

# A human rights foundation for ethical mental health practice

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There are close links between clinical ethics, human rights and the lived experience of mental illness and mental health care. Principles of professional ethics, national mental health legislation and international human rights conventions all address these themes in various ways. Even so, there are substantial deviations from acceptable standards at certain times, resulting in significant violations of rights in the developing and developed worlds. An explicitly human rights-based approach has improved matters in, for example, Scotland. External drivers of change, such as legislation, standards, codes of practice, inspections and sanctions for violations, are all needed. Attitudes and culture are also critical drivers of change. Most importantly, the principles and values of ethical, human rights-based professional practice need to be taught and modelled throughout professional careers. Ongoing training in this area should form a central element of programmes of continuing professional development, delivered by people with expertise and understanding, including service users.

Received 25 July 2016; Revised 10 October 2016; Accepted 13 October 2016; First published online 21 November 2016

**Key words:** Ethics, human rights, mental health, mental health legislation, psychiatry, training.

## Introduction

In December 2014, the BBC broadcast a report on human rights violations in Federico Mora Hospital psychiatric hospital in Guatemala, titled *Inside the World's Most Dangerous Hospital*.<sup>1</sup> The reporters entered the hospital in the guise of a charity agency which would provide financial support to the hospital. They filmed surreptitiously.

The footage showed the utter degradation of patients kept in subhuman conditions. They were heavily sedated, with harshly shaven heads. Some were dressed in rags and some naked. They were tied to walls at times. Many had been committed to the hospital despite the fact that they could have been cared for in the community.<sup>2</sup> The ward was grossly under-staffed, with two or three nurses to look after up to 70 patients, reflecting poor clinical and management practice. Sexual abuse was common. In 2012 the Inter-American Commission on Human Rights issued

an emergency measure seeking for the Guatemalan government to remedy matters, to little or no avail.

While this level of active abuse and gross neglect is not a feature in Ireland today, it is notable that the situation in Irish psychiatric institutions in the 1800s was not at all dissimilar. In 1817, the Select Committee on the Lunatic Poor in Ireland (1817), heard evidence from the illustrious Thomas Spring Rice (1790–1866) who, in 1815, ‘visited the asylums of Cork, Waterford, Clonmel and Limerick’ (p. 12). While many of these asylums gave cause for concern, conditions were especially disturbing at the ‘Lunatic Asylum of Limerick, in which the accommodation afforded to the insane’ was ‘such as we should not appropriate for our dog-kennels’. There was no heating or ventilation, and the mentally ill were ‘exposed during the whole of the winter to the extremities of the weather’, resulting in amputations (owing to ‘that mortification in the extremities, to which the insane are peculiarly liable’) and deaths (owing ‘to the extreme coldness of the situation’):

...two, and sometimes, I believe, three of the insane have been condemned to lie together in one of those cells, the dimensions of which are six feet by ten feet seven inches; some of them in a state of furious insanity. In order to protect them from the obvious results, the usual mode of restraint was by passing their hands under their knees, fastening them with manacles, fastening bolts about their ankles, and passing a chain over

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The authors wish to state that this article represents their opinion that a human rights approach can provide a worthwhile foundation for ethical mental health practice. We are aware that other philosophical approaches may also be valid. We would welcome a debate on the issue and believe that the improvement of the mental health services requires such a debate.

<sup>1</sup> <http://www.bbc.com/news/magazine-30293880>.

<sup>2</sup> An issue also in many parts of modern western states.

all, and then fastening them to a bed. I can assure the Committee, from my own knowledge, they have continued for years, and the result has been (and I believe an honourable friend of mine may also have witnessed the fact) that they have so far lost the use of their limbs, that they are utterly incapable of rising (pp. 14–15).

Other parts of the Limerick establishment were designated for the physically ‘sick, as well as for such insane as may be trusted at large without actual danger’:

In one of these rooms I found four-and-twenty individuals lying, some old, some infirm, one or two dying, some insane, and in the centre of the room was left a corpse of one who died a few hours before. Another instance was still stronger: in the adjoining room I found a woman with the corpse of her child, left upon her knees for two days; it was almost in a state of putridity. I need not say the woman was almost in a state of distraction; another was so ill that she could not leave her bed; and in this establishment, with governors *ex officio*, and with all the parade of inspection and control, there was not to be found one attendant who would perform the common duties of humanity (p. 15).

