

Mental health, community care and human rights in Europe: Still an incomplete picture?¹

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'One of the key messages to governments is that mental asylums, where they still exist, must be closed down and replaced with well-organized community-based care and psychiatric beds in general hospitals. The days of locking up people with mental or behavioural disorders in grim prison-like psychiatric institutions must end.'

World Health Organisation,
World Health Report 2001: Mental Health – New Understanding, New Hope, p4.

1. Introduction

a. The recognition of human rights of those suffering from mental illness

According to the European Union Green Paper *Improving the mental health of the population: Towards a strategy on mental health for the European Union*, more than 27% adult Europeans are likely to suffer from at least one form of mental illness during any one year and by 2020 depression is expected to be the highest ranking cause of disease in the developed world³. A recent article which reported the results of a global study in *The Lancet* also comments that “depression impairs health state to a substantially greater degree than other diseases”⁴.

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3 European Union, *Improving the mental health of the population: Towards a strategy on mental health for the European Union*, Brussels COM (2005) 484, p4, referring to H.U. Wittchen and F. Jacobi (2005), ‘Size and burden of mental disorders in Europe: A critical review

and appraisal of 27 studies’, 15(4) *European Neuropsychopharmacology* 357; World Health Organisation (WHO), *World Health Report 2001: Mental Health – New Understanding, New Hope*, www.who.int/whr/2001 (accessed 8 September 2007).

4 S. Moussavi et al (2007), ‘Depression, chronic diseases, and decrements in health: results from the World Health Surveys’, 370 *The Lancet* 85, www.thelancet.com (accessed 8 September 2007).

Mental health issues are increasingly finding their way onto national, European and international agendas. Moreover, the term ‘mental health’, though sometimes difficult to define with precision, has been taken to include not only mental ill health but also the maintenance of good mental health in general⁵.

There has also been a growing recognition that persons who suffer from mental ill-health must be protected from discrimination and abuse. The World Health Organization and the European Union have both, for example, emphasised the importance of protecting the rights of those suffering from mental ill-health and of ensuring and maintaining social inclusion for this vulnerable group of persons. In a welcome development, the United Nations finally adopted its *Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities*⁶ in December 2006 although it is not yet in force. Amongst other things, this treaty specifically refers to those suffering from mental or intellectual impairment⁷.

It has also gradually become accepted that those suffering from mental illness possess rights which must be respected. Since 1979, the European Court of Human Rights, in particular, has developed a body of case law affirming that certain European Convention on Human Rights (ECHR) rights are relevant to mental health. The emphasis has thus been on civil rights that mainly relate to the detention and treatment of the mentally ill, such as the rights to personal liberty; respect for private and family life; procedural justice; and cruel and the prevention of inhuman treatment⁸. Latterly, this recognition at European level has found expression at national level in that domestic legislation and case law are starting to reflect the relevant provisions of the ECHR. Clearly, in the UK, the *Human Rights Act 1998* has been influential in this respect⁹ and relevant ECHR provisions are reflected, to some extent, in the provisions of the *Mental Health (Care and Treatment) (Scotland) Act 2003* and the *Mental Health Act 2007*, and they have created some judicial dilemmas, particularly in the realm of public safety and involuntary treatment¹⁰.

b. De-institutionalisation and the increasing importance of socio-economic rights

Given the historical emphasis on civil and political rights in Western Europe, and the fact that traditionally the care and treatment of those with mental illness took place mainly in an institutional setting¹¹, it is unsurprising that civil rights associated with the detention and conditions of treatment of the mentally ill were the first to be recognised by the European Court of Human Rights and also within

5 The WHO, for example, defines mental health as: “a state of well-being in which the individual realises his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (WHO, *Strengthening Mental Health Promotion*, Geneva 2001 (Fact Sheet no.220)).

6 Doc. A/61/611, 6 December 2006.

7 Article 1. See also *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care* (1991).

8 For example, on Article 5 ECHR see *Winterwerp v Netherlands* (1979) 2 EHRR 387 (definition of ‘unsound mind’ and detention), *Aerts v Belgium* (1998) 29 EHRR 50 (no detention of mental patients in prison), *Johnson v UK* (1999) 27 EHRR 440 and *Kolanis v UK* (2006) 42 EHRR 12 (timely release from psychiatric institution) and *E v Norway* (1994) 17 EHRR 30 (review of detention). See also *Bensaid v UK* (2001) 333 EHRR 10 (mental

health is a vital aspect of family life), *Keenan v United Kingdom* (2001) 33 EHRR 38 (segregation and extension of prison term), *Peers v Greece* (2001) 33 EHRR 51 (prison conditions), *H L v United Kingdom* (2004) 40 EHRR 761 and *Storck v Germany* [2005] ECHR 406 (involving the interplay of Articles 5, 8 and 3 ECHR).

