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What is the future of Human Rights? A Discussion on Assisted Suicide and Mental Health

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Abstract

The present paper argues that human rights are a wonderful way to understand and to introduce the debate on assisted suicide that our contemporary society needs. People with mental illness are a very vulnerable group in society and we need to do all we can to better protect their rights as they face a lot of stigma and discrimination due to their mental condition. This thesis will first present the main arguments that constitute the existing literature on how assisted suicide contributes to the protection of the human rights of people with mental illness. Secondly, it will demonstrate the practical applicability of the stated arguments through three comparisons of different cases, meant to reinforce the strong points of the debate. Assisted suicide is a strong pain relief and a mechanism that enforces people's human rights through autonomy and self-determination, and it should be an available option for people suffering from a mental condition.

List of Acronyms

AS – Assisted Suicide

CAT – Convention Against Torture

CLR – Centre for Legal Resources

CPT - European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment

CRPD – Convention on the Rights of Persons with Disabilities

EAS – Euthanasia or Physician-Assisted Suicide

ECHR – European Convention of Human Rights

ECtHR – European Court of Human Rights

EU – European Union

NGO – Non-governmental Organization

PAD – Physician-Assisted Death

UK – The United Kingdom

US – The United States

WHO – World Health Organization

Chapter 1: Introduction

‘Hi, my name is Elisa. I am calling you from the mental health hospital I am living in.’
‘Hi, Elisa. How can we help you?’
‘I was diagnosed with a severe form of schizophrenia and these voices are haunting me for more than 5 years, some of them are with me since I was very little, but the ones that added over the years are bad, very bad...’
‘I’m sorry to hear that. Elisa, are you in a safe place at the moment?’
‘Yes, I am alright but the voices will tell me to harm myself very soon, I am completely alone in this world, I have nobody to talk to and I really want to end it all!’
‘Elisa, what do you mean by that?’
‘I know you can help me end my life, because alone I cannot do it, I am too scared.’
‘Someone recommended our association?’
‘Yes, as I keep trying to take my own life every couple of weeks, my physician gave me your number, here it is against the law to obtain the lethal substance, please help me!’
‘Elisa, we are here for you, can you give us more details about your condition?’
‘I really need your help, I cannot wait anymore as I had enough, I want all this to end!’
‘Elisa, in which country are you located?’

No answer.

‘Hello, Elisa! Are you still there?’

Silence...the connection is lost.

The next morning the association was called as there was no need for their help anymore because Elisa hanged herself the previous night.

In 2016, approximately 800 000 people died by suicide (World Health Organization, 2018, p.7) The World Health Organization (WHO) also concluded that one in every four people, or 25% of the entire population, both from developed and developing countries, has a mental or behavioural disorder at some stage in their life (WHO, 2001). This shows us that mental illness is no longer an alien condition to us and we should fight the segregation and stigma that comes with it. People with mental health issues receive the same access to treatment as other people in society, but they are perceived differently as communities prefer their segregation more than their integration most of the time. Moreover, in most countries that have not abolished forced detention for this group of people, forced treatment and the lack of consent they receive, allows States to normalize certain abnormal behaviours. This further leads to human rights violations and abuses towards people with mental illnesses. The existing law is constructed to protect this vulnerable group, but at the same time, it makes them experience discriminatory measures (Roig and Angels, 2012). This is the reason why we need to focus on how the attitudes towards this vulnerable group in society can change by tackling the gaps in international law and using States' positive obligations in order to create a more inclusive and equal society for people with mental illness and become more open in understanding mental health.