Not unlike the report from Guatemala, Rice also reported that ‘the keeper of the lunatics [in Limerick in 1815] claimed an exclusive dominion over the females confided to his charge, and which he exercised in the most abominable manner; I decline going into the instances, the character of which are most atrocious’.

While matters have, of course, improved greatly in Ireland over the intervening two centuries, the Guatemalan footage demonstrates that no institutions or hospitals can let themselves become complacent, even today. Indeed, recent decades have seen significant concern in Ireland about conditions in certain residential centres for the intellectually disabled and in certain nursing homes. While the deficiencies identified do not approach the level of the problems in Guatemala or the 19th century Irish asylums, they are nonetheless significant indicators of the very real possibilities of systematically substandard care, even in 21st century Ireland.

Against this background, we must ask ourselves: how do these things happen in a modern, sophisticated, developed country? Why do they still occur? Is it due to poor legislation, poor culture, inadequate resources or inadequate oversight? Where is the professionalism of those placed in charge? Where is the ethical thinking? Is it possible to eliminate risk of these occurrences through training and culture change? Is there sufficient

knowledge or understanding of the principles of human rights? Even if professionals are comprehensively trained, will they always act in accordance with that training?

This paper explores some of these questions. We explore, in particular, the overlap and interactions between human rights and mental health, and the treatment for mental illnesses. We look at how national legislation and international human rights conventions address this matter. We also explore the mechanics of psychiatric ethics and the role human rights plays in the development of a robust ethical approach to mental health care. We look at an example of an explicitly human rights-based approach in Scotland. Through analysis of various official documents, including reports of the Inspector of Mental Health Services and the review of the Mental Health Act 2001, we seek to ascertain the state of Ireland’s mental health services, the role of human rights, and opportunities to use the principles of human rights to improve professional practice and enhance the experiences of those with mental conditions/disability in Ireland and elsewhere.

### Human rights and ethics

The term ‘human rights’ is now so ubiquitous in western societies that it almost in the category of a cliché (Witte, 2006). This is an indication of both how important the concept has become, and how it continues to be promoted by international organisations such as the United Nations (UN) (1948, 1966, 2006) and Council of Europe (1950).

While the modern idea of human rights had a period of gestation lasting millennia (Ishay, 1997), its most recent re-birth was in the encounter between 16th century Spanish neo-scholasticism and the New World (Carozza, 2003). It was Bartolomé De Las Casas,<sup>3</sup> a lawyer cleric, deeply familiar with the work of Thomas Aquinas with respect to natural law, who extracted from Aquinas’s description of our universal and natural inclinations the principle that we also have natural rights. These rights, in turn, give rise to the duties of others in a fundamentally interconnected way. On this basis, recognition of the human rights of others formed the basis for ethical thought and practice. The concept of human rights duly grew throughout the enlightenment era and was eventually incorporated into the constitutions of the United States and France.

Human rights as a concept did not find significant traction more broadly, however, until after the Second World War when the countries of the world, appalled by

<sup>3</sup> Bartolomé De Las Casas, Brief Account of the Devastation of the Indies, 1542 <http://www.swarthmore.edu/SocSci/bdorse1/41docs/02-las.html>.

the abuses that occurred during that conflict, came together under the UN (1948) to adopt the Universal Declaration of Human Rights on the 10 December 1948. This was the foundation document which generated several other statements with different emphases and more nuanced approaches to rights for specific individuals, groups and contexts. The statement of most importance in Ireland emanated from the Council of Europe (1950), and is the Convention for the Protection of Human Rights and Fundamental Freedoms [European Convention on Human Rights (ECHR)], which Ireland ratified in 1953. This convention is part of Irish law and its influence is felt in all areas of law, including mental health legislation. An individual must usually have exhausted remedies in the domestic courts before taking a case to the European Court of Human Rights. ECHR rights are protected by Irish courts, even though constitutional rights take primacy

In terms of the ethics which govern the professionals working in mental health services, human rights were a surprisingly minor feature in the seminal textbook of *Psychiatric Ethics* edited by Bloch *et al.* (1999). Nonetheless, the *ideas* that underpin rights were clearly evident in various ways throughout the chapters, even if the specific term 'human rights' was not quite as ubiquitous as one might have expected. Beauchamp & Childress (1994), similarly, espouse a set of principles which govern the practice of professional ethics and bear strong relation to key concepts in human rights, including respect for a person's autonomy (respecting the decision-making capacity of autonomous persons); non-maleficence (avoidance of the causation of harm); beneficence (providing benefits and balancing these against risks); and justice (fairness in the distribution of benefits and risk).