9 See also J. Stavert (2007), ‘From avoidance to acceptance: Mental health and the role of human rights in Europe’, 356 *Scolag Legal Journal* 119.

10 For example, *A v Scottish Ministers* 2001 SC 1 (concerning the issue of public safety and individual rights and Articles 2 and 5 ECHR); *R (on the application of Wilkinson) v RMO, Broadmoor Hospital Authority* [2001] EWCA Civ. 1545 (involuntary treatment and Article 3) and *R (on the application of N) v M* [2003] 1 WLR 562 (involuntary treatment and Article 3 ECHR).

11 C. Unsworth (1993), ‘Law and Lunacy in Psychiatry’s “Golden Age”’, 13 *Oxford Journal of Legal Studies*, 479.

the UK. That being said, whilst the development of human rights associated with mental health has naturally been very welcome, it nevertheless has not yet appeared to go far enough. An example of this can be seen in the progressive move away from institutionalisation to care in the community. Currently, predominant 'Western' clinical opinion holds that, excepting where it is otherwise necessary to protect the individual or public, persons suffering from mental ill health and disability should be treated and supported in the community¹².

This shift away from a mainly institutional approach to an emphasis on 'care in the community', together with the recognition that people suffering from mental health problems form a vulnerable group worthy of protection under the law, has occurred over the last century. In the UK, this gradual approach can be discerned from the *Mental Treatment Act 1930* to the Percy Commission Report in 1957¹³, through the *Mental Health Act 1959* and *Mental Health (Scotland) Act 1960*, the *Mental Health Act 1983* and the *Mental Health (Scotland) Act 1984* to, finally, the *Mental Health (Care and Treatment) (Scotland) Act 2003* and the *Mental Health Act 2007*.

It is generally recognised, in most Western European states at least, that for vulnerable members of society to be fully protected and enabled to seek and obtain those goods, services and support that they need and want, there must be clearly stated and defined rights which are underpinned and enforced by law. Recognised and enforceable human rights standards may stem from international and regional treaties, but these, in turn, must be incorporated or transposed within states through legislation and by receptive courts¹⁴.

As the move away from institutionalisation has progressed, there has emerged an appreciation of those civil, social and economic rights necessary to ensure adequate treatment and support outside the confines of institutions, and of the need to respect and protect such rights¹⁵. Indeed, we are nowadays arguably moving beyond the development of civil rights of judicial process towards a conception of entitlement to the least restrictive, but adequate, manner of treatment¹⁶.

It is accordingly essential that socio-economic rights are recognised and enforced if care in the community and social inclusion¹⁷ are to be effective and more than merely aspirational¹⁸. The purpose of this article is therefore to reflect on this issue in the light of direction from Europe.

12 WHO (2007), *Community mental health services will lessen social exclusion, says WHO*, News, 1 June 2007; World Health; WHO, *World Health Report 2001*, *op cit*.

13 Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency. 1954–1957. Chairperson: Lord Percy. Cmnd 169. HMSO, May 1957.

14 WHO (2005), *Mental Health: Human rights and legislation*, p6.

15 L. Gostin (2001), 'Beyond moral claims – A human rights approach to mental health', *Special section: Keeping human rights in the bioethics agenda*, 10(3) *Cambridge Quarterly of Healthcare Ethics* 264.

16 L. Gostin (1983), 'Perspectives on Mental Health Reforms', 10 *Journal of Law and Society* 47. Gostin was writing about the *Mental Health Act 1983* in England and Wales; P Fennel (1999), *The Third Way in Mental*

Health Policy: Negative Rights, Positive Rights, and the Convention, 26 *Journal of Law and Society* 103, p105.

17 By "social inclusion" the author means access to those goods and services which are necessary for individuals to fully and effectively participate in society or the communities in which they live. Note also that 'social inclusion' and 'care in the community', whilst sharing a number of common attributes, are not the same.

18 Note also that, in some cases, there should be rights of access to and receipt of appropriate services in order to support those caring and supporting others with mental illness (and, conversely, rights for those suffering from mental illness to protect them from abusive carers and relatives). See, for example, J. Atkinson (2006), *Private and Public Protection: Civil Mental Health Legislation*, Edinburgh: Dunedin Academic Press, pp59–68.

2. Rights for inclusion in the community: Beyond civil rights

When ascertaining precisely which rights are required to enable a person with mental illness to successfully participate in society outside institutions it is necessary to first separate two aspects of community care.

