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TITLE: Human rights in mental health.

YEAR: 2017

Book 7: Ethics in Mental Health-Substance Use

Chapter 14: Human rights in mental health

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Word Count: 5275

Chapter 14 – Human Rights in Mental Health

Article 1 of the Universal Declaration of Human Rights (UDHR) states:

'All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood'. (United Nations 1948, p.2).

Introduction

Human rights can be understood as entitlements inherent to all humans simply because they are born human and irrespective of race, creed, gender, ethnicity, nationality or any other subdivision of their humanity. Human rights are secured in law and include civil and political rights as well as economic and social rights (*See* table 14.1)

INSERT TABLE 14.1 HERE

Throughout human history there are documented examples of what we now understand as attempts to define and protect peoples' 'rights'. As far back as the first century AD the Roman Stoic philosopher Seneca delivered teachings on the importance of beneficence, connectedness and fellowship of human beings (Seneca 1968). Indeed, even further back in history in Ancient Greece whilst Plato and Aristotle mused about justice and the common good, the term 'cosmopolitan' meaning 'world citizen' was coined (Nascimento 2016). From these early works came the concept of natural rights which were considered the basic inalienable rights of all humans, bestowed by nature rather than by man-made laws. The

philosopher John Locke considered these rights to include life, liberty and estate (property) and these rights were prominent in discussions during the French and American Revolutions of the late 18th Century, eventually leading to the French Declaration of the Rights of Man and of the Citizen and the American Declaration of Independence (Donnelly 2013).

It is fair to say that, until recently, ethics and human rights have rarely been an important consideration in the field of mental health. During the French Revolution the psychiatrist Phillipe Pinel introduced the notion of treating patients with human dignity through 'moral therapy' which involved having staff interact with patients in as normal a way as possible and involving patients in discussions about their treatment (Pinel 1806). This was entirely at odds with common practice up to that point which had involved patients being held in iron shackles for their entire lives and displayed to members of the public for an admission fee, as people feared that mental disorder was a sign of demonic possession (Osborn 2009). Pinel's work led to a move towards the humanitarian treatment of individuals experiencing mental health problems both in his home country and overseas, including in the UK by the early 19th Century. Things had changed by the end of the 19th Century with people literally being dumped in asylums for spurious reasons and neglected and ill-treated for decades to come (Musto 1991).

The history of human rights as we understand them today however, is a relatively short one. In the wake of the atrocities committed during World War II and the creation of the United Nations, World leaders collaborated to develop the Universal Declaration of Human Rights – a guidance document designed to guarantee the rights of everyone, everywhere and thus protect against such atrocities occurring again (Donnelly 2013). This declaration is not a legally binding document in itself but has inspired in excess of 60 human rights instruments

addressing rights in relation to a variety of issues including war crimes, marriage, social welfare, health and many more (Office of the United Nations High Commissioner for Human Rights (OHCHR) 2016). These tools together set out a universal standard of human rights.

The application of human rights creates obligations through international law for States to respect, protect and fulfil human rights for all. This means they must not interfere with or remove human rights (respect), they must protect both individuals and groups from human rights abuses (protect) and they must be pro-active in enabling the enjoyment of human rights (fulfil). Whilst everyone is entitled to have their human rights respected, protected and fulfilled there is also a universal
obligation to ensure that our actions or inaction do not infringe the human rights of others.

Human rights are interdependent and interrelated i.e. if one right is fulfilled it aids the achievement of others and, conversely, if one right is denied it makes the fulfilment of others more challenging.

Mental Health Act

While mental health legislation differs across the UK each of the Acts is built around similar ethical principles. In Scotland the Millan Committee (2001) was commissioned by Parliament to make recommendations for a new Mental Health Act including consideration of an ethical underpinning for the compulsory treatment of people experiencing mental disorders. The committee developed a set of principles which they recommended mental health law should be based on. These are now known as the 'Millan Principles':

Millan Principles

1 Non-discrimination

2 Equality

3 Respect for diversity

4 Reciprocity

5 Informal care

6 Participation

7 Respect for carers

8 Least restrictive alternative

9 Benefit

10 Child welfare (Millan Committee 2001)

Human Rights Law

There are a number of core United Nations (UN) human rights treaties (or conventions) setting international standards for particular human rights issues such as the elimination of racial discrimination and the rights of persons with disabilities. Each member state is obliged to implement these standards within their own legal and policy processes. Some states simply integrate the conventions into their legal systems, however the UK does not do this as

standard. The UK has its own Human Rights legislation: In Scotland there is the Scotland Act (1998) and the Human Rights Act (1998) in the rest of the UK . These laws make the rights contained in the Convention for the Protection of Human Rights and Fundamental Freedoms (European Human Rights Convention) (1950) enforceable in law in the UK.