Mental health is a precisely debated topic in connection with human rights, because it involves the power of States to decide if a person is capable of consenting to a decision about his own health, body, or legal situation. Human Rights apply to people with mental problems because they involve many personal fundamental rights. The Convention on the Rights of Persons with Disabilities (CRPD) that was adopted in 2008 is one of the most powerful guardians of people with mental disabilities. After its adoption, administrating involuntary medical procedures on persons with mental disorders that can lead to their moral or physical suffering can be considered torture or cruel, inhuman or degrading treatment or punishment. But currently, the jurisprudence of the CRPD and the Committee against Torture do not condemn any denial of legal capacity based on mental disorder. In some situations, the Committee against Torture questioned the involuntary treatment of patients with a mental disorder. In others, it had neither directly acknowledged the permissibility in a mental capacity, nor denied it. This proves that involuntary psychiatric treatment is still considered legitimate by the Committee (Litins'ka, 2018, pp.115–116). This underlines that the international legislation that is responsible for the protection of people with mental illness is not yet enough developed and enough inclusive and we have to further work on developing it through a closer analysis on the European Convention of Human Rights (ECHR) and the cases affiliated to it.

The aim of this thesis is to prove that we should pay more attention to suicide and human rights mechanisms are the only ones that can help us develop and protect the rights of people with mental illness. Assisted suicide can offer pain relief and can give people the accomplishment of their last wish of dying in dignity. This process also serves in making

states more responsible to make sure that people have the right to informed consent on their medical treatment as what happens to their deaths should not be an arbitrary decision. The following thesis is structured in two important parts. The first four chapters represent a sum of the existing literature on the mental health and the most pressing issues regarding the protection of the vulnerable people in this category. Then, the review continues by expressing the differences between the positive and the negative obligations of states as these obligations can be used in arguing for the decriminalization of assisted suicide. The next debated issue is the connection between mental health and assisted suicide and about how not only patients that consent to treatment should have access to euthanasia, but also patients that lack the capacity to consent to their treatment as euthanasia can be their only way of easing their long pain. The literature part ends with the right to health and its importance for the protection of mentally ill patients. The following part presents three different case analysis which are meant to underline the most important arguments in favour of assisted suicide. The first comparison shows how suicide is perceived with the help of human rights. The second comparison of cases emphasises the way the European Convention on Human Rights serves in identifying ways to give autonomy to the mentally ill in establishing their end of life. The last chapter of this paper shows how not only people from community need suicide awareness, but also those people institutionalized in a State's institution. Lastly, the thesis ends with an explanation of the methodology used and of the limitations encountered during the research and with an overall conclusion.

Chapter 2: Mental Health and Human Rights

Mental Health

One of the most current and concerning issues is the mental health of all members of society. And in order to achieve a true and real change in how mental illness is perceived, there is need for both litigation and political change to work hand in hand (Bartlett et al., 2007,p.28). This is why this chapter will focus on how mental health is perceived and what human rights can be associated with the protection of this vulnerable group in contemporary society.

The international concern towards mental health is not a new one. Since the 1991 when the United Nations (UN) adopted the *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*, there has been permanent research and advocacy on the human rights of people with mental illness. Moreover, the UN Convention on the Rights of Persons with Disabilities passed in 2006, showing how there was a worldwide interest in protecting the rights of the most vulnerable of our society. Such initiatives invoke the importance of human rights principles in order to prohibit the unlawful deprivation of liberty and the cruel, inhumane or degrading treatment to which more often than not, people with mental disabilities are exposed to. As observed in recent years, the existence of numerous human rights documents was not enough to decrease the human rights violations. Despite many decades of international efforts, many countries of the world still apply a public policy of maltreatment and negligence towards those with mental illness (Read et al., 2009, p.2-3). But for a more concise and focused research, we will discuss, most of the times, the human rights abuses of people experiencing mental health problems in Europe.

Understanding the current mental health problems and how to communicate them from a legal and political perspective, can help us shape future laws and public policies in order to protect those in need. Here we are not describing disability as a problem of an individual, but more as ‘a problem of social responses to the individual’ (Bartlett, 2017, p.130). While this paper touches thoroughly topics such as social integration, stigma and economic, political and cultural integration in community, it stays far from a technical, medical, evaluation. Understanding the current mental health debate, not only shows us the ways towards non-discrimination and the obligation to provide a complete social interaction, for vulnerable groups such as people with mental illnesses, but it also helps us acknowledge the way we socially deprive those that need our care and kindness the most. In the UK, for instance, the employment statistics shows that between 86-90% of people with mental disorders who are unemployed, would like to work. But instead, the system holds them captive in a vicious circle of compulsory treatment, detention and stigma (Bartlett, 2017. p.133). The key to a more inclusive international public policy for people with mental disabilities is the understanding of which regulations and legislations affect this

vulnerable group the most, and how their protection can increase through the reinforcement of the protection of their human rights.

