Irish Journal of Psychological Medicine (2014), **31**, 75–81.
doi:10.1017/ipm.2014.22

EDITORIAL

Dignity, human rights and the limits of mental health legislation

Brendan D. Kelly*

Associate Clinical Professor of Psychiatry, Department of Adult Psychiatry, University College Dublin, Mater Misericordiae University Hospital, Dublin, Ireland

A right is an entitlement that one may legally or morally claim. Human rights are of particular importance in mental health care owing to the existence of laws that permit involuntary admission and treatment under certain circumstances, and compelling evidence of persistent social exclusion of some individuals with mental disorder. Ireland's mental health legislation, which is currently under review, meets most international human rights standards in areas of traditional concern (involuntary admission and treatment) but not in other areas (especially social and economic rights). These deficits would be addressed, at least in part, by replacing the principle of 'best interests' with the principle of 'dignity' as the over-arching principle in Irish mental health legislation. Such a change would help ensure that decisions made under the legislation actively facilitate individuals with mental disorder to exercise their capabilities, help promote human rights and protect dignity. Even following such a reform, however, it is neither practical nor realistic to expect mental health legislation *alone* to protect and promote all of the broader rights of individuals with mental disorder, especially social and economic rights. Some rights are better protected, and some needs better met, through social policy, mental health policy and broader societal awareness and reform.

Received 20 December 2013; Revised 26 April 2014; Accepted 14 May 2014

Key words: Capabilities, dignity, human rights, legislation, mental disorders, psychiatry.

Mental disorder and human rights

In 1817, the House of Commons (of Great Britain, then including Ireland) established a committee to investigate the plight of the mentally ill in Ireland. The committee reported a disturbing picture:

> When a strong man or woman gets the complaint [mental disorder], the only way they have to manage is by making a hole in the floor of the cabin, not high enough for the person to stand up in, with a crib over it to prevent his getting up. This hole is about five feet deep, and they give this wretched being his food there, and there he generally dies (Quoted in Shorter 1997: 1–2).

The situation in 19th-century Ireland was not unique, as the majority of individuals with mental disorder in Ireland, England and many other countries lived lives of vagrancy, destitution, illness and early death (Robins 1986; Torrey & Miller 2001; Porter 2002).

Two centuries later, in 2010, the *Guardian* newspaper reported on the death of a man with schizophrenia in central London:

> *[MR AB] was found dead on 9 January last year, having died from heart disease. Ulcers in his stomach were a strong sign of hypothermia. The 59-year-old, who had schizophrenia, lived in a dirty, damp and freezing flat, with mould growing on the floor and exposed electrical wires hanging off the walls. His boiler had broken, the bathroom ceiling had collapsed, and neighbours began to complain about the smell. His brother… describing the scene as 'squalor', said: 'Even an animal couldn't have lived in that'.*
>
> *The disturbing circumstances of [Mr AB's] death have exposed serious flaws in the way mental health law is implemented in the case of vulnerable people… Everyone knew the conditions [Mr AB] was living in, but he refused to move for cleaning and refurbishment work to be done. Despite four years of pleading from his family, NHS [National Health Service] care staff would not intervene – wrongly thinking they would be violating his human rights* (Harding 2010).

In the two centuries between these reports, Ireland and England saw much apparent change in the treatment of individuals with mental disorder: there was the rise of the large public asylums in the 1800s and early 1900s, the decline of those asylums in the mid-1900s, the emergence of a language of human rights in many countries around the world and (later) its application to the mentally ill, significant social changes around the time of accession to the European Union, and the introduction of new mental health legislation in the early 2000s. And yet, these two stories, from Ireland in 1817 and London in 2010, have much in common and

* Address for correspondence: B. D. Kelly, Associate Clinical Professor of Psychiatry, Department of Adult Psychiatry, University College Dublin, Mater Misericordiae University Hospital, 62/63 Eccles Street, Dublin 7, Ireland.

(Email: brendankelly35@gmail.com)

both relate to the denial of human rights to individuals with mental disorder in a disturbingly similar fashion.