Reflective Practice Exercise 14.1

Time: 15 minutes

It has been said that nurses are caught between two moral imperatives:

1 To protect the individual from harm

2 To uphold the principle of self-choice

- Think about a time when you have found yourself in a situation like this… what does it feel like?
- Which imperative won out in the end?
- Does this mean that particular imperative carries more weight? Why?

Capacity and the law

Whilst each of the constituent countries of the UK has its own legislation in place around mental capacity they are all based on the principles of justice, autonomy, beneficence and non-maleficence. In Scotland the Adults with Incapacity (Scotland) Act 2000 provides a

system for protecting the welfare, finances and property of adults (age 16 and over) who lack capacity to make decisions for themselves due to mental disorder or an inability to communicate due to physical impairment.

The Act authorises other relevant and appropriate people to make decisions on behalf of people who are deemed to lack capacity. However, there are a number of safeguards in place that are intended to prevent abuse of these decision making powers. These protections include the prevention of certain decisions being made on the person's behalf such as giving consent to marriage or the drawing up of a will. Additionally, persons acting on behalf of someone who is deemed to lack capacity are prevented from having the person admitted to a mental health hospital against their will or consenting to certain medical treatments on their behalf.

One of the underpinning principles of the Act is that peoples' autonomy should be respected by allowing (and enabling) them to make any and all decisions for themselves that they are capable of making. This means that the person may not have the capacity to make certain decisions, whilst retaining the capacity to make others.

The Act requires that those who are making decisions on behalf of another person follow the following principles:

- Act in the benefit of the person

- Take the least restrictive option
- Consult with relevant others
- Encourage, in the person, the use of existing skills and development of new skills
- Act in fitting with the present and past wishes of the person

It is easy to see how these principles are grounded in the aforementioned underpinnings of beneficence, non-maleficence, autonomy and justice. It would be comforting to think that everyone acting on behalf of someone with impaired capacity would always follow these principles, however, this is not always the case. In order to protect the interests of people who lack capacity the Act tasks four public bodies with the supervision and regulation of the people who are authorised to make decisions for them: the Mental Welfare Commission for Scotland, the Office of the Public Guardian (Scotland), local authorities and the courts. These bodies variously offer support and advice, supervise financial decisions made on behalf of people with impaired capacity, investigate complaints and reduce or remove any decision making powers previously granted.

Living Wills

A Living Will is, as the name suggests, a statement of wishes during a person's life, rather than following their death. Known as advance directives in Scotland and advance decisions in the rest of the UK they allow a person to communicate their decision to refuse specified medical treatments in the future should they be unable to communicate their preference at that time, or lack the capacity to make such a decision. Again, this is autonomy in practice,

allowing people to refuse ahead of time any medical treatment, including treatment that is life-sustaining. Of course, advance directives are not valid while the person has capacity to make decisions and can communicate their wishes. In England and Wales advance decisions are legally binding, whilst in Scotland advance directives are not. If a medical decision were ever to be challenged in court however, it is highly unlikely a judge would rule against respecting the person's advance directive.

If a decision is taken or treatment given which conflicts with a person's advance directive this must be reported to a number of parties. The Mental Health (Care and Treatment) (Scotland) Act 2003 requires that the person (or tribunal) authorising or giving the treatment must make a written record of why the decision was taken, including the context and circumstances around the decision. This must be recorded in the person's medical notes and a copy sent to:

- The person who made the advance directive.
- The person's named person
- Any welfare guardian or welfare attorney of the person
- The Mental Welfare Commission

In addition to advance directives a person can set out their personal wishes in relation to treatment for a mental disorder in a personal statement. This is a written document which details the person's wishes for what they would like to happen and how they would like to be treated if, for instance they have to be admitted to hospital. A personal statement may include preferences relating to, for example, how the person wishes to be addressed, any dietary preferences, wishes regarding who should visit or have contact with the person.

Personal statements do not require to be witnessed by another person and can be attached to a person's advance directive but they do not carry the same weight in law.

While people are free to refuse medical treatment there is no legal provision for requesting or demanding a particular treatment, though people are entitled to have the reasons for not providing a particular treatment to them or request a second opinion.