### Mental health legislation in Ireland

Legislation plays an especially important role in relation to the human rights of the mentally ill owing to both the possibility of involuntary care and the fact that certain persons can lose mental capacity to the point where they have diminished ability to make certain decisions (usually on a temporary basis) (Kelly, 2016). Mental health legislation has existed in Ireland from before the early 1800s as various laws were created to safeguard against abuses and regularise the epidemic of institutionalisation that swept across Europe and North America in the 19th century. These were superseded by the Mental Treatment Act of 1945 which came into effect in 1947 (Kelly, 2008).

In Ireland, as well as in other jurisdictions, the main purpose of much of this legislation was to regulate the admission of individuals to psychiatric facilities on an involuntary basis due to *mental disorder*.<sup>4</sup>

<sup>4</sup> Current legal terminology under Mental Health Act 2001.

The underlying principles were generally those of *Parens Patriae*, rooted in the welfare-based attitude of the state towards citizens who were vulnerable and deemed in need of protection. The other principle was that the state had a duty to protect its citizens from those who might present a public risk as a result of a mental disorder. These two principles effectively gave the state the power to admit and treat individuals for their own good, the good of society or both. Ireland's 1945 Act predated the Universal Declaration of Human Rights and paid relatively little attention to protecting the basic human rights of the individual (e.g. there was no automatic review of involuntary admission).

Following Ireland's ratification of the ECHR in 1953, it was open to an individual or a state to apply to the Court of Human Rights for legal relief with respect to any infringement of an individual's rights. On that basis, one detained psychiatric patient argued in the courts that he did not have proper access to review of his involuntary admission; he had been detained as a result of mental disorder and had perpetrated violence against psychiatric nurses who came to take him to the hospital.<sup>5</sup> In the end, the Irish state agreed a settlement involving a commitment to introduce legislation whereby individuals would have their detention subject to review by an appropriate judicial or quasi-judicial body. This led to the Mental Health Act 2001 which provided for tribunals to hear the cases of those involuntarily detained, and permits appeal of tribunal decisions to the courts.

The 2001 Act also established the Mental Health Commission which aimed to improve the standards of mental health care in Ireland, set up and manage mental health tribunals, and appoint the Inspector of Mental Health Services. The inspector was obliged under the 2001 Act to publish an annual review of the state of the mental health services in Ireland, as well as report on the quality of those services with respect to published rules, regulations, and codes of practice.

The Mental Health Act 2001, fully implemented in 2006, centred on the concept of the 'best interests' of the patient:

In making a decision under this Act concerning the care or treatment of a person (including a decision to make an admission order in relation to a person), the best interests of the person shall be the principal consideration with due regard being given to the interests of other persons who may be at risk of serious harm if the decision is not made.... due regard shall [also] be given to the need to respect the right of the person to dignity, bodily integrity, privacy and autonomy (Section 4).

<sup>5</sup> Croke v Smith [1994] 3 IR 529; Croke v Smith (No. 2) [1998] 1 IR 101; Croke v Ireland (2000) ECHR 680.

These principles were generally thought to be sufficient to balance the patient's right to liberty with the necessity to provide treatment. In 2012, however, the Steering Group on the Review of the Mental Health Act (2012) expressed disappointment with how this had worked out in practice:

The Mental Health Act 2001 introduced a human rights ethos into our mental health law. It was anticipated that the introduction in the Act of the statutory 'best interests' principle would lead to a new emphasis on the rights of the patient, but the reality is that the principle has been interpreted by the Courts in a paternalistic manner. This paternalistic interpretation of the 2001 Act is undermining the significant advances in mental health law which the Act was intended to enshrine, and has given rise to concerns that the human rights aspects of the legislation have been diluted and diminished [...]

The paternalistic approach to medicine presumes that the doctor knows best i.e. the doctor is the best person to determine the treatment a patient should receive. On the other hand, the autonomy approach supports the right of a patient to make their own treatment decisions, including the provision of support to help a patient make those decisions. There has been a general move worldwide away from paternalism in favour of autonomy with a growing recognition that all adults, including those living with a disability, have a right to autonomy and self-determination. In human rights debates, challenging the exclusion of persons with mental illness from the medical decision making process, has become a central theme (pp. 9, 10).