In order to emphasize the fact that people with mental disorders are vulnerable in many ways, we need to analyze the notion of the informed consent and its importance. Most medical ethical policies worldwide require informed consent from patients prior to any intervention. The emphasis of informed consent developed during the second half of the 20th century and international codes, such as the Declaration of Helsinki, reveal the most important considerations needed to establish if a person is legally, mentally or physically incapable of giving consent. When a person lacks the capacity to give his or her consent, a family member or a legally authorized person takes the decision on their behalf (Amer, 2013). But the real problem appears when the family member or the legal tutor is the one violating the human rights of the person with mental issues placed in their care. If a woman with dementia is living in the UK in a care home, and her husband initiates a sexual act that is agreed and enjoyed by both partners. However, the woman has no real understanding of the sexual nature of the husband's behaviour. Therefore, a person without real capacity to consent cannot do so, and if the perpetrator is aware of this situation, than she or he will be guilty of one of the violations covered by the Sexual Offences Act 2003 present in the UK's national legislation (Bartlett, 2010). This is how assimilating the notion of informed consent in more depth, can guide us further, towards concrete answers of how and why violations of the human rights of people with mental disabilities take place and how can they be prevented.

Therefore, mental health is a current and concerning issue in society and this chapter will focus on how we can understand mental health vulnerabilities in order to shape future public policy into a more inclusive one that protects those with mental illnesses. Looking at the case of the women diagnosed with dementia from the UK, we were able to understand how informed consent can be used in order to analyze a sexual offence. This leads us to the second part of this chapter, which will underline the human rights that are the most important for the protection of people with mental health issues.

Contemporary struggles with Mental Illness

Many people with mental disorders are neglected or abused in public mental hospitals as well as in private institutions, community facilities or in their own house. The main aim would be the deinstitutionalization of vulnerable people with mental illnesses, while at the same time, developing sustainable alternatives in community to support both the families and the patients themselves. Until this aim will become a reality, we need to focus on making sure that people with mental disabilities would not be deprived of their liberty and of their social and active life, and will not suffer for further stigma and discrimination in society (Maj, 2011). To be able to become more inclusive towards mentally ill, we need first to understand the current debates on mental health and human rights. This paper explains four of the most pressing issues:

The first current problem is the depravation of liberty for people with mental health issues that in some situations leads to inhumane treatment. Dainius Puras, the current special rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, expressed in 2018, that current places in which people are held in custody, are not an effective environment for psycho-social healing or for creating positive therapeutic relationships. People with serious mental health issues face overcrowding, involuntary treatment and use of force in some cases as a form of punishment or discipline that constitutes torture and ill-treatment (OHCHR, 2018). The consequences of this situation creates a lot of crisis for people suffering and in need of mental health treatment that are detained, this can further lead to a growing suicide rate in detention facilities. When we talk about detention, we refer to mental health facilities, hospitals or prison areas especially designed for mental health treatment. Another important connection between depravation of liberty for the mentally ill and recurrent suicide cases is society is their concerning high number. Studies place between 55% and 81% detentions being linked to the risk of the detained person to be a danger to their own self rather than a danger to harming someone else. And if we look more in depth, there were 6507 deaths by suicide in the UK in 2018. Suicide remains one of the greatest causes of death globally (Warrington, 2019).