Reflective Practice Exercise 14.2

Time: 20 minutes

- Should people have the right to demand particular medical treatments?
- What would this mean for the health professions?

Mental Health Tribunals

Mental Health Tribunals (MHTs) are independent judicial organizations that deal with one of the fundamental human rights: the right to liberty. These tribunals are tasked with making certain decisions about the compulsory care and treatment of people experiencing mental disorder. The Mental Health Tribunal for Scotland was established by the Mental Health (Care and Treatment) (Scotland Act, 2003) and similarly the tribunals in England, Northern Ireland and Wales were set up by their respective pieces of mental health legislation. These tribunals serve very similar functions and the focus here is on the Mental Health Tribunal for Scotland. The tribunal aims to provide an independent and impartial service for those who

are subject to the 2003 Act (and for those who have had an application made to subject them to the Act). The tribunal is overseen by a President and each tribunal panel must consist of three members: one legal (a lawyer), one medical (a psychiatrist) and one general (a layperson with some mental health experience – this is sometimes a person experiencing mental health problems, or a carer).

What does the tribunal do?

The tribunal's main tasks are to make decisions on applications for compulsory treatment orders (CTOs) and to consider and adjudicate on appeals made against CTOs imposed under the 2003 Act. The tribunal plays an important role in reviewing existing CTOs and deciding whether these should continue or be discharged if no longer required.

The person whose situation is being considered by the tribunal is invited to attend and can bring a supporting person with them. The person themselves, as well as anyone else who has an interest that the tribunal thinks should be allowed to speak will be allowed to do so.

Conflict

Whilst on an individual basis, and from an objective point of view, we can look at human rights and agree what appears to concord with our professional ethical framework. It is when rights come into conflict that we swim into muddy waters. Ethics is not science, and when two rights come into conflict, there must be a detailed discussion between professionals as to which should become the clinical priority.

‘Man is born free, and everywhere he is in chains’. (Rousseau, 1913)

The UDHR refers to human rights as inalienable, meaning that they cannot be removed, however there is a caveat to this… they can be removed in certain situations as provided for by part 2 of Article 29:

‘In the exercise of his rights and freedoms, everyone shall be subject only to such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society’ (UDHR 1948).

It is here that subjectivity plays an important role and this can lead to discord and frustration.

Particularly challenging in mental health care, with reference to the use of detentions under the mental health act, is the conflict between any perceived clinical need for intervention, versus a person’s right to liberty. The mental health act, whilst differing in terminology across the British Isles, has the consistent aim of protecting the rights of people experiencing mental health issues. However, this protection extends to granting professionals legally sanctioned powers to remove liberty, administer medication (knowingly and covertly) and contain risk through detention within hospital settings. These measures are taken if there is a justification based on risk, and a person’s perceived lack of capacity as a result of their mental health. However, these actions can be taken in the name of risk not only if a person

cannot consent to treatment, but also if they *will not* consent (Richardson 2002). This is entirely at odds with the treatment of people who are physically ill and refuse treatment, for instance Jehovah's Witnesses who refuse blood products despite the fact that this may present serious risk to them. Those working in the field can often find themselves in a difficult situation where under-estimation of risk may lead to disastrous consequences and potential trial by media, an over-estimation of risk jeopardizes both therapeutic relationships and the professional's position of providing beneficent care. Certainly, to the person involved whilst professional intentions may be pure and beneficent, intervention may not always feel like protection and instead may be perceived as paternalistic, maleficent and bereft of justice.

Removing Autonomy and its Justification

A useful question to ask is; 'just what is being protected by a person's detention?' Whilst clinical reasoning would perhaps cite a risk to self and a risk to others (with risk covering multiple physical, environmental and psychosocial factors), if there is no obstacle to any persons right to life, through no risk of harm to themselves or the general public, can detention ever be justified? This echoes the sentiment of Thomas Szasz (2010), who argued that any person who was not in breach of criminal law should be left in peace, with any coercion deemed a breach of that person's human rights. This idea would allow a person to be 'pleasantly mad', being mentally ill as per our working definitions, yet living their own life in their own way. It could be argued that intervention and coercion with this person is an attempt to correct social deviance, with a societal pressure to make people 'more like us' and closer to our social norms and expected patterns of behaviour (*See* Case Study 14.1).

