group of people in the world.

Gael Robertson – a perspective from Nepal

A traumatised nation

Nepal is a nation in trauma the result of a 10 year long violent insurgency. The human rights situation in Nepal is one of the worst in the world. Currently, Nepal has the highest number of disappearances. The Maoist insurgents and the State are both committing atrocities. In the past 10 years 13,000 people have been killed. Men, women and children are suffering. Mental health is neglected. Human rights are neglected.

Mental health and human rights in Nepal?

In Nepal mentally ill people are stigmatised and excluded. A national mental health policy was agreed in 1995, and has as one of its objectives “to protect the fundamental rights of the mentally ill in Nepal”. The rights of mentally ill people in Nepal remain unaddressed. To date there is no law to protect the rights of a person with a mental illness. But there is some legal provision, established in 1963, concerning the States responsibility for a mentally ill person. This responsibility is primarily jail. The few mental health services available are urban based with a medical focus. People in rural Nepal (most of the country) have no access to mental health services. Over the years human rights organisations in Nepal have failed to address economic social or cultural rights.

The gap in international development

The international development agenda ignores mental health. Mental health is excluded from the millennium development goals (MDGs). The MDGs drive the funding of development activities. A further gap exists between the human rights framework and the MDGs. The MDGs focus on quantity rather on process, they are unable to address the complexity and interconnectedness of peoples lives. While, international development advocates rights based approaches it has steered the international development agenda in a direction that violates the International Covenant on Economic, Social and Cultural Rights through the failure to “recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”.

Mental health is a development issue

The result of the violent armed conflict in Nepal has worsened the mental health and human rights situation in the country. On top of this, the situation of inadequate mental health and social services as well as the lack of legal provision to ensure the rights of people with a mental illness remain. Action is needed. In a country like Nepal mental health must become a development issue to ensure that a connection is made between human rights and mental health. First, international development needs to embrace that physical and mental health go hand in hand as a human right.

Simon Bradstreet – Recovery: Raising Awareness and Expectations

“The concept of recovery from illness is a fundamental human rights issue. If people are seen as helpless, they are not allowed to take charge of decisions and cannot even stand for their own rights.”

Eric Rosenthal, Executive Director, Mental Disability Rights International

Long-term outcome studies and personal narratives show us that people can and do recover from long-term mental health problems and mental illness. We are starting to learn more about the role and importance of promoting a more hopeful outlook, building on people’s strengths and capacities and creating an expectation of recovery.

This presentation will look at:

- The work of the Scottish Recovery Network (one part of the Scottish Executive’s National Programme for Improving Mental Health and Well being) and the wider Scottish policy context.
- How we understand and interpret recovery in this context.
- Some learning about the key elements and themes of recovery.
- Suggestion and ideas for getting recovery thinking into practice in mental health services and out with them.

It will make the case that people who experience long term mental health problems have the right to be involved in decisions about their own health and well being, the right to play an active and meaningful part in their community, the right to challenge pessimistic and stigmatising messages. In short the right to recover.

Graham Morgan – Individuals: Listening, Involving and Advocacy

The Highland users group is a self advocacy organisation of users of mental health services who live in the Scottish Highlands.

It is supported by one full time and 2 part time workers who have themselves experienced mental illness. It is a project of Highland Community Care Forum.

It produces 6 reports a year on the issues that its members find important examples varying from; employment to medication to complaints and recovery. These act as its policy documents when giving voice to its members views.

Workers and members speak at conferences and committees other meetings in order that their voice can be heard. These meetings happen at a local, regional and national level.

Its reports and activities have resulted in tangible changes occurring and have been used across the Highlands, Scotland and beyond.

Half of its activity involves its members speaking out and being involved in challenging stigma and discrimination. This happens in the following ways:

Working with young people, providing mental health awareness training, working with the media, creating dvd's of personal testimony, producing newsletters and arts magazines that give voice to members shared experiences, operating a website (hug.uk.net) and producing publicity materials on a mental health theme.

Our presentation will describe our activities what they have achieved and look at how we involve our members in these processes.

The organisers would like to thank all those who participated in the event.



SCOTTISH EXECUTIVE