It was unclear whether or not this alleged 'paternalism' was proportionate to the state's strong constitutional responsibility to protect the vulnerable (Kennedy, 2012). The Steering Group also referred to the UN Convention on the Rights of Persons with Disabilities (CRPD) (UN, 2006) which guarantees all rights and fundamental freedoms to all persons with disabilities, including those with long-term mental health condition/disability. The social model of disability, promoted in the CRPD, points to the need to change or alter social structures that create disability. This approach moves away from diagnoses and deficits in capacity to supporting people to exercise their capacity to make decisions for themselves. Under this model, people with psychosocial and other disabilities are presumed to have legal capacity to make decisions with an appropriate level of support if needed. These supports should not be imposed on the person.

The CRPD presumes that all people regardless of their disability (mental or otherwise) have the legal capacity to make decisions on an equal basis with

others in all aspects of life. Ireland is due to ratify this Convention in the near future. The Convention states that impairments/deficits in mental capacity should not be used to deprive a person of his/her legal capacity. The Convention instead advocates a system of supports (if needed) to enable the person to exercise his/her legal capacity to make decisions.

In this context, it is clearly critical that we view people suffering from varying degrees of mental distress as human beings deserving equality and respect. Everyone experiences varying degrees of mental or emotional distress at different times. It is important to destigmatise mental illness and promote involvement of service users in the delivery of mental health services. Consistent with this, the CRPD seeks to prevent the long-term detention of individuals with disabilities on account of that disability alone. In practice, one of the key mechanisms in place in Ireland to minimise the possibility of violations of such rights in psychiatric settings is the system of inspections by the Inspector of Mental Health Services, under the 2001 Act. These inspections, as well as the system of automatic review of involuntary admissions and various other safeguards established in the 2001 Act, were mainly introduced to safeguard rights established under the ECHR, which is binding and has to be taken into consideration by the Irish courts.

### **Reports of the inspector of mental health services**

The annual reports of the Inspector of Mental Health Services in Ireland include evaluations of levels of compliance by various mental health services with predetermined standards, focussed chiefly, although not exclusively, on 'approved centres' which provide inpatient care (i.e. psychiatric hospitals or psychiatric units in general hospitals).

The reports have consistently pointed out the failure of significant percentage of these centres to adhere fully to the legal requirements with respect to various care practices (e.g. Inspector of Mental health Services, 2014). In particular, reports commonly note room for improvement in relation to due process and paperwork for involuntary admissions, as well as the legal requirement for each patient to have an individual care plan. Further difficulties in certain areas relate to seclusion, restraint and electroconvulsive therapy (ECT).

In 2012 the inspector identified human rights as a key element of the approach to compliance with legislative requirements:

Approaching the delivery of mental health services from a human rights perspective will be an important philosophical adjustment which should impact positively on the quality of care and treatment. The concept of universal human



rights can be understood in relatively simple terms and can cause clinicians to think twice with respect to particular treatments or approaches with particular patient/service users.

For example, understanding and respecting the liberty rights of a patient/service user and recognising that curtailment of these rights requires the closest scrutiny of procedure and process might mean that clinicians will pay more attention to these matters.

In addition, the human right to bodily integrity must be taken into account when assessment is made of the mental capacity of an individual to give or withhold consent to a particular treatment, e.g., medication or ECT. [...] The concept of recovery can be understood in terms of the human right to autonomy and self-fulfilment of the individual (Inspector of Mental Health Services, 2013, p. 56).

The report also noted that 'nowhere in our mental health services is the concept of the essential dignity, autonomy and right to self-fulfilment of the individual more enshrined than in the individual care plan. Here, according to the Mental Health Act regulations, the patient/service-user participates in planning his own treatment' (p. 56).

The following year, the 2013 report strongly re-emphasised the centrality of human rights:

Knowledge and appreciation of the human rights of individuals, but especially in a situation of power imbalance which pertains with involuntary detention, will have a strong influence on practice and will also help professionals to understand the importance and provenance of certain statutory provisions (Inspector of Mental Health Services, 2014; p. 61).

### Human rights and mental health

The links between mental health and human rights are close, complex and crucial. Gostin & Gable (2004) note that three basic relationships exist between human rights and mental health: (1) mental health policy invariably affects human rights; (2) human rights violations affect mental health; and (3) positive promotion of human rights and mental health are mutually reinforcing. Dignity is a key value at the heart of all rights, and increased emphasis on dignity in mental health legislation would help ensure that all decisions actively facilitate individuals with mental disorder to exercise their capabilities, promote human rights, and protect dignity (Kelly, 2015).