Interpretations of Risk and Social Norms

It is here we perhaps see an interpretation of risk which presupposes that mental health which differs from social norms harms a person's social dignity. Foreseeable Risk as a concept aims to…

… 'anticipate the likelihood of injury or damage associated with a given set of circumstances' (Fisher and Scott 2013, p.21).

This perceived injury or damage appears in an all-encompassing array of categories that extend to risk which is; material or psychological, immediate or delayed, arising from our own actions or that of others, and resulting in us paying a price in many different ways (Fischhoff and Kadvany 2011). With the concept of risk allowing such subjectivity of interpretation, it is vague enough to accommodate a risk to social dignity which could justify professional intervention. Ethics, like all philosophy, often sees an infinite wall of questions surrounding an answer. To further our discussion, two rhetorical bricks in this wall would be; what is the level of good mental health necessary for sufficient social dignity, and who decides on its definition?

If good mental health is linked to social norms, we should reflect on our not too distant (and it could be argued shameful) past, where homosexuality was classified as a mental illness (Bayer 1981). Using this example to highlight the obvious; social norms change. Therefore, mental health could be bound to the culture and time in which it presents. In this way mental health can be viewed as a wholly social construct, in which deviance (illness) is contained and corrected (treated), with the societal need being expressed as clinical need. The use of

coercion to correct difference could be viewed as a ‘militant goodness’ to give people the social dignity of a life **we think** is worth living, whilst any attempt to define a true and objective ‘life worth living’ has been described as absurd (Glover 1990).

Moving on, we can explore the experience of the person meeting current criteria of mental illhealth, and ask whether or not they are in distress. Beyond the idea of risk to self and others, and whether or not risk also includes a social dignity, exploring the person’s level of distress could see any intervention based on compassion. More questions arise when we examine whether the person expresses this distress, or whether it is subjectively inferred through the assessment of professionals (Szasz 1997). Again there is dispute about whether the priorities are based on the individual experiencing the mental health issue or the expectation that anyone outside social norms must be distressed and ‘corrected’ for their own good.

A Human Right to Good Mental Health?

Mental ill health…

‘…comprise a broad range of problems, with different symptoms. However, they are generally characterized by some combination of abnormal thoughts, emotions, behaviour and relationships with others’ World Health Organisation (WHO) (2016).

However, consider a person with ‘abnormal’ thoughts, emotions and behaviours, who presents no risk to themselves or the public, and who does not voice any psychological distress (*see* Case Study 14.1). The Human Rights Act (1998) cites a right to freedom of thought, conscience and religion, with a right to freedom of expression. Could freedom of thought extend to include a right to unusual (being out-with social norms) ideas, and could freedom of expression extend to the expression of these ideas in an unusual way? These human rights are in tension with the right to liberty, when there is a perceived professional need to intervene. Have we subconsciously created a new and unwritten human right, that of a right to a standard of good mental health, and has meeting this standard become a perceived clinical need? If so, there must be an acute awareness that the social expectations of others which form our ethical, legal and professional frameworks are only objective within their own context and subjective across time and culture.

Conflicts in the Mental Health Tribunal Process

Vitally the human right to liberty and autonomy, if removed by mental health legislative frameworks, allows an appeals process through that of a mental health tribunal. Here the person experiencing a mental health issue has their right to autonomy weighed up against the clinical need for coercive intervention. Tribunals open up individual cases to a more detailed scrutiny, examining the subjective view of mental health professionals, ensuring justice on behalf of the person involved. Nonetheless, this process is not bereft of moral tension, as there may be instances which involve more than the individual, and that of carers and families. Whilst we previously discussed the concept of the ‘pleasantly mad’ person, if there are families involved this becomes more complex.

It could be argued from a utilitarian and consequentialist standpoint that to ensure the greatest happiness for the greatest number of people, families need to be taken into account. If the mental health condition of the person has an inevitable spill into the lives of the ones closest to them, the person may not meet the criteria for continued detention, but may return to a family environment, where the 'mad' is experienced as anything but pleasant. Here we could see justice through a person's autonomy being returned, while what may seem the beneficent act of returning an individual's freedom indirectly breaches the concept on non-maleficence through the impact to family. Whilst the tribunal aids the human rights of the person experiencing the mental health condition, there may be unseen consequences.