Human rights and mental health

A *right* is an entitlement, something that one may legally or morally claim (Pearsall & Trumble 1996: 1240). The term *human* rights refers specifically to rights which a human being possesses by virtue of the fact that he or she *is* a human being (Edmundson 2004; Ishay 2004; Hunt 2007). Human rights recognise *extraordinarily* special, basic human interests and do not need to be earned or granted; they are the birth-right of all human beings simply because they are human beings (Edmundson 2004).

In the early 21st century, the term 'human rights' is most commonly understood by reference to statements of human rights dating from the mid-1900s, including, most notably, the *Universal Declaration of Human Rights* (UDHR) adopted by the UN General Assembly in 1948 (UN 1948). Other relevant UN statements include the *UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* (UN 1991) and the *UN Convention on the Rights of Persons with Disabilities* (CRPD) (UN 2006). From a legal perspective, however, most weight is accorded to the *European Convention on Human Rights* (ECHR) (Council of Europe 1950) which is incorporated into national law in Ireland through the European Convention on Human Rights Act 2003 and in England through the Human Rights Act 1998.

In Ireland, the Mental Health Act 2001 addresses certain human rights issues in relation to individuals with mental disorder, chiefly related to involuntary treatment and assuring standards. Notwithstanding the challenges that the legislation presents to mental health services, there is significant agreement that it improves protection of the right to liberty among individuals with mental disorder and increases Ireland's adherence to international human rights standards in areas of traditional concern in mental health care, especially involuntary admission and treatment (Mental Health Commission 2008; O'Donoghue & Moran 2009; Jabbar *et al.* 2010; Jabbar *et al.* 2011; Kelly 2011; Ramsay *et al.* 2013).

It is important, however, to emphasise that rights-based approaches to any matter, including mental healthcare, occur in specific social and political contexts; for example the *legal* observance of many civil rights, for example, requires relatively ready access to an independent court system (Osiatyński 2009). Mental health legislation may meet this requirement by ensuring access to mental health tribunals, free legal representation and advocacy. In Ireland, the Mental Health Act 2001 makes specific provisions for free legal aid (Section 33(3)).

These measures, however, presume the *existence* of an independent court system and *availability* of public resources to fund legal representation and advocacy. On this basis, while human rights themselves may be '*universal*' (Cassese 1992), the effectiveness of human rights-based approaches to specific issues, such as mental health care, relies on a set of assumptions which all societies may not meet; that is the existence of an independent court system, clear legislative provisions relating to mental disorder, certain standards of democratic governance and the (related) likelihood that human rights concerns will inform systemic change (Rose 1985; Prins 2010; Richardson 2010).

Many of these requirements reflect other human rights, emphasising the indivisibility of all human rights. The necessity for an independent court system, for example, is underlined in the ECHR which states that 'everyone who is deprived of his liberty by arrest or detention' shall be entitled to 'take proceedings by which the lawfulness of his detention shall be decided speedily by a court' (article 5(4)). On this basis, the rights that mental health legislation may seek to protect (e.g. right to liberty) are inextricably linked with other rights (e.g. right to access a court system or tribunal).

The situation is rendered more complex in countries where a rights-based approach to mental health care may not rest easily with certain societal practices and cultural beliefs, especially countries with different economic, professional and cultural contexts than the economically advantaged countries in which human rights discourse is most prevalent (e.g. England, Ireland, United States) (Bartlett 2010; Fennell 2010). This point emphasises the importance of human rights as *one element* within a broader approach to social justice, combined with political activism and social advocacy, especially in relation to mental disorder.

Dignity as a central human right

The idea of dignity is central to the ideas of rights and social justice, and there is arguably no human right unconnected to human dignity (Feldman 2002). Moreover, in the context of mental health care, the idea of dignity is important to *all* individuals with mental disorder and not just the minority who are subjected to involuntary detention and treatment.

Indeed, for the majority of patients, who engage voluntarily with primary care or mental health services, the key issue is *not* loss of dignity through violation of rights by mental health professionals or the state, but simple access to services (Petrilia 2010). An approach which recognises human dignity as a key value underpinning human rights permits a nuanced response to such a situation, aiming to achieve optimal observance of

https://doi.org/10.1017/ipm.2014.22 Published online by Cambridge University Press

rights including a right to a basic level of care consistent with human dignity (UDHR, article 25(1)); McSherry 2010).