On the one hand, there is a need to consider those situations where certain restrictions and requirements must exist in order to ensure that the individual can function within the community whilst, at the same time, protecting other members of society¹⁹. Here, although all categories of rights are applicable, civil rights (for example, relating to liberty, the right to life²⁰ and protection from cruel and inhuman treatment) tend to take on greater prominence. Reciprocity is important, in that if an element of compulsion exists in community care and treatment, then there should be commensurate obligations on public authorities to provide appropriate services²¹.

On the other hand, whilst civil rights (for example, rights relating to procedural fairness and non-discrimination in terms of accessing and receiving services and guardianship) are of course relevant, so are those socio-economic rights which enable individuals to seek, access and receive those goods, services, and support which enable them to function to the best of their ability in the communities in which they live. This includes rights to health services (for both mental and physical health), benefits and rehabilitation services, housing and access to education and employment. Non-discrimination and equality are also vital components in the provision of such assistance.

As already stated, for such rights to be effectively implemented, there needs to be a relevant international and/or regional human rights framework supported by appropriate legislation and recognition by domestic courts. It is therefore necessary to first consider which international and regional socio-economic rights standards exist that are relevant to mental health care in Europe.

3. International and European frameworks for mental health and related socio-economic rights

a. International instruments

At international level, various documents have aligned socio-economic rights with mental health, either expressly or by implication. *The International Covenant on Economic, Social and Cultural Rights* (ICESCR) does not expressly refer to persons with mental illness, or indeed with any form of disability, but the Committee on Economic, Social and Cultural Rights makes it clear that such persons are included under the Covenant²². It has stated that the obligation of states parties to promote progressive realisation of full participation and equality in society requires 'positive action'²³. The Committee further states that 'this almost invariably means that additional resources will need to be made available for this purpose and that

19 However, it is arguable that the public safety risk, though tragic when supervisory systems provide to be ineffective, may be over-exaggerated, particularly by the media. Indeed, evidence suggests that severe mental illness of itself does not necessarily equate with greater criminal activity and that factors such as being in receipt of state benefits and having no fixed accommodation may be more influential. See C.T. Sheldon et al (2006), 'Social disadvantage, mental illness and predictors of legal involvement', 29 *International Journal of Law and Psychiatry* 249, p253. This article presents data collected in a study conducted in Ontario, Canada. See also WHO,

World Health Report 2001, *op cit*, p4.

20 This includes members of the public and those who are mentally ill.

21 Atkinson, *op cit*, pp76–78.

22 *Persons with disabilities :General Comment 5*. 09/12/94 Doc. E/1995/22, para 3 (adopting the *Standard Rules on the Equalization of Opportunities for Persons with Disabilities*, Annexed to General Assembly resolution 48/96 of 20 December 1993 (Introduction, para. 17)).

23 *General Comment 5*, *ibid* at para 9.

a wide range of specially tailored measures will be required'. Rights which are specifically relevant to mental health are identified as the right to work, to social security, to protection of the family and of mothers and children, to an adequate standard of living (including accommodation), to physical and mental health (including the right to rehabilitation services), to education, and to participate in cultural life and enjoy the benefits of scientific progress²⁴. Equality and non-discrimination are also important. Sadly, however, the Committee has also noted that states parties' promotion of such rights has not always been encouraging²⁵.

Similarly, the *United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*²⁶, refers to the right to be treated in the community²⁷ and in the least restrictive environment²⁸. Likewise, Article 1 of the *UN Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities* makes it clear that the term 'disability' includes mental illness and, amongst other rights, Article 19 contains specific provisions relating to integration into society for those with mental illness. This includes the opportunity to choose how and where to live²⁹ and access to a range of services to assist and support in such integration³⁰.

Against this international background, European regional instruments are more directly reflected at municipal level.

b. European instruments

The Council of Europe's original 1961 and revised 1996 versions of the *European Social Charter* (ESC) contain socio-economic rights which are relevant and applicable to integration into society of those with mental illness. Provisions of the ECHR, such as Article 6 in terms of procedural matters relating to the assessment and provision of goods and services, may also have relevance here. However, being an instrument of civil and political rights, the ECHR is better at protecting individuals from unnecessary or uninvited treatment and detention than at ensuring they receive that which is essential for them to effectively integrate into society³¹. For example, it protects individuals from unwarranted and excessive detention and treatment under Articles 5, 3 and 8, and ensures fair procedures when matters are adjudicated. However, these negative rights are insufficient by themselves if those suffering from mental ill health are to be fully and effectively integrated into the communities in which they live and work and cared for and supported there. The ESC therefore has a potentially important supplementary role.