Secondly, there is an increasing institutional corruption that harms the mental health policies and services. The lack of transparency in the relationship between the pharmaceutical industry and academic medicine leads to the development of questionable diagnostics. For instance, the Special Rapporteur observed in 2017 that pharmaceutical companies have a fixed interest in finding a new disorder for their drugs when a licence expires, as in this way the drug manufacturer obtains another three years of exclusivity for their drug. Thus pharmaceutical companies used their products' exclusivity as an unofficial mechanism to extend patient protection. This leads to one of the most severe consequences of institutional corruption, the medication of human diversity which increases the number of patients labelled with mental illness. And as WHO stated, around the world, more than 300 million people of all ages suffer from depression as depression is the leading cause of disability globally (United Nations, 2017, pp.18–19). Moreover, increased corruption is associated with numerous mental health problems of the population. The influence of corruption can be noticed more in high-income countries than in low-income ones (Hutchinson et al., 2013). This can only lead us towards realizing how important is to tackle corruption worldwide in order to first, prioritize the human rights of people with mental illness over the interests of pharmaceutical industries, and then, slowly stoop the factors that lead to future mental health problems in society.

Another pressing issue is the global neglect of mental health care and the inappropriate models of care that persist in many countries which still provide stigmatizing and human right-unfriendly services. There is need for a right-based mental health agenda that would make countries to closely work with private organizations in order to collectively respond to the global challenges in mental health. Having their voices heard is a potential cure for the inequality and

stigma that mentally ill face in society. This is why states need to collaborate and take measures towards respecting the right to health. At the moment, states participate actively in the global failure to address human rights violations in mental health-care systems (United Nations, 2020). One of these violations is the failure to address the issue of suicide prevention. Many states adopt regularly national suicide prevention plans, but their effectiveness is rarely discussed. Suicide prevention is possible according to a study conducted in 2005 that measured how up to 83% of suicides have met a primary care physician within a year of their death and up to 66% within a month. States need to prepare their primary care physicians to better recognise when a patient is at risk of committing suicide and national strategies need to include an advanced plan of major depression treatment (Mann et al., 2005, p.2065).

Finally there is a pressing need to discuss more autonomous options such as assisted suicide for people with mental illness. In all matters of society, we assume that a person is already responsible and autonomous in the decisions she takes, unless she is mentally ill. This autonomy is guaranteed by itself as an individual is accountable for his behaviour. But, when we discuss about clinical decisions, the situation slightly changes as in the case of people with mental illness, the decisions are a lot based on the participation and review of carers and medical professionals involved (Randall and Downie, 1999, p.3). Autonomy in decision making regarding medical treatment is essential for the future of the human rights of people with mental illness. Many physicians agree with having an option for euthanasia for people with mental illness that can consent to their medical treatment. Many more consider euthanasia problematic in serious psychiatric cases such as advanced dementia where patients lack the capacity to consent to their treatment. The biggest issues are: the criteria concerning unbearable suffering without possibility of relief, and the voluntariness of the request for assisted suicide. Euthanasia should not be viewed as a substitute for good care, rather as an option that respect the patient's self-determination (Lavoie et al., 2015, p.3).

To conclude, the present chapter aimed at explaining the most pressing issues that are currently under debate regarding mental health and human rights. The first problem identified was the depravation of liberty for people with mental illness which in some of the cases, leads to torture and degrading treatment. The second perspective mentioned was the increasing institutional corruption that harms the mental health polices producing abuses. Then the issue of a global neglect in mental health care, that leaves room for many countries to stigmatize and violate the human rights of mentally ill patients, was discussed. The last fact mentioned, and the most important one, was the crucial need to discuss more about autonomy in decision making as a way towards respecting the option of assisted suicide at mental health patients.