There may, however, be additional complexity in mental health settings, especially if the individual in question temporarily lacks the insight and/or mental capacity to exercise their own rights or promote their own dignity in certain important respects. For example, an individual with psychosis, who is untreated, homeless, and singing aloud or undressing on the street is, by most objective standards, in an undignified position, but the individual may not perceive this indignity *subjectively*, owing to the effects of illness. An individual *without* such a mental disorder in a similar position is more likely to perceive their situation differently, experience subjective indignity, and take corrective action.

This situation and dilemma highlight the fundamental conceptualisations of dignity outlined by Beyleveld and Brownsword (2001). Their idea of 'dignity as empowerment' focuses on dignity as advancing the individual's autonomy in a direct fashion, but they also recognise that dignity can reflect an objective value reaching beyond the individual such that, if an individual inadvertently violates this value, human dignity is compromised irrespective of whether or not the individual has knowingly agreed to perform the act in question. Therefore if the individual with severe mental disorder lacks sufficient insight into his or her situation, he or she may violate this shared, objective idea of dignity, possibly resulting in arrest (at worst) or involuntary treatment under mental health legislation owing to mental disorder and/or risk of harm.

Feldman (2002) notes the importance of the objective aspect of dignity among individuals who (usually temporarily) lack the insight and/or mental capacity to cultivate subjective dignity or recognise its loss, to varying extents. Critically, these individuals, always and forever, still possess intrinsic human dignity by virtue of the simple fact that they are human. In such circumstances, there is a powerful moral and, ideally, legal duty to protect and restore the dignity of such individuals by having regard for their dignity, rights *and* welfare when making decisions in relation to them. To a certain extent, the Mental Health Act 2001 imposes such a duty on mental health services and the Gardaí in relation to individuals with mental disorder, although it is limited by the fact that the over-arching principle of the legislation is 'best interests' (Section 4(1)) rather than dignity itself.

Encoding and interpreting principles in law

On this basis, there are compelling arguments in favour of incorporating dignity as the over-arching principle in Irish mental health legislation. If encoded in law, however, it is possible that objective conceptualisations of dignity would be interpreted inappropriately in certain circumstances. This points a broader problem with legislation-based solutions to problems experienced by individuals with mental disorder who have reduced insight into their own mental state and, occasionally, into the maintenance or loss of dignity. The key issue here is that the rule of law takes as its subject the fully rational, self-determining person and generally lacks a sufficiently nuanced approach to individuals who have diminished rationality, reduced mental capacity or limited insight for specific periods of time (Weller 2010).

This issue is especially complex in Ireland owing to the emphasis that the Constitution of Ireland (article 40 (1) and (3)) places on welfare-based concerns for the vulnerable (Whelan 2009). Consistent with this, the Irish Supreme Court makes it explicit that the Court should approach certain medical matters 'from the standpoint of a prudent, good and loving parent' (Re A Ward of Court (Withholding Medical Treatment) (No. 2) [1996] 2 IR, [1995] 2 ILRM 40; p. 99). The High Court has also made this explicit in the specific context of the Mental Health Act 2001:

> *In my opinion having regard to the nature and purpose of the Act of 2001 as expressed in its preamble and indeed throughout its provisions, it is appropriate that it is regarded in the same way as the Mental Treatment Act of 1945, as of a paternal character, clearly intended for the care and custody of persons suffering from mental disorder* (MR v Cathy Byrne, administrator, and Dr Fidelma Flynn, clinical director, Sligo Mental Health Services, Ballytivnan, Co. Sligo [2007] IEHC 73; p. 14).

The Supreme Court agrees that interpretation of the 2001 Act 'must be informed by the overall scheme and paternalistic intent of the legislation' (EH v St. Vincent's Hospital and Ors [2009] IESC 46; p. 12), as exemplified by the 2001 Act's requirement that the 'best interests of the person shall be the principal consideration with due regard being given to the interests of other persons' (Section 4(1)). The High Court has stated that this section 'infuses the entire of the legislation with an interpretative purpose' (T O'D. v Harry Kennedy and Others [2007] IEHC 129; p. 21).