In terms of social integration, Article 15 ESC is the most prominent,³² although, given the Charter's provisions on non-discrimination and equality, its other provisions are clearly applicable. The objective of Article 15 of the Revised ESC is that persons with disabilities, including those with mental illness, are able to function to the best of their ability within their communities and therefore includes the right to "independence, social integration and participation in the life of the community"³³. This takes forward the right contained in the original 1961 version of the Charter which provided for "the effective exercise

24 ICESCR Articles 6–8, 9, 10, 11, 12, 13, 14 and 15 respectively. See *General Comment* *ibid*, Parts III and IV.

25 *General Comment* 5, *op cit* at para 10.

26 Adopted by General Assembly Resolution 46/119 of 19 December 1991.

27 Principle 7.

28 Principle 9.

29 Article 19(a).

30 Article 19(b) and (c).

31 B. Hale (2007), 'Justice and equality in mental health law: The European experience', 30 *International Journal of Law and Psychiatry* 18.

32 Council of Europe, *Rights of people with disabilities: Fact sheet on Article 15 of the Revised European Charter*.

33 Article 15 Revised *European Social Charter* 1996. See also *European Committee of Social Rights* (2003), *Statement of Interpretation on Article 15, Conclusions*, p10, and *European Committee of Social Rights* (2006), *Digest of the Case Law*, December, p114.

of the right of the physically or mentally disabled to vocational training, rehabilitation and resettlement” to be achieved through the provision of public and private training facilities and employment³⁴.

Article 15 of the Revised Charter³⁵ refers to “the effective exercise of the right to independence, social integration and participation in the life of the community” and stipulates that this includes the provision of mainstream or, where this is not possible, specialised “guidance, education and vocational training”³⁶. It also states³⁷ that this includes the promotion of employment in the ordinary workplace where this is possible. In regard to other measures to promote access to employment, states are afforded a margin of appreciation, but this will not prevent the Committee from considering whether or not such measures effectively comply with the provision³⁸. Article 15(3) also places an obligation on States to promote “full social integration and participation in the life of the community” using measures “to overcome barriers to communication and mobility and enabling access to transport, housing, cultural activities and leisure”. This obligation includes providing effective remedies for those who have been unlawfully treated³⁹. Moreover, in relation to housing, the European Committee of Social Rights has stated⁴⁰ that “The needs of persons with disabilities must be taken into account in housing policies;”⁴¹.

However, despite these provisions, in terms of direction and effectiveness, the European system has its imperfections.

4. Human rights and community care: An intricate web?

a. Council of Europe direction

The socio-economic rights referred to in the aforementioned international and European instruments have to be realised and implemented at national level. The problem is that, unfortunately, state promotion of these rights, despite the realisation in recent years that these should be given equal weight to civil and political rights⁴², has tended to lag behind that of civil and political rights. In terms of leadership and direction, the Council of Europe has also been slower in pursuing this category of rights, particularly in relation to persons with disabilities. The social right to independence, social integration and participation in community life for those with disabilities set out in Article 15 of the ESC are not ‘core’ rights under the Charter, notwithstanding the fact that mental health and rights has been gathering momentum.

34 *This includes specialised placing services, facilities for sheltered employment and measures to encourage employers to employ disabled persons.*

35 *See also Council of Europe Parliamentary Assembly, Recommendation 1185 (1992) on rehabilitation society policies for the disabled which also notes the need for those suffering from a disability (including mental illness) to be fully integrated into society and to have greater ownership in regard to the process of such integration.*

36 *Article 15(1). See European Committee of Social Rights (2006), Digest, ibid and Autism Europe v France, Complaint No. 13/2002, Decision on the merits of 4 November 2003, para 48. “...The underlying vision of Article 15 is one of equal citizenship for persons with disabilities and, fittingly, the primary rights are those of “independence, social integration and participation in the life of the community”. Securing a right to education for children and others with disabilities plays an obviously important role in advancing these citizenship rights. This explains why education is now specifically mentioned in*

the revised Article 15 and why such an emphasis is placed on achieving that education “in the framework of general schemes, wherever possible”. It should be noted that Article 15 applies to all persons with disabilities regardless of the nature and origin of their disability and irrespective of their age. It thus clearly covers both children and adults with autism. See also European Committee of Social Rights (2005), Conclusions, p96 (regarding Cyprus).

