Correspondence

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Letter to the Editor

In the December issue of the *Irish Journal of Psychological Medicine*, Cronin *et al.* (2017) wrote a helpful comparison of the mental health legislations in the Republic of Ireland, England and Wales, Scotland, Ontario (Canada), and Victoria (Australia). The authors examined the regulations concerning coercive practices and explored the influence of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) (United Nations, 2006). They concluded that the legislation in these five jurisdictions 'reflected adherence with international standards and incorporation of human rights-based principles'.

The fact that these pieces of legislation are similar to each other does not demonstrate adherence to international standards. The most comprehensive guideline regarding the content of mental health legislation is the *World Health Organisation's Resource Book on Mental Health, Human Rights and Legislation* (WHO-RB) (WHO, 2005). While these standards were published before the CRPD they still place a strong emphasis on human rights. The WHO-RB includes a 175 item checklist; Kelly (2011) used this checklist to demonstrate the many areas in which the Irish and the English and Welsh laws were non-concordant with these standards. Irish legislation covered only 48.2% of these items while England and Wales met 54.2%. Areas of low concordance included economic and social rights, the protection of vulnerable patients and capacity. The latter may be addressed by the Assisted Decision-Making (Capacity) Act 2015.

Similarly, the fact that these five jurisdictions have been influenced by the CRPD does not mean that they are concordant with it. Many items currently in the Irish Mental Health Act 2001 fail to live up to the standards of the CRPD. This is especially true in the area of involuntary admissions, seclusion and restraint. Human rights groups, especially mental health advocacy groups played a highly influential role in the development of the CRPD (Byrnes, 2014). An individual's right to retain capacity at all times and deinstitutionalisation became non-negotiables in the drafting of the convention (Melish, 2014). Consequently, careful consideration needs to be given to any limitation of liberty or capacity and any measures that may be perceived as coercive or inhumane.

This may explain Ireland's ten year delay in ratifying the CRPD despite signing it in 2007. The CRPD is one of the main forces driving recent change in mental health legislation, it underpins the evolution of mental health law from a focus on *treatment* to one on *rights*. Despite the clear benefits of the CRPD, it will bring many challenges. Careful implementation of the CRPD will be required as an overly literal application may actually impair the rights of individuals with mental illness (Freeman, 2015).

Much change is needed to deliver pragmatic, rights based mental health legislation, and an unexpected role model is emerging. In April 2017, India passed its new Mental Healthcare Act (MHA), only 9 months later in January 2018 they began to implement it. Both this Act and India's Rights of Persons with Disabilities Act (RPDA) 2016, were explicitly written to be concordant with the CRPD. From a theoretical point of view, the Indian legislation addresses more of the WHO-RB's standards than Ireland or England and Wales (Duffy and Kelly, 2017). In an attempt to be concordant with the CRPD India has introduced the concept of supported admission in the place of involuntary admission (MHA, Sections 89 & 90), India has also put a strong emphasis on advance directives (MHA, Sections 5–13) and the role of nominated representatives (MHA, Sections 14–17). The RPDA has replaced the concept of *guardian*s and *managers* with *limited guardians* (RPDA, Section 14) and has legislated for social rights. These changes may appear to be only semantic but they are important; they empower individuals to exercise their existing capacity and places an obligation on mental health practitioners to build individuals capacity where they can.

The Indian Act is far from perfect and some may question if it is fully concordant with the CRPD. However, it is a significant attempt to develop human rights based legislation. India's ability to implement such an ambitious change remains to be seen, and in this venture human resource problems may be the limiting factor. One worrying difference is that the agent of coercion could shift from the psychiatrist, with professional standards and comprehensive training, to the nominated representative, who may have competing interests and a limited knowledge or experience in the area of mental health. Nominated representatives will need sufficient support from mental health professionals.

Ireland's hesitation to ratify the CRPD partly reflected a desire to ensure our legislation was concordant prior to ratification. However, political consideration overcame these legislative concerns. This more cautious approach may have been better than that of countries who have ratified it but demonstrated little dedication to modifying non-concordant elements of their legislation. The ratification of the CRPD needs to be

celebrated; it will bring many vital protections to individuals with disabilities and may provide the necessary impetus to revise the relevant legislation. If Ireland really wants mental health law that reflects 'adherence with international standards and incorporation of human rights-based principles' we will need a drastic revision of our mental health law, if not an entirely new Mental Health Act. If we are serious about such change, India's current endeavour deserves our attention. The similarity of our legislation to that of other countries should not assure us of its quality.

Conflicts of Interest

The author declares that no conflicts of interest.

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