Overall, the courts' explicit paternalism in the interpretation of the Mental Health Act 2001 may, on the one hand, represent a disproportionately disempowering approach to mental health law, at least in certain cases (Craven 2009), but it also very clearly reflects the Irish state's constitutional obligation to protect the vulnerable (Kennedy 2012). In England, the tendency towards paternalism is less pronounced overall and is generally attributable to public safety concerns rather than a stated obligation to protect the vulnerable (Fennell 2007).

https://doi.org/10.1017/ipm.2014.22 Published online by Cambridge University Press

Some of these concerns may be resolved, at least in part, by mental capacity legislation which assumes a nuanced approach to mental capacity, facilitates careful evaluation of the individual's capacity to make specific decisions, and offers supported decision-making procedures (Joint Committee on Justice, Defence and Equality 2012). In Ireland, the Assisted Decision-Making (Capacity) Bill published in July 2013 offers a real opportunity to achieve some of these goals (Kelly 2014). Even in England, however, which has revised both its capacity and mental health legislation relatively recently, there is still evidence of significant difficulty integrating the concepts of human rights and dignity with legitimate and necessary welfare-based concerns, in a reasonable, balanced and empowering fashion.

Balancing and integrating rights, dignity, capability and welfare-based concerns

The difficulty with balancing and integrating rights, dignity and welfare-based concerns relating to the mentally ill is apparent throughout the recent and current processes of legal reform in Ireland and England. Any proposed solution that is based solely in mental health or capacity legislation will, however, invariably be subject to the intrinsic limitations of legal approaches to such problems; that is, requirements for an independent court system, financial resources to access courts, and certain standards of democratic governance. In addition, developing ever more detailed mental health or capacity legislation has the distinct demerit of expanding the remit and complexity of such legislation (Bowen 2007), and potentially reinforcing the discriminatory assumption that individuals with mental illness or impaired capacity are sufficiently dangerous as to require elaborate legislation in order to maintain public safety (Campbell & Heginbotham 1991; Campbell 1994).

A further complexity associated with exclusively legal solutions to dilemmas relating to mental disorder or impaired capacity stems from the fact that not all human needs are best met through dedicated legal assurances of specific rights. Indeed, a great majority of human needs are not claimed as rights at all but fulfilled by mechanisms other than legally based human rights claims; for example by means of exchange, political (as opposed to judicial) allocation of public resources, charity, etc. (Osiatyński 2009).

This fact is reflected, at least in part, by a strictly rights-based analysis of mental health legislation in Ireland and England which showed that recent revisions of mental health legislation in both jurisdictions have resulted in stronger protections of certain civil rights of the mentally ill (e.g. right to liberty) but that the greatest remaining deficit relates to protection of social and economic rights *through mental health legislation* (Kelly 2011). This supports the idea that mental health legislation is best suited to the protection of so-called 'negative rights' (e.g. prohibitions on torture and degrading treatment) rather than so-called 'positive rights' (e.g. right to access health-care) (Edmundson 2004; Ishay 2004; Hunt 2007).

In other words, while constitutional rights and dedicated mental health legislation can and should guarantee basic rights, and assure that the rights and needs of vulnerable persons and the underprivileged are not neglected by the political process, these are not necessarily the only or even the best mechanisms for fulfilling positive rights to, and needs for, healthcare, housing, social protection, etc. (Osiatyński 2009). The most important governmental interventions in these areas are based not on enforcing direct laws but on implementing sustainable policies, creating accountable institutions to meet collective needs and, occasionally, direct provision of goods and services.

This emphasis on human rights *and* needs may be usefully complemented by an emphasis on human *nature*; that is a combination of shared observations about the state of being human, including, for example, the existence of an individual sense of human dignity. This is consistent with the importance that Nussbaum (1992, 2000, 2011) attaches to human *capabilities*, a concept which was notably absent from the processes of legislative reform in Ireland and England in recent years. This is a real pity because creating circumstances in which individuals can exercise their capabilities is central to the restoration and maintenance of dignity, especially in the context of mental health care.