37 *Article 15(2).*

38 *European Committee of Social Rights (2006), op cit, p115; European Committee of Social Rights, Conclusions XVII- 2, Belgium, p152.*

39 *European Committee of Social Rights (2006), op cit, p116.*

40 *Ibid, p116.*

41 *Ibid, p116.*

42 *See, for example, the UN Vienna Declaration and Programme of Action, A/CONF.157/23, 12 July 1993.*

To date, apart from the European Committee of Social Rights commenting once on Article 15 compliance under the reporting system⁴³, there only appear to have been two complaints brought under the European Charter which specifically relate to mental disability⁴⁴. There are none relating specifically to mental illness. That being said, the Committee appears to adopt a strict approach to the interpretation of the Charter when presented with alleged violations. The complaint of *IAAE v. France* related to insufficient educational provision, in both mainstream and specialist institutions and services, for children and adults with autism. IAAE alleged that, whilst French law was *prima facie* in compliance with Articles 15(1), 17(1) (The right of children and young persons to social, legal and economic protection) and E(non-discrimination) of the Revised Charter, in terms of implementation it did not comply. It also noted that the allocation of insufficient resources was an important factor. The Committee decided that all three articles had been violated, and, whilst it made no specific comment on the adequacy of resource allocation, it can be reasonably inferred that the Committee did not consider it to be sufficient in this particular case. States may even try to use their own non-acceptance of Article 15 to avoid responsibility under the ESC. For example, in *Mental Disability Advocacy Center v Bulgaria*, the Bulgarian government argued that, as it did not accept Article 15(1), a complaint to the Committee concerning the lack of education provided for children living in homes for the mentally disabled was inadmissible, on the grounds that, although the complaint was made under Articles 17 and E of the Revised Charter, it should have correctly been made under Article 15(1)⁴⁵. Encouragingly, however, it would seem that the Committee gave short shrift to this argument⁴⁶. It considered that the case was admissible on the basis that, although the rights of persons with disabilities are guaranteed under Article 15(1), this does not exclude relevant issues being raised elsewhere under the Revised Charter. Accordingly, as this case was also about education, it could legitimately be considered under Article 17(2) of the Revised Charter.

b. Resourcing

Even where a particular country's laws and constitutional structure ostensibly provide the means to seek respect for and protection of the rights of those with mental disabilities, the implementation of these is often an entirely different matter⁴⁷. Council of Europe standards and national laws can thus only go so far and are inevitably subject to political influences and resources. Implementation of economic and social rights requires that positive steps be taken by the state, generally progressively and often including the allocation of substantial amounts of resources. Yet, insufficient funding is allocated to mental health expenditure⁴⁸. Only those states that possess, or are prepared to allocate, the resources and relevant information will ensure that the implementation of these standards is other than illusory⁴⁹. According to the EU Green Paper, the UK spends in the region of 12% of its total health expenditure on mental health and Luxembourg slightly under 14%, Slovakia only 2% and the Czech Republic 3%, and France 5%⁵⁰.

43 European Committee of Social Rights (2003), *European Social Charter: Conclusions XVII-2, vols 1 and 2 and European Committee of Social Rights, European Social Charter (Revised) Conclusions 2003, vols 1 and 2*.

44 *International Association Autism-Europe (IAAE) v. France Complaint No. 13/2002, Decision on the Merits, 7 November 2003 (violation of Articles 15(1), 17(1) and E of the Revised Charter) and Mental Disability Advocacy Center v Bulgaria Complaint No. 41/2007, Decision on Admissibility, 26 June 2007 (alleged violations of Article 17(2) and E of the Revised Charter)*.

45 At para 8.

46 A paras 9–11.

47 O. Lewis (2002), "Mental disability law in central and Eastern Europe: paper, practice, promise", 8 *Journal of Mental Health Law*, 283.

48 D. McDaid et al (2005), "Mental Health III: Funding mental health in Europe", Policy Brief, WHO European Centre for Health Policy, Brussels.

49 Kwame Aduffo (2004), "The involuntary detention of persons with mental disorder in England and Wales – A human rights critique", 27 *International Journal of Law and Psychiatry* 109, p131.

50 *European Union (2005), Improving the mental health of the population: Towards a strategy on mental health for the European Union, Brussels COM 484, p21*.

Indeed, the assessment of entitlement to goods and services which support integration in the community, may require those suffering from mental ill-health to compete with other vulnerable groups of persons. Moreover, allocation of these resources is often subject to a number of different, and occasionally contradictory, policies and laws. This is particularly evident in, but not confined to, the case of accommodation. In Scotland, a recent decision of the Outer House of the Court of Session, whilst not specifically referring to social rights, appears to highlight some of the difficulties faced in relation to establishing a priority need for housing for those suffering from mental illness and the allocation of resources. In this case, *Morgan v Stirling Council*⁵¹, it was held that the petitioner, who suffered from “depression and nervous disability”, did not fulfil the criteria to establish a priority need under s.25(1)(c)52 of the *Housing (Scotland) Act 1987* for local authority accommodation. The sub-section states that for a priority need to be established one must show that one is vulnerable as a result of *inter alia* mental illness. Adopting the comparative assessment test in *Wilson v Nithsdale District Council*⁵³ and judgments in the English cases *R v London Borough of Camden ex p Pereira*⁵⁴ and *Griffin v Westminster Council*⁵⁵, the court stated⁵⁶ that, in order to establish that the petitioner is vulnerable under this sub-section, all the circumstances must be taken into account and “it must appear that her ability to fend for herself whilst homeless is more likely to result in injury or detriment to her than would be the case with an ordinary homeless person.”⁵⁷ In this case, it was considered that the local authority had applied this comparative test and had acted reasonably in accordance with the *Wednesbury* test in determining that a priority need did not exist. This was despite the fact that the petitioner was homeless, her boyfriend’s parents no longer had room to accommodate her, and her Community Alcohol and Drugs Service community charge nurse expressed concern that her homeless state might have a detrimental effect on her stability and progress in recovery from drug abuse. The court also made it clear that the local authority, and not the court, is best placed to make decisions on priorities, as the local authority possesses the most appropriate knowledge of housing and applicants within its area⁵⁸.