All of this occurs in specific social and political contexts, and it is firmly established that adverse social circumstances are experienced disproportionately by the mentally ill and their families (Kelly, 2005; 2014). These circumstances constitute a form of 'structural violence' by which the disability associated with mental disorder is exacerbated by social exclusion, poverty, homelessness, imprisonment and lack of observance of basic rights. This issue is clearly acknowledged in the UN International Covenant on Economic, Social and Cultural Rights (1966) which recognises 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' (article 12) and notes that 'the ideal of free human beings enjoying freedom from fear and want can only be achieved if conditions are created whereby everyone may enjoy his economic, social and cultural rights, as well as his civil and political rights' (preamble).

The attainment of this freedom is necessarily located in specific contexts which can affect the degree to which such freedom can be achieved and enjoyed. Those with inadequate access to treatment will likely suffer continued mental ill-health, increased risk of social decline, and effective exclusion from society in a manner inimical to even the most basic human rights, including the right to liberty. It is due to these forces that the mentally ill commonly find themselves deprived of their liberty *through relentless social exclusion* even more commonly than through involuntary admission.

Regarding the latter, the ECHR, which is legally binding in Ireland, states that 'no one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law' and includes, in this list, 'the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants' (Council of Europe, 1950; article 5).

It is also required that the state does not deprive people of their liberty unlawfully or arbitrarily, and ensures that private parties within its jurisdiction do not do so either. The power to detain on grounds of unsoundness of mind is, in addition, subject to specific criteria, including that there must be objective medical evidence of mental disorder presented to a competent authority; the mental disorder must be of a nature or degree warranting confinement; and there must be periodic review of the continued need for detention.<sup>6</sup> Proportionality is important, as is the principle of the 'least restrictive alternative', and respecting the individual's rights to personal integrity and a private life.

Many of these principles were re-stated and operationalised in the World Health Organisation's (WHO)

<sup>6</sup> *Winterwerp v Netherlands* [1979] 2 EHRR 387.

*Resource Book on Mental Health, Human Rights, and Legislation* (WHO, 2005), which notes that violations of human rights are relatively common among the mentally ill. The WHO also observes that human rights form a fundamental basis for mental health legislation, with key rights including equality, non-discrimination, privacy, individual autonomy, freedom from inhuman and degrading treatment, the least restrictive environment, information and participation, as well as access to care.

The WHO notes that mental health legislation should complement mental health policy; people with mental disorder require additional protection of their rights; mental health legislation is necessary to protect rights in both institutional settings and the community; and mental health legislation provides a legal framework for addressing many critical issues including access to services, integration in the community, and promotion of mental health across society. On this basis, then, there are strong links and synergies between mental health legislation, mental health policy and the lived experience of those individuals with mental health conditions and their families and friends. Ultimately, these factors are interlinked to the point of inseparability.

### **A human rights-based approach**

Given these close ties between legislation, policy and the lived experience of the mentally ill, it is apparent that even though Ireland's Mental Health Act 2001 now accords with most WHO standards regarding involuntary care (Kelly, 2011), this does not by any means guarantee that individual patients will necessarily have their rights adequately vindicated, protected and promoted by mental health and social services, or the criminal justice system (Kennedy, 2016). Moreover, these standards are likely to evolve in the coming years, requiring reconsideration of the adequacy of existing legislation. Non-legislative determinants of service delivery (e.g. local resource limitations, levels of staff training and commitment, and various other matters) are also important factors in determining the experiences of individual patients with mental disorder.

Against this background, the WHO (2003) formulated a human rights-based approach to health whereby all programmes of development and policies should further the realisation of human rights and be guided by human rights standards. All development operations should contribute to the capacity of 'duty bearers' to meet their obligations and help 'rights holders' to claim their rights.

On this theme, the Scottish Human Rights Commission (SHRC) undertook an independent evaluation of the experience of a special National Health Service Health

Board which had sought to adopt a human rights culture (Scottish Human Rights Commission, 2009). The State Hospital is a high security forensic mental health hospital for Scotland and Northern Ireland providing psychiatric care in conditions of high security for those compulsorily detained under mental health or criminal law.

