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Correspondence

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Letter to the Editor

To the Editor,

We thank Duffy for his interest in our paper and his comments on this critical and controversial topic of adherence to human rights principles during coercive psychiatric care. However, we maintain that the phrase he takes issue with is justifiably included in the paper, and that the mental health laws discussed in our article do adhere with human rights-based principles. Duffy strongly relies on the United Nations Convention on the Rights of Persons with Disabilities (CPRD) as the standard to adhere to, however we contend that human rights principles and standards within mental health legislation extend beyond convergence with the CRPD and are strongly reflected in the jurisdictions. Ontario, was first to integrate human rights-based code into mental health legislation when the Canadian Charter of Rights and Freedoms (based on the Universal Declaration of Human Rights) became part of the constitution in 1982 (The Constitution Act, 1982). Similarly, MHA reform in the UK and Ireland was driven by the ratification of the European Convention on Human Rights into domestic law (Council Of Europe, 1953). While in Victoria, the Charter of Human Rights and Responsibilities 2006 informed the drafting of the MHA, the Charter itself based on the UN International Covenant on Civil and Political Rights (United Nations, 1966). These international agreements form the foundation of modern human rights law and the framework for the World Health Organisation's Resource Book on Mental Health, Human Rights and Legislation (WHO-RB).

Duffy, citing Kelly (2011), portrays the Irish mental health legislation's mixed adherence to WHO-RB as an example of Irish law falling short of international standards. However as the author points out, many of the WHO-RB areas that Irish mental health legislation does not cover are economic or social rights, and are not best legislated through mental health law, but go beyond its remit and purpose.

This leads us to the General Comments made by the Committee overseeing the CPRD that all forms of substitute decision-making due to mental disability are discriminatory and should be abolished (United Nations, 2006). The assumption that people have capacity at all times regardless of disability paradoxically may result in the right to access care for those who need it the most being withdrawn and thus deprive individuals of another human right: the right to the highest standard of health (Freeman et al., 2015). Whereas an episodic mental illness such as bipolar disorder is often a long-term condition, it is likely that individuals with this disorder will only lack capacity to make decisions about their treatment for brief periods during manic relapse. The General Comment fails to make this discrimination. A more workable and realistic interpretation of the Convention would permit substitute decision-making in exceptional circumstances but would not constitute discrimination on the grounds of disability (Dawson, 2015).

Therefore we contend that the CRPD should not be considered the gold standard when it comes to rights-based treatment of people with serious mental illness. Freeman has outlined several areas where the CPRD, as interpreted by the General Comments, may in fact violate certain rights such as access to care, to life, and to justice (Freeman et al., 2015). Duffy correctly states advocacy groups have called for the ratification of CPRD. It is also important to note that various patient advocacy groups called for the continued use of substitute decision-making and involuntary treatment when the Committee was drafting its General Comment on involuntary treatment (United Nations, 2014).

Duffy suggests looking to the new Indian MHA as a 'role model' for the revision of Irish mental health law. However a recent analysis of the Indian MHA in a paper by Duffy and Kelly (2017) noted a number of weaknesses. Firstly, there is the absence of time-bound reviews protected in legislation for involuntary admissions or coercive practices such as seclusion that already exist in the Irish MHA, for example. Secondly, the authors noted the Indian MHA's use of vague language, particularly related to capacity and consent, in its attempt to be concordant with the CPRD. We agree that there is a risk of potential for harm with the use of a nominated representative in assisted decision-making, who may have competing interests and uninformed views regarding the extent to which psychotic illness may impact upon decision making capacity, as compared to psychiatrists who are professionally trained and regulated. This may ultimately affect the Indian MHA's implementation and delivery in practice, potentially leading to more coercive practices given the lack of adequate review of nominated persons.

The area of coercive care within psychiatric practice is likely to remain controversial as stakeholders seek to

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balance those competing human rights of autonomy and access to care and treatment. We disagree that Ireland should now drastically change its mental health laws, but rather should continue its gradual evolution in the context of international best practice and consensus, and ultimately be guided by the principles of effective, equitable and quality mental health care.

Conflict of interest

The authors have no conflicts of interest

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