Cases such as this raise the issue of what is and what is not acceptable in terms of ‘progressive realisation’ of socio-economic rights. They also raise the thorny issue of the extent to which the courts should effectively adjudicate on the allocation of resources, given that this potentially strays onto the territory of the other institutions of government. It is certainly the case that the courts in some Eastern European countries, such as Hungary, may, somewhat ironically, seek to maintain the status quo and prevent the erosion of social rights which existed during the Communist era in the face of the currently more market-driven policies⁵⁹. They are, in other words, effectively enforcing social rights negatively. However, the generally positive nature of social and economic rights nevertheless calls into question fundamental constitutional principles such as judicial independence and its potential compromise. This can present difficulties unless the view is adopted that courts play an integral, but not dominant or directive, role in the whole process of recognition and implementation of socio-economic rights⁶⁰.

51 2006 SLT 962.

52 ‘The following have a priority need for accommodation... (c) a person who is vulnerable as a result of ... (ii) mental illness;’

53 1992 SLT 1131.

54 (1999) 31 HLR 317.

55 [2004] EWCA Civ 108.

56 Lord Glennie at 963.

57 Lord Glennie at 963.

58 Lord Glennie at 965.

59 A. Sajó (2006), ‘Social Rights as Middle-Class Entitlements in Hungary: The Role of the Constitutional Court’, in R. Gargarella et al (eds), *Courts and Social Transformation in New Democracies: An Institutional Voice for the Poor?*, Aldershot: Ashgate, pp83–105.

60 R. Gargarella (2006), ‘Theories of democracy, the Judiciary and Social Rights’, in R. Gargarella et al, *ibid*, pp13–34.

Difficulties may also occur where care and treatment in the community contain elements of compulsion. Questions arise here as to the choices that an individual can and should be able to make⁶¹. The role of law here may in fact militate against the realisation of human rights. Indeed, where the law provides for compulsory community care it can actually be disempowering to those suffering from mental illness, in that it extends the control of medical practitioners and restricts patient choice⁶².

c. Fragmented and disjointed laws

Positive rights that might be implied from ECHR principles are not usually interpreted to imply absolute obligations to provide services. For example, although Article 5(4) ECHR provides for the release of patients from detention often into community care,⁶³ this does not necessarily automatically equate with an absolute obligation being placed on public authorities to provide appropriate support for those persons released into the community. In the UK, for instance, in *R(K) v Camden and Islington*⁶⁴ the Court of Appeal held that if the necessary care⁶⁵ cannot be found in the community then a breach of Article 5 does not occur if the patient remains in detention. It considered that health authorities are only obliged to make reasonable efforts to comply with the conditions of the discharge order and are not under an absolute duty in this respect⁶⁶.

The split between rights to care and duties of care provision may be exacerbated by fragmented or inadequate laws relating to service provision. In Hungary⁶⁷, for example, programmes providing community-based care are generally inadequate and inconsistent across the country⁶⁸. Likewise, in England there is a confusing array of enactments dealing with community care services starting with the *National Health Service and Community Care Act 1990* and also including Part III *National Assistance Act 1948*, s45 *Health Services and Public Health Act 1968*, s21 and Sch8 *National Health Service Act 1977* and s117 *Mental Health Act 1983*⁶⁹. In Scotland, the *Social Work (Scotland) Act 1968* has been much amended over time to bolster community care provision⁷⁰. However, evaluation is difficult given the lack of availability of the current version of the 1968 Act⁷¹. Moreover, ss.25, 26 and 27 of the *Mental Health (Care and Treatment) (Scotland) Act 2003*, providing for services for care and support, the promotion of well-being and social development and travel assistance, are important but do not state how long these services will be provided for persons suffering from mental illness. Certainly, it is implicit that these

61 *Hale, op cit.*

62 C. Unsworth (1993), 'Law and Lunacy in Psychiatry's "Golden Age"', 13 *Oxford Journal of Legal Studies*, 479. In addition, the effectiveness of community treatment orders has also not yet been conclusively determined. See J. Dawson et al (2003), 'Ambivalence about Community Treatment Orders', 26 *International Journal of Law and Psychiatry*, 243, which notes this and advocates that more extensive research is undertaken in this area.