The mental health professional, whilst championing the concept of care which is beneficent, often does so through a deontological and Kantian concept of duty (Kant 2005). This is where morality is neither rooted in intention nor consequence, but a strict duty to do what is right. One difficulty the professional may face would be to see a person with a mental illness walk away from treatment, feeling they have a duty to intervene, with a tribunal overriding this duty with a respect for autonomy and justice. Reflecting on the loose definition of risk, the failure to act in the moment may result in the delayed risk of a condition worsening, and more challenging circumstances for the person experiencing the condition, and more difficulty for the professionals in providing effective treatment.

Moral Triage: Intentions, duties and consequences

Much of our moral sensibilities can be captured through the triage of intentions, duties and consequences, and reflecting on these can be useful when examining any tension. Mental

health professionals it would be hoped would carry an innate virtue, being a caring profession, and their intentions to fulfil care which respects principles of beneficence, non-maleficence, justice and autonomy should be expected. However, when it comes to duties and consequences, the clarity ends. As regards duties, we may ask whether or not these duties are to the profession e.g. nursing, medicine etc, whether they are to the person receiving treatment, or whether they can extend to others beyond this. Certainly with a view to containing risk, there is often a duty to protect the person, and protect others. Nevertheless, how risk is defined is sufficiently vague to allow a variety of consequences and it is here that the confusion reaches its peak. How can professionals potentially predict consequences sufficiently to inform care?

Case Study 14.1

Mrs O was detained in an acute mental health ward under the mental health act on a short term detention. She had made contact with several health boards over a three-year period, travelling frequently and presenting as eccentric with unusual beliefs regarding snakes in the water pipes. She did not voice any internal distress, had never been in breach of clinical law, and was not deemed a risk to herself or others.

In her time on the ward she was entirely pleasant in manner, yet clearly meeting professional criteria of a psychotic episode without insight. The pleasantry of her manner was pushed however by the coercion involved in her hospital stay. She was pleasant in all interactions, besides the conversations with professionals regarding their perceived clinical need for her to receive treatment for a mental health condition.

Mrs O challenged her detention, and after a mental health tribunal ruled in her favour, she was allowed to leave the ward.

Self-Assessment Exercise 14.1

Time: 30 minutes

Consider the following questions:

a What was the clinical need for Mrs O's detention?

b What, if any, risks do you think were perceived by the professionals involved in Mrs O's care.

c Would you agree with the mental health tribunals decision? Why?

d Which moral principles were involved in the decision making process?

Reflective Practice Exercise 14.3

Time: 15 minutes

People receiving methadone maintenance treatment for opioid dependence are often asked to attend pharmacies only during limited hours or to enter via a separate door to the general public. Is this a breach or protection of their human rights? Do these practices protect their right to privacy or breach their right to be treated equally?

Review Questions 14.1 – Answers on pp. xxxx

1 The guidance document ‘The Universal Declaration of Human Rights’ was designed to protect the rights of:

a Everyone everywhere

b Everyone everywhere, except prisoners

c People who are subject to mental health legislation

d Victims of war crimes

2 The Adults with Incapacity (Scotland) Act 2000 is not based on which of the following principles:

a Act in the benefit of the person

b Take the least restrictive option

c Consult with relevant others

d Control financial decisions

3 Which of the following statements is true in the UK:

a People have a legal right to request specific medical treatments

b Personal statements are legally binding

c Advance statements are legally binding in Scotland but not in England and Wales

d Advance statements are legally binding in England and Wales but not in Scotland

4 The main tasks of a Mental Health Tribunal include which of the following:

a Making decisions on applications for compulsory treatment orders (CTOs)

b Deciding the appropriate medication to be given to a person subject to a CTO

c Considering and adjudicating on appeals made against CTOs imposed under mental health legislation

d Considering and adjudicating on conflicts between treatment and wishes set out in personal statements

References

Adults with Incapacity (Scotland) Act 2000. a.s.p 4. www.legislation.gov.uk/asp/2000/4/contents

Bayer, R., 1981. *Homosexuality and American psychiatry: The politics of diagnosis*. New York, NY: Basic Books.

Convention for the Protection of Human Rights and Fundamental Freedoms (European Human Rights Convention) (Rome, 4 November 1950; T.S. 71(1953)); Cmd. 8969. www.echr.coe.int/Documents/Convention_ENG.pdf

Donnelly, J., 2013. Universal Human Rights in Theory and Practice. 3rd ed. Ithaca, NY: Cornell University Press.

Fischhoff, B. and J Kadvany. 2011. *Risk: A Very Short Introduction*. Oxford: Oxford University Press.

Fisher, M and M Scott. 2013. *Patient Safety and Managing Risk in Nursing*. London: Sage.

Glover, J. 1990. *Causing Death and Saving Lives*. London: Penguin.

Human Rights Act 1998. c. 42. www.legislation.gov.uk/ukpga/1998/42/contents

Kant, I. 2005. *The Moral Law: Groundwork of the metaphysics of morals, Translated and analysed by H.J Paton*. London: Routledge.

Mental Health (Care and Treatment) (Scotland) Act 2003. a.s.p 13. www.legislation.gov.uk/asp/2003/13/contents

Millan Committee. 2001. *New Directions: Report on the Review of the Mental Health (Scotland) Act 1984*. (Chairman: Rt. Hon Bruce Millan). Edinburgh: Scottish Executive.

Musto, D. 1991. A historical perspective. Edited by S Bloch and Chodoff. *Psychiatric ethics* (2nd edn). Oxford: Oxford University Press.

Nascimento, A. 2016. Human Rights and the Paradigms of Cosmopolitanism: From Rights to Humanity. Edited by M. Lutz-Bachmann and A. Nascimento. *Human Rights, Human Dignity, and Cosmopolitan Ideals. Essays on Critical Theory and Human Rights*. New York, NY: Routledge.

Office of The United Nations High Commissioner for Human Rights (OHCHR), 2016. Universal Human Rights Instruments. [online]. Geneva: United Nations. www.ohchr.org/EN/ProfessionalInterest/Pages/UniversalHumanRightsInstruments.aspx

Osborn, LA. 2009. "From Beauty to Despair: The Rise and Fall of the American State Mental Hospital". *Psychiatric Quarterly*, 80: 219-231.

Pinel P. 1806. *A treatise on insanity, in which are contained the principles of a new and more practical nosology of maniacal disorders than has yet been offered to the public. Translated from the French by D.D. Davis*. London: W. Todd.

Richardson G. 2002. "Autonomy, guardianship and mental disorder: one problem, two solutions". *The Modern Law Review*, 65: 702–722.

Rousseau, J-J. 1913. *Social Contract and Discourses. Translated with introduction by G.D.H. Cole*. New York: E.P. Dutton & Co.

Scotland Act 1998. c. 46. www.legislation.gov.uk/ukpga/1998/46/contents

Seneca, LA. 1968. *The Stoic Philosophy of Seneca: Essays and Letters. Translated and with an introduction by M. Hadas.* New York: WW Norton.

Szasz, TS. 1997. *Insanity: The Idea and its Consequences*. New York: Syracuse University Press.

Szasz, TS. 2010. *The Myth of Mental illness*. Revisited paper presented at the Annual Conference of the Royal College of Psychiatrists, Edinburgh.

United Nations, 1948. *Universal Declaration of Human Rights*. New York, NY: United Nations.

World Health Organisation. 2016. *Health Topics: Mental Disorders*. [online]. Geneva: World Health Organisation. www.who.int/topics/mental_disorders/en/

To Learn More

Mental Welfare Commission for Scotland, 2011. *The Right to Treat*. Edinburgh: Mental Welfare Commission for Scotland.

Mental Welfare Commission for Scotland, 2013. *Good Practice Guide: Deprivation of Liberty*. Edinburgh: Mental Welfare Commission for Scotland.

Mental Welfare Commission Scotland: http://www.mwcscot.org.uk

Principles into Practice: www.principlesintopractice.net

Mental Health Tribunal for Scotland: www.mhtscotland.gov.uk

Answers to Review Questions 14.1 pp. xxxx

1 The guidance document ‘The Universal Declaration of Human Rights’ was designed to protect the rights of:

a Everyone everywhere

2 The Adults with Incapacity (Scotland) Act 2000 is not based on which of the following principles:

d Control financial decisions

3 Which of the following statements is true in the UK:

d Advance statements are legally binding in England and Wales but not in Scotland

4 The main tasks of a Mental Health Tribunal include which of the following:

a Making decisions on applications for compulsory treatment orders (CTOs)

c Considering and adjudicating on appeals made against CTOs imposed under mental health legislation

Table 14.1 Examples of Civil, Political, Economic and Social Rights

Examples of Civil and Political Rights	Examples of Economic and Social Rights
Right to freedom of assembly	Right to adequate food, housing, water & sanitation
Right to freedom of expression	Right to an adequate standard of living
Right to freedom of religion or conscience	Right to education
Right to privacy	Right to health
Right to property	Right to science and culture
Right to vote	Right to work & fair working conditions