Seedhouse and Gallagher (2002) place capabilities at the centre of their definition of dignity, arguing that an individual has dignity if he or she is in a set of circumstances that permit him or her to exercise his or her capabilities. As a result, promoting dignity among individuals with mental disorder would involve the individual himself or herself, supported if necessary by health and social services, improving capabilities and/or improving circumstances with a view to greater exercise of his or her own capabilities. From the point of view of mental health service-providers, improving capabilities may involve judicious use of psychiatric treatments which enhance capabilities (e.g. psychological therapies, medication) *and* measures to improve circumstances, which may involve providing services and care in dignified, empowering settings, and actively promoting social integration and political empowerment of individuals with mental disorder.

Incorporating dignity into Ireland's mental health legislation

Broader recognition of these kinds of values, especially dignity and capabilities, in Ireland's mental health

https://doi.org/10.1017/ipm.2014.22 Published online by Cambridge University Press

legislation would not only advance protection of human rights through mental health legislation and help realise the 'general principles' of the CRPD (UN 2006), but also acknowledge the intrinsically complex, multi-faceted nature of mental health care and decision making in relation to mental disorder.

The current review of the Mental Health Act 2001, makes this a good time to replace 'best interests' (Section 4(1)) with 'dignity' as the over-arching principle of the legislation. Wording along the following lines, adapting the current Section 4(1), is suggested:

> 'In making a decision under this Act concerning the care or treatment of a person (including a decision to make an admission order in relation to a person), the dignity of the person shall be the principal consideration with due regard being given to the interests of other persons who may be at risk of serious harm if the decision is not made'.

In order to assist with the interpretation of 'dignity', it would be judicious to adapt some wording from the Assisted Decision-Making (Capacity) Bill along the following lines:

> *The word 'dignity' is to be interpreted according to the following principles. There is a presumption that the patient is the person best placed to determine what promotes or compromises his or her own dignity. If that presumption is not met, other considerations are relevant and these should include, in this order:*
>
> - *The known or ascertainable will and preferences of the person; the past and present wishes and feelings of the person; the beliefs and values of the person (in particular those expressed in written form) relevant to the matter concerned to which the intervention relates, and other factors which the person would be likely to consider if he or she were able to do so;*
> - *The person being permitted and encouraged, in so far as is practicable to participate, or to improve his or her ability to participate, as fully as possible, in the intervention;*
> - *Consideration of the views of anyone named by the person as a person to be consulted on the matter concerned or any similar matter;*
> - *Consideration of all other circumstances of which the person assisting with the decision is aware and which it would be reasonable to regard as relevant;*
> - *Consideration of the views of anyone engaged in caring for the person, anyone who has a* bona fide *interest in the dignity and welfare of the person, and/or relevant healthcare professionals.*

Wording along these lines would replace 'best interests' with 'dignity' as the over-arching principle in mental health legislation; ensure, as best as possible, that it is interpreted in a robust fashion, with due regard for will and preferences; and ensure consistency with the law as it relates to those with impaired mental capacity – all of which is strongly consistent with the CRPD (UN 2006),

Dignity would be especially useful as an over-arching concept owing to its clear interpretation in situations in which the individual has full insight and capacity (e.g. if I am elderly and decline an indwelling catheter as I see it as undignified, that is entirely my choice to make) *and* situations in which the individual's insight and/or mental capacity may be impaired. In the latter situation, it may be necessary, for a period of time, to rely on objective or shared conceptualisations of dignity which may, of course, be disputed, but which (a) would be guided by the interpretative guidelines provided (above), with a strong emphasis on the will and preferences of the person; and (b) are arguably less disputable that certain other concepts (such as 'best interests') and for which a significant literature exists to guide and assist with interpretation (e.g. Beyleveld & Brownsword 2001; Seedhouse & Gallagher 2002; Kogstad 2009).

Incorporating dignity into Irish mental health legislation in this assertive fashion would also significantly advance the principles of the CRPD, the explicit purpose of which is 'to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity' (article (1)). In more practical terms, it would mean that practitioners, mental health tribunals and courts would have to consider explicitly the effects of their decisions on the dignity of patients, weighing up the indignity of untreated mental illness against the dignity-related implications of involuntary treatment. It would also create an incentive for treatment to be offered in a fashion that explicitly prioritises dignity, an approach which would be best advanced through the provision of effective, efficient treatment in a respectful and dignified fashion, on a voluntary *or* involuntary basis. Finally, prioritising dignity in this fashion would also greatly promote the more detailed suggestions for legislative revision presented by the Steering Group on the Review of the Mental Health Act 2001 (2012) in their *Interim Report of the Steering Group on the Review of the Mental Health Act 2001.*

Conclusions

Dignity should become the over-arching principle of Ireland's mental health legislation. Even if this occurs, however, it would still be a mistake to rely exclusively on legislation to promote the dignity and protect the rights of individuals with mental disorder. The history of Irish mental health services over the past five decades provides an excellent example of this.

https://doi.org/10.1017/ipm.2014.22 Published online by Cambridge University Press

Between 1945 and 2006, when the Mental Health Act 2001 was implemented in full, mental health legislation did not change significantly in Ireland. Nonetheless, between 1963 and 2003, the number of psychiatric inpatients decreased by 81.5% (from 19 801 to 3658) (Kelly 2007). This reform was a result of changes in mental health policy (Department of Health 1984) and attitudes of Irish society in general (Viney 1968), rather than changes in mental health legislation. While this level of change raises unresolved issues about the right to treatment, and there are undoubtedly substantial problems with levels of mental disorder in prisons (Linehan *et al*. 2005; Flynn *et al.* 2012; Kennedy 2012), it remains the case that while the psychiatric inpatient population declined by 16 143 between 1963 and 2003, the prison population rose by just 16.4% of this number (2642) (Kelly 2007).

These trends provide compelling evidence of the unique power of mental health and social *policy* to increase the liberty enjoyed by the mentally ill. Today, Ireland's involuntary admissions rates are toward the lower end of rates across other European countries (Fiorillo *et al*. 2011), with an involuntary admission rate of 41.9 per 100 000 population per year in Ireland in 2012 (Daly & Walsh 2013), which compares favourably with, for example, England's rate of 53.8 (Health and Social Care Information Centre 2013). In addition, Ireland's mental health legislation now meets the vast majority of international human rights standards in relation to involuntary detention and treatment (Kelly 2011). As a result, while there is always room for improvement with legislation, it is neither practical nor realistic to expect mental health legislation *alone* to protect and promote the broader rights of individuals with mental disorder, especially social and economic rights.

In the specific context of mental health, there is particular need for a broad-based, collaborative approach to human rights and dignity, involving mental health service-users, families and carers, mental health service-providers, social services, health and policy planners, Gardaí, voluntary groups and legal practitioners. The actions of all of these stakeholders impact directly on the dignity and rights of individuals with mental disorder, so it is now timely that the principle of dignity would become the over-arching principle in Ireland's mental health legislation and that this principle would be carried well beyond mental health services, tribunals and courtrooms into the arenas of health and social policy, and throughout our society in general.

Acknowledgements

Extracts from the *Guardian* newspaper are reproduced by kind permission of the Guardian News & Media Ltd. The author is very grateful to the peer-reviewers for their helpful comments and suggestions.

Conflicts of Interest

The author is Editor-in-Chief of the *Irish Journal of Psychological Medicine* but had no role in the editorial or review processes relating to this paper. The author also represents the College of Psychiatrists of Ireland on the Expert Group to Review the Mental Health Act 2001 (2012-2014). This editorial is written in a personal capacity, as a psychiatrist.

References

Bartlett P (2010). Thinking about the rest of the world: mental health and rights outside the 'first world'. In *Rethinking Rights-Based Mental Health Laws* (ed. B McSherry and P Weller), pp. 397–418. Hart Publishing: Oxford and Portland, Oregon.

Beyleveld D, Brownsword R (2001). *Human Dignity in Bioethics and Biolaw*. Oxford University Press: Oxford.

Bowen P (2007). *Blackstone's Guide to the Mental Health Act 2007*. Oxford University Press: Oxford.

Campbell T (1994). Mental health law: institutionalised discrimination. *Australian and New Zealand Journal of Psychiatry* **28**, 554–559.

Campbell T, Heginbotham C (1991). *Mental Illness: Prejudice, Discrimination and the Law*. Dartmouth Publishing Group: Aldershot.

Cassese A (1992). The General Assembly. In *The United Nations and Human Rights: A Critical Appraisal* (ed. P Alston), pp. 25–54. Clarendon Press: Oxford.

Council of Europe (1950). *European Convention on Human Rights (Convention for the Protection of Human Rights and Fundamental Freedoms)*. Council of Europe: Strasbourg.

Craven C (2009). Signs of paternalist approach to the mentally ill persist. *Irish Times* (27 July), p. 18.

Daly A, Walsh D (2013). *HRB Statistics Series 20: Activities of Irish Psychiatric Units and Hospitals 2012*. Health Research Board: Dublin.

Department of Health (1984). *The Psychiatric Services: Planning for the Future*. Stationery Office: Dublin.

Edmundson W (2004). *An Introduction to Rights*. Cambridge University Press: Cambridge.

Feldman D (2002). *Civil Liberties and Human Rights in England and Wales*, 2nd edn. Oxford University Press: Oxford.

Fennell P (2007). *Mental Health: The New Law*. Jordan Publishing Limited: Bristol.

Fennell P (2010). Institutionalising the community: the codification of clinical authority and the limits of rights-based approaches. In *Rethinking Rights-Based Mental Health Laws* (ed. B McSherry and P Weller), pp. 13–50. Hart Publishing: Oxford and Portland, Oregon.

Flynn D, Smith D, Quirke L, Monks S, Kennedy HG (2012). Ultra high risk of psychosis on committal to a young offender prison: an unrecognised opportunity for early intervention. *BMC Psychiatry* **12**, 100.

Fiorillo A, De Rosa C, Del Vecchio V, Jurjanz L, Schnall K, Onchev G, Alexiev S, Raboch J, Kalisova L, Mastrogianni A, Georgiadou E, Solomon Z, Dembinskas A, Raskauskas V, Nawka P, Nawka A, Kiejna A, Hadrys T, Torres-Gonzales F, Mayoral F, Björkdahl A, Kjellin L, Priebe S, Maj M, Kallert T

https://doi.org/10.1017/ipm.2014.22 Published online by Cambridge University Press

(2011). How to improve clinical practice on involuntary hospital admissions of psychiatric patients: suggestions from the EUNOMIA study. *European Psychiatry* **26**, 201–207.

Harding E (2010). Acts of contradiction. *Guardian (Society)* (http://www.theguardian.com/society/2010/mar/31/mental-health-law-vulnerable-people-intervention). Accessed 17 May 2014.

Health and Social Care Information Centre (2013). *In-Patients Formally Detained in Hospitals Under the Mental Health Act 1983*. Health and Social Care Information Centre/National Statistics: London.

Hunt L (2007). *Inventing Human Rights*. W.W. Norton and Company: New York and London.

Ishay MR (2004). *The History of Human Rights*. University of California Press: Berkeley and Los Angeles.

Jabbar F, Doherty AM, Aziz M, Kelly BD (2011). Implementing the Mental Health Act 2007 in British general practice: lessons from Ireland. *International Journal of Law and Psychiatry* **34**, 414–418.

Jabbar F, Kelly BD, Casey P (2010). National survey of psychiatrists' responses to implementation of the Mental Health Act 2001 in Ireland. *Irish Journal of Medical Science* **179**, 291–294.

Joint Committee on Justice, Defence and Equality (2012). *Report on Hearings in relation to the Scheme of the Mental Capacity Bill*. Houses of the Oireachtas: Dublin.

Kelly BD (2007). Penrose's Law in Ireland: an ecological analysis of psychiatric inpatients and prisoners. *Irish Medical Journal* **100**, 373–374.

Kelly BD (2011). Mental health legislation and human rights in England, Wales and the Republic of Ireland. *International Journal of Law and Psychiatry* **34**, 439–454.