A critical report by a regulatory agency in 2000 prompted hospital authorities to conduct a fundamental examination of their human rights practices. The Human Rights Act 1998 was used as a vehicle for cultural change, putting the rights of staff, patients, and carers family members at the heart of the hospital's services. Human rights were seen as a means (a way of doing things) by human rights standards and principles, as well as an end in themselves. The commission promoted a human rights-based approach with emphasis on the following principles:

- P: Participation
- A: Accountability
- N: Non-discrimination and equality
- E: Empowerment
- L: Legality

A human rights working group was led by senior management and involved clinical and non-clinical staff who underwent training in human rights with an expert in human rights. Policies were examined with respect to their compliance with human rights requirements and were rectified accordingly. Human rights training for staff was developed as well as the creation of an 'Equality, Diversity and Human Rights Group', to ensure a human rights approach to the delivery of equality duties.

The SHRC found that a human rights-based approach was successful in supporting cultural change. In an institution where rights had not previously been central to procedures and policies, there was now a more positive and constructive atmosphere with greater mutual respect between staff and patients. This resulted in increased work-related satisfaction among staff and increased satisfaction among patients with their care and treatment. Staff reported less stress and anxiety. Knowledge of human rights improved staff's understanding as to how to make choices and take decisions.

The human rights-based approach gave rise to a reduction in 'one-size-fits-all' policies and increased focus on individual risks of patients. One staff member reported 'patients have increasingly recognised their responsibilities as well as their rights'. From the patient's perspective, procedures to manage violence and aggression were now seen as more proportionate. Seclusion was not routinely used as a punishment and patients were actively engaged in decisions that

affected them. The hospital used three simple tests which were introduced by the human rights-based approach: 'Is it legal? Is it necessary? Is it proportionate?' This led to greater understanding among all parties. Using the human rights-based approach as a lens also made it possible to integrate equality and freedom of information requirements into mental health duties.

The SHRC report concluded that the human rights-based approach was effective because of buy-in by senior executives, early involvement of human rights expertise, a human rights audit, investment of time and resources, a proportionate approach, and a focus on the rights of *everyone*: staff as well as patients and carers who were involved. The human rights-based approach promoted understanding of how to balance the rights of different parties, as well as how to justify limitations of those rights in defined circumstances.

## Conclusions

Human beings are capable of great nobility, but also capable of great cruelty and viciousness towards each other. Nowhere is this more pronounced than in scenarios of imbalance of power. Even with the best intentions, people in caring and treating professions can lose their high ideals and focus, and treat others in a neglectful or abusive manner, ignoring human rights considerations, especially in institutional contexts. External drivers of positive change, such as legislation, standards, codes of practice, inspections and sanction for violations, are all needed. Attitudes and culture are also critical drivers of change.

It is also clear that many professional workers and staff in various institutions, such as Federico Mora Hospital psychiatric hospital in Guatemala and elsewhere, are under-trained, over-worked and placed in environments which, at the very least, do not prevent abuse and possibly even facilitate it. It is also clear that they work in a culture where the residents, vulnerable in terms of their disabilities, are deeply dehumanised. Changing this behaviour requires attitudinal and cultural shifts across entire organisations.

It is usually the case that professionals enter the caring professions with high ideals and high hopes to better the lives of others. It is disheartening to note how idealism can tire and be replaced by apathy or cynicism. It is, on the other hand, encouraging to see evidence of the positive role that can be played by a human rights-based approach, as demonstrated in Scotland. Legislation, too, has a key role in operationalising human rights principles with respect to training and accreditation of various professionals. Regulation, governance, and oversight are also important and necessary.

Without any of the above, human rights abuses will proliferate.

Even all of these measures, however, might still not be sufficient to ensure ethical mental health practice in all cases and at all times. The principles and values of ethical, human rights-based professional practice need to be taught and modelled in a balanced way, taking into account often competing rights. This is possibly the most important measure we can take and it needs to start at an early stage in training, and to be continually reinforced and evaluated throughout professional careers. Ongoing training in this area should form a central element of programmes of continuing professional development and should involve experts in human rights and service users.

Patients, like health care professionals, are fellow human beings with the same range of rights and responsibilities, and need to be treated with absolute dignity and respect at all times. The essence of mental health services is a human interaction between two people, each showing consideration, care and respect for the other. All the technical expertise in the world is as nothing if this value does not remain central at all times.

## Acknowledgements

The authors are very grateful to the editor and reviewers for their comments and suggestions.

## Financial Support

This research received no specific grant from any funding agency, commercial or not-for-profit sectors.

## Conflicts of Interest

One of the authors, P.D., was Inspector of Mental Health Services from 2008 to 2015.

## Ethical Standards

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committee on human experimentation with the Helsinki Declaration of 1975, as revised in 2008. The authors assert that ethical approval was not required by their local REC.

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