Chapter 3: Positive vs. Negative Obligations of States

The second chapter described in detail the current and most pressing issues that people with mental illness experience regarding their human rights. Further, the third chapter will explain how their protection can be assured based on the positive obligation of states. First we need to define the obligations of states under the jurisprudence of the European Court of Human Rights. The Court established two types of obligations for each state that signed the ECHR – negative obligations, and positive obligations. The negative obligations require states not to interfere in the exercise of rights guaranteed by the Convention. The positive obligations, suggest an active attitude from the states in order to protect the human rights of the present ECHR (Lazar, 2015, p.132). The present chapter will first prove why positive obligations of states are an important starting point in understanding the active protection of human rights when it comes to people with mental illness. It will also be explained how positive obligations of states open the flow for different sub-rights, how they are not specifically explained in national constitutions or in European conventions and how political and religious interests should not interfere with the positive obligations of States to protect the mentally ill. This chapter will also explain how negative obligations of states serve this debate by: understanding the non-interference with people's human rights and power of self-determination, providing alternatives to life-long medical treatments, and to not interfere with the progress in medical ethics.

Positive Obligations of States

Firstly, the main purpose of positive obligations is to secure the perspective of the active protection of human rights in various circumstances. In the case of defending the mentally ill, this purpose is essential in establishing if a state's failure could be seen as an omission or as having a legitimate aim of interference (Xenos, 2012, pp.89–90). This helps the Court decide if the negligence of a State in a case involving a person suffering from a mental health condition was legitimate or was a result of a too wide and unjustified margin of appreciation. Therefore, we can consider a positive obligation of a State to take those measures necessary to leave room in its legislation for a dignified suicide. This does not omit the fact that the same State is entitles to a certain margin of appreciation which differs according to the nature of the problems and the interests at stake, these being lawful, medical or cultural. The positive obligation of a State to adopt measures facilitating dignified suicide is of great significance to individuals desiring suicide assistance in jurisdictions where assisted death is unlawful. This is because in impermissible regime is harder to demonstrate that the restrictions imposed are proportionate to the legitimate aim pursued so it is harder for these states to find a balance between the positive obligations to protect the life of the weak and vulnerable and the permission to a dignified suicide (Black, 2012, pp.162–166).

Secondly, positive obligations create space for multiple sub-rights that derive from the Human Rights Convention. These are mainly categorized as physical or ethical rights out of which personal autonomy is of great importance. This is how the right to physical and moral integrity can be applied in cases about both abortion and assisted suicide (Burbergs, 2013, p.326). Positive obligations give states the possibility to find ways to adapt to the rising issues of a permanently developing society and to the right holders, the practical enjoyment of their human rights and not just promises written on paper. Another way to put it is by comparing positive obligations to positive duties of states. For instance, many socio-economic rights generate duties which can sometimes overlap with the civil and political rights. The right to housing restricts a State to make unlawful evictions which covers the civil and political rights for privacy, home and family life. Another example would be the right to equality which is a civil and political right calling for the State to refrain from discriminating. However, it can easily become a positive duty of the State to promote equality (Fredman FBA, 2008, p.68). By the same structure, we can now see how a negative obligation of a State not to interfere with the dignified life of a person can be seen also as a positive obligation to make sure the same person has the possibility and access to this dignified life. And if this is not possible and the person in question desires a harmless and painless suicide, the State should be able to provide it.

Thirdly, positive obligations are not yet defined in European Conventions or in the majority of national legislations, and we need to aim for a specific way in which these can be exercised by the states without affecting their autonomy. To make sure the positive obligations are met, a State first blocks the access to lethal drugs to all, and then re-opens access to those who request it and accomplish certain conditions. This task can be delegated to physicians and it becomes their positive duty to do what is necessary to enable a patient to exercise his or her rights (den Hartogh, 2017, p.669). Moreover, patients in liberal democracies have the right to suicide, including by refusal of eating and drinking. Giving the fact that they will be able to end their lives pursuing this kind of actions or any other similar or more violent ones, their interests would be better saved by medical aid in dying. Considering that medical aid in dying would result in an easier death for such a determined patient than him or her dying as a result of starvation and dehydration. This argument is relevant only in jurisdictions that have not decriminalized assisted suicide and that still have a powerful influence of organized religion in society and in political decision making processes (Savulescu and Schuklenk, 2017, p.170).