Kelly BD (2014). The Assisted Decision-Making (Capacity) Bill 2013: content, commentary, controversy. *Irish Journal of Medical Science* [Epub ahead of print] doi:10.1007/s11845-014-1096-1

Kennedy H (2012). 'Libertarian' groupthink not helping mentally ill. *Irish Times* (12 September), p. 14.

Kogstad RE (2009). Protecting mental health clients' dignity – the importance of legal control. *International Journal of Law and Psychiatry* **32**, 383–391.

Linehan SA, Duffy DM, Wright B, Curtin K, Monks S, Kennedy HG (2005). Psychiatric morbidity in a cross-sectional sample of male remanded prisoners. *Irish Journal of Psychological Medicine* **22**, 128–132.

McSherry B (2010). The right of access to mental health care: voluntary treatment and the role of law. In *Rethinking Rights-Based Mental Health Laws* (ed. B McSherry and P Weller), pp. 379–396. Hart Publishing: Oxford and Portland, Oregon.

Mental Health Commission (2008). *A Recovery Approach Within the Irish Mental Health Services*. Mental Health Commission: Dublin.

Nussbaum MC (1992). Human functioning and social justice: in defence of Aristotelian essentialism. *Political Theory* **20**, 202–246.

Nussbaum MC (2000). *Women and Human Development: The Capabilities Approach*. Cambridge University Press: Cambridge.

Nussbaum MC (2011). *Creating Capabilities: The Human Development Approach*. Harvard University Press: Cambridge, MA.

O'Donoghue B, Moran P (2009). Consultant psychiatrists' experiences and attitudes following the introduction of the Mental Health Act 2001. *Irish Journal of Psychological Medicine* **26**, 23–26.

Osiatyński W (2009). *Human Rights and Their Limits*. Cambridge University Press: Cambridge.

Pearsall J, Trumble B (editors) (1996). *The Oxford Reference English Dictionary*, 2nd edn. Oxford University Press: Oxford.

Petrila J (2010). Rights-based legalism and the limits of mental health law. In *Rethinking Rights-Based Mental Health Laws* (ed. B McSherry and P Weller), pp. 357–378. Hart Publishing: Oxford and Portland, Oregon.

Porter R (2002). *Madness: A Brief History*. Oxford University Press: Oxford.

Prins H (2010). Can the law serve as the solution to social ills? *Medicine, Science and Law* **36**, 217–220.

Ramsay H, Roche E, O'Donoghue B (2013). Five years after implementation: a review of the Irish Mental Health Act 2001. *International Journal of Law and Psychiatry* **36**, 83–91.

Richardson G (2010). Rights-based legalism: some thoughts from the research. In *Rethinking Rights-Based Mental Health Laws* (ed. B McSherry and P Weller), pp. 181–202. Hart Publishing: Oxford and Portland, Oregon.

Robins J (1986). *Fools and Mad: A History of the Insane in Ireland*. Institute of Public Administration: Dublin.

Rose N (1985). Unreasonable rights: mental illness and the limits of law. *Journal of Law and Society* **12**, 199–218.

Seedhouse D, Gallagher A (2002). Clinical ethics: undignifying institutions. *Journal of Medical Ethics* **28**, 368–372.

Shorter E (1997). *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac*. John Wiley and Sons: New York.

Steering Group on the Review of the Mental Health Act 2001 (2012). *Interim Report of the Steering Group on the Review of the Mental Health Act 2001*. Department of Health and Children: Dublin.

Torrey EF, Miller J (2001). *The Invisible Plague: The Rise of Mental Illness from 1750 to the Present*. Rutgers University Press: New Jersey.

United Nations (1948). *Universal Declaration of Human Rights*. United Nations: Geneva.

United Nations (1991). *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*. United Nations, Secretariat Centre For Human Rights: New York.

United Nations (2006). *Convention on the Rights of Persons with Disabilities*. United Nations: Geneva.

Viney M (1968). Mental illness. *Irish Times* (23–30 October).

Weller P (2010). Lost in translation: human rights and mental health law. In *Rethinking Rights-Based Mental Health Laws* (ed. B McSherry and P Weller), pp. 71–72. Hart Publishing: Oxford and Portland, Oregon.

Whelan D (2009). *Mental Health: Law and Practice*. Round Hall: Dublin.