63 *Winterwerp v Netherlands, op cit.* See also *Johnson v UK* (1999) 27 EHRR 440 and *Kolanis v UK* (2006) 42 EHRR 12.

64 [2002] QB 198. See also *R (H) v Secretary of State for Home Department* [2004] 2 AC 253 (Article 5 ECHR is not violated if a person of 'unsound mind' is detained but may be better cared for in a different way).

65 The issue in this case involved a condition requiring medical supervision of a conditionally discharged patient in the community. However, a doctor who would agree to

supervise the patient in the community could not be identified.

66 pp228–229.

67 Which ratified the original ESC and has signed but not yet ratified the Revised Charter.

68 *Human Rights and Mental Health: Hungary, op cit*, pp58–64.

69 See P. Bartlett and P. Sandland (2007), *Mental Health Law: Policy and Practice*, 3rd ed. Oxford University Press, pp435–496.

70 By the *National Health Service and Community Care Act 1990*, *Community Care (Direct Payments) Act 1996*, *Carers (Recognition and Services) Act 1995* and generally strengthening *Community Care and Health (Scotland) Act 2002*.

71 H.Patrick (2006), *Mental Health, Incapacity and the Law in Scotland*, Edinburgh/Haywards Heath: Tottel Publishing, p27.

services are only to be provided for those persons who are subject to compulsion under the Act⁷² and may therefore lead to a lack of uniformity in service provision⁷³.

d. Cultural and political interpretations

Underlying implementation of socio-economic rights – in fact, of human rights in general – is the issue of the impact which different cultural and political attitudes and ideologies have on the recognition and implementation of human rights, including socio-economic rights. This is compounded where the human rights of those with mental ill health are concerned. The extent to which those suffering from mental ill health are indeed entitled to “rights” and the manner in which “mental health” and “mental illness” is interpreted is very pertinent. In terms of different political attitudes, the Russian State⁷⁴ has in the past and is still prepared to detain its opponents in psychiatric hospitals⁷⁵. Larisa Arap⁷⁶ was involuntarily detained and treated only this year after her criticisms of state psychiatric provision. Although she was eventually released, her initial detention was without judicial sanction and later, alarmingly, with it.

In terms of cultural attitudes, we might consider Hungarian out-patient programmes for the mentally ill, which lack provision for supported accommodation and employment, psychological rehabilitation and advocacy services⁷⁷. A lack of funding is a major contributor to this⁷⁸, but cultural interpretations of mental health are also influential. Although the situation is slowly changing, mental illness tends to be stigmatised and with symptoms, rather than the actual condition, being treated by the medical profession. Moreover, the residue of stigmatisation of certain social problems, such as unemployment, from the communist era remains, and may be experienced by the sufferers as symptoms which equate to mental illness⁷⁹. Both sufferers and community have also generally considered in-patient care as being the only adequate form of treatment for mental illness⁸⁰.

Nor is it certain that the European Union’s Charter on Fundamental Rights,⁸¹ if and when it becomes legally binding, will bring about improved human rights protection. It has all the correct ingredients, including civil, political, social, economic and cultural rights, and it refers to responsibilities as well as rights. Whether this will appeal to the wide spectrum of political and cultural ideologies across Europe remains to be seen. Socio-economic considerations may have traditionally been of greater concern to non-Western European states⁸². It would, however, be unwise to assume that all new Member States share

72 Atkinson, *op cit*, p77.

73 *Ibid*, p77.

74 Which signed both the original and Revised ESC but has ratified neither and has ratified the ECHR.

75 See, for example, Mental Disability Advocacy Center, ‘Psychiatric ‘care’ still a political weapon in Russia?’, Media Release, 21 August 2007.

76 In July 2007, Larisa Arap, a political activist and opponent of the Russian government, was involuntarily detained and treated in a psychiatric hospital after she had published a story criticising state psychiatric care of children. Her initial detention was without judicial oversight. A court order, authorising the detention and treatment, was obtained approximately two weeks later. The Russian Human Rights Ombudsman ultimately confirmed that her detention had been illegal and she was released after 47 days. There was considerable support amongst human rights commentators for the view that this was an example of state abuse of psychiatry. See Mental

Disability Advocacy Center, ‘Psychiatric ‘care’ still a political weapon in Russia?’ *ibid*.

77 Mental Disability Rights International (1997), *Human Rights and Mental Health: Hungary*, Washington D.C., 58, p61.

78 *Ibid*, p62.

79 *Ibid*, p67.

80 *Ibid*, p67. See also J. Furedi and B. Buda (1987), ‘Recognition Problems for Psychiatry as an Independent Discipline in Hungary’, 7 *American Journal of Social Psychiatry* 199.

81 Charter of Fundamental Rights of the European Union 2000 O.J. (C364) 1.

82 R. Nordahl, ‘A Marxist Approach to Human Rights’ in A.A. An-Na’im (ed) (1995), *Human Rights in Cross-Cultural Perspectives: A Quest for Consensus*, Philadelphia: University of Philadelphia, 162, p162; J.J. Shestack (1998), ‘The Philosophical Foundations of Human Rights’, 20(2) *Human Rights Quarterly* 201, p210.

common political, social and cultural traditions⁸³. It must also not be forgotten that Western European states have historically tended to place greater emphasis on civil and political rights and their implementation. Moreover, whether accession to the EU will bring about more widespread human rights observance in general within Member States is debateable, even though the EU proclaims respect for the rule of law, democracy and human rights. Despite the rulings in *Carpenter*, *Schmidberger* and *Omega Spielhallen*⁸⁴, the importance which the European Court of Justice will ultimately ascribe to fundamental rights is at present not yet completely clear⁸⁵. Some pessimism certainly exists on the issue of whether accession to the EU will result in better human rights respect and protection for those persons with mental disabilities in central and eastern European countries given the EU's predominantly economic focus⁸⁶. That being said, the fact that there is ostensibly greater reciprocity in terms of the benefits that membership of the EU may bring might perhaps encourage greater and more effective implementation.

6. Conclusion

Over the last two decades we have come some way in Europe towards recognising that those suffering from mental illness require enforceable rights so that they are not subjected to abuse and neglect. These rights are, however, mainly civil rights which are applicable to the patient-institution relationship. If care takes place outside institutions, a far greater emphasis on socio-economic rights is required. This will enable those with mental illness to access and receive those services and that support which is necessary for them to function as effectively as possible within the communities in which they live. Yet, despite international and European standards⁸⁷ to this effect, the actual realisation of these at national level is slow⁸⁸. Undoubtedly the lack of imperative is largely owing to the very nature of socio-economic rights and the positive obligations they place on states.

Adequate rights and the law do not alone, of course, provide the answer to full and effective care in the community. There is always a balance to be struck between the desire to provide community care and availability of resources, the rights of the person suffering from mental ill health and public safety.

Socio-economic rights are, however, incontrovertibly an important component in the achievement of the 'well-organized community-based care' envisaged by the WHO⁸⁹, the community care provisions in the *Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities*⁹⁰ and 'independence, social integration and participation in the life of the community' referred to in the Revised ESC⁹¹. Their recognition and implementation, together with adequate resourcing and proper coordination between relevant care givers, will reduce the risk that individuals will ultimately not benefit from care in the community, and possibly become subject to compulsory admission to psychiatric units or the criminal justice system⁹².

- 83 O. Lewis (2002), 'Mental Disability law in central and eastern Europe: paper, practice, promise', 8 *Journal of Mental Health Law*, 293, p293; See also M Ishay (2005), 'The Socialist Contributions to Human Rights: An Overlooked Legacy', 9(2) *International Journal of Human Rights* 225 (in which the author argues that the so-called international human rights instruments were in fact influenced by socialist ideals).
- 84 Case C-60/00 *Carpenter* [2002] ECR I-6279, Case C-112/00 *Schmidberger* [2003] ECR I-5679; Case C-36/02 *Omega Spielhallen* [2004] ECR I- 9609. The rulings in these cases, amongst others, indicate that the European Court of Justice is increasingly prepared to give weight to human rights considerations.
- 85 See, for example, S. Douglas-Scott (2006), 'A Tale of Two Courts: Luxembourg, Strasbourg and the Growing European Human Rights Aquis', 43 *Common Market Law Review* 629 and J. Morijn (2006), 'Balancing Fundamental Rights and Common Market Freedoms in Union Law: *Schmidberger* and *Omega* in the Light of the European Constitution', 12(1) *European Law Journal* 15.
- 86 O. Lewis, *op cit*, p303.
- 87 See Section 3 above.
- 88 See Sections 3 and 4 above.
- 89 WHO, *World Health Report 2001*, *op cit*, p4.
- 90 Article 7.
- 91 Article 15.
- 92 See H.W. Wales and V.A. Hiday (2006), 'PLC or TLC: Is the outpatient commitment the/answer?', 29 *International Journal of Law and Psychiatry*, 451-468, p452. who consider this risk to be significant.