Lastly, States have the positive obligation to protect people with mental illness without any political or religious influences. Different surveys and studied showed that religion has an important part in the view society has upon assisted-suicide. In 1992 the Evangelical Lutheran Church Council adopted their official position against assisted-suicide as in their view, it allows the private killing of a person by another and this will inevitably cause abuses towards vulnerable groups in society such as the elderly. The Episcopal Church on the other hand, opposes physician-assisted suicide, as in their view, such acts might deny others the sense of meaning and purpose in life (Burdette et al., 2005, p.82). In Christianity, taking your own life is

a capital sin and only God can decide that (Quffa and Voinea, 2013, p.264). For instance, Romania is one of the countries which definitely rejects the practice of assisted suicide because of religion. The development of current medical science offers the possibility to keep a person in a vegetative state for a long period of time in case cerebral death does not occur. The present jurisprudence, even if medical reports indicate imminent death in the future, there is no possibility of considering passive euthanasia, until cerebral death occurs, because the penal code would target it as attentive murder. There is an increasing need to reconsider the legislation all over the European Union (EU) and take into consideration the permanent developments in medical techniques towards a greater respect for human rights and individual autonomy (Quffa and Voinea, 2013, p.265).

Negative Obligations of States

One meaning of the negative obligations of states is that they are not allowed to interfere with a person's human right. It is a negative obligation because it implied not taking any action against a particular right. In the case of those suffering from mental illness, the state's duty is not to interfere with their dignity when there is no possibility for them to live a dignified life anymore and they have the consciousness needed to take such decisions for themselves. If we refer to physicians as relievers of discomfort and promoters of health, assistance with suicide can be viewed as an obligation they have not to pursue the patients' pain. Most of the time, patients live with the permanent fear that when their suffering will become unbearable, they will be denied the means necessary to end their suffering, and they not only refuse to reach out for help, but they often end up taking their own life (Orentlicher, 1996, p.664). In the situation in which healthcare practitioners might claim that their moral integrity needs to be respected so they have the right not to perform or take part in activities requested by patients such as assisted-suicide, the health and protection of the patient in question deserves a more close attention. If a doctor refuses to relieve a mentally ill patient's pain due to personal cultural or religious beliefs, might violate the human rights of that patient and it is often in the state's hands to prevent and regulate that (Giubilini, 2014, p.163).

Another argument explaining the negative obligations of a State would be for this State not to interfere with a person's self-determination. The legalization of assisted death supports the dignity and reduces the unbearable suffering experienced by a patient. Self-determination also means that patients might have a different end-of-life wishes, their self knowledge should be respected as they best know their wishes and needs (Lamers and Williams, 2016, pp.1073–75). When self-determination is not taken enough into consideration, ways such as self-euthanasia and non-physician assisted suicide become a possibility for the mentally ill. These suicides are more well considered and carefully prepared and are expressed more openly towards others. Even if a physician can be involved in this process by for instance, offering care during the process of voluntary refusing food and fluid, it is totally different from assisted suicide. In this case, if we look at the Dutch Law, the physician is not responsible for administrating the means that can cause death. In the Netherlands, a study conducted in 2010 showed that between 0.4%

and 2.1% of all annual deaths happened through voluntary starvation and between 0.2% and 1.1% of all annual deaths happened through taking fatal medication. With a total of 4000 people that died through physician assisted suicide, in 2010 in the Netherlands, there is one conclusion we have to pay attention to: assisted suicide is a possibility, especially when a State such as the Netherlands respects the self-determination of its citizens (Hagens et al., 2014, p.2).

Furthermore, another negative obligation of the State is to provide people with mental illness with alternatives to their life medication treatment. After their disease is discovered, people suffering from a mental illness receive a certain medical treatment in order to become functional in society, and if they decide to die, this can also be a consequence of their long and painful medical treatment. The mentally ill, from a moral point of view, are more entitled to the option of assisted suicide, if they so whish, than patients suffering from a mental condition spontaneously (Rivera-López, 2017, p.405). There is unavoidable serious harm associated with the medical sphere, because the moral questions are more demanding. Because of their serious involvement in the life of their patients, that could bring harm as well as relief, doctors have to consider all maters in forming their judgment. In extreme cases of assisted suicides, even if the patient wants to die, the doctor is the one making the final decision, in the cases of people with mental health problems. The judgment of doctors are crucial in prescribing a lethal drug for a mentally ill patient, even if the patient has an informed, rational and capable desire to obtain this drug (Savulescu, 1995, p.329).This is why, the state has a negative obligation not to interfere with mentally ill patients' wish, and with the moral judgment of doctors that have been trained professionally and emotionally to assist the patients in their death.

Finally negative obligations of states also include to not intrude with the progress in medical ethics that demonstrate that with the progress of society, there should also be a development in how human rights are perceived. The current debate about physician-assisted death (PAD) is divided into two sides arguing the following: on the liberal side, the arguments in favour for PAD relate to ending suffering, to the autonomy of individuals and to the right to a dignified death; on the conservative side, the arguments are connected to the role of medicine to protect the life of patients, and to the value of life (Holm, 2015, p.40). This thesis specifically argues on the liberal side and refers to the autonomy of two different groups of people with mental illness: those capable of deciding for themselves, and those considered incapable to take a decision as a consequence to the severity of their illness. The main points for PAD found in recent medical ethical literature emphasize the respect for the patient's autonomy and the relief of suffering. An autonomous person has the right to live his life in accordance with his own view of how and if it should continue. This right assumes that when he autonomously wants that, a person is allowed to end his life and is entitled to the assistance from health care providers in accomplishing his wish. On the suffering side, a person should not have to experience more distress than he can bear. When the nature of the suffering proves its relevance, it is commonly requested that the distress that PAD brings must be enduring and unavoidable as there is no other way of alleviating it other than by ending the patient's life (Varelius, 2015, p.61). This is applicable

especially in the cases of people with mental illnesses that lack the capacity to decide from themselves, but that their assisted suicide might prove the only ground to relief their suffering.

To conclude, this third chapter tried to explain in detail both positive and negative obligations of states in the debate on assisted-suicide as a way of protecting people with mental illness and their human rights. The first purpose of positive obligations is to make sure the protection of human rights is taking place, then to acknowledge that these obligations create multiple sub-rights as personal autonomy, after that there should be more ways to apply them in both European and national legislations, ultimately, positive obligations of states should be disconnected to political or religious interests. The second section presents the meanings of negative obligations for the protection of those suffering from mental illness. States ought not to interfere with people's human rights and should respect their self-determination. Moreover, states should offer alternatives to life medication treatments and to keep away from disturbing the progress in medical ethics.

Chapter 4: Mental Health and Assisted Suicide

The previous chapter explained both the positive obligations of states, as well as the negative ones in protecting the human rights of people suffering from mental health problems. In this chapter, the argument for assisted suicide for this vulnerable group in society will be introduced. But first we need to keep in mind that autonomy-based and well-being-based arguments tend to refer to cases of competent individuals as they best know what their level of well-being is and how it should be guarded by institutions, but well-being-based arguments leave more space for criticism in non-voluntary cases, where individuals are no longer capable of formulating their wills (Ruijs et al., 2014, p.30). This is why, this chapter will argue that both competent and those individuals considered incapable of taking their own decisions, should have the option for an assisted suicide. It will first present the way individuals with a mental illness that are capable to decide for themselves, should have the option to assisted suicide as a result of respecting their autonomy and self-determination. Then the chapter will explain in detail why severe psychiatric patients should also have the power to request assisted-suicide even if they are considered legally unapt to take such decisions concerning their treatment.

Individuals capable to decide for themselves

Firstly, mentally ill people are not a curious vulnerable group in society, but they are among our family, friends and community and they have the autonomy to take their own decisions. It is generally assumed that all adult patients are capable in consenting to their own medical treatment until proven otherwise. One of the most well-validated capacity assessment tool, the McArthur Competence Assessment Tool for Treatment showed that 70% to 80% of involuntarily hospitalised patients with mental illness are capable in taking decisions with respect to their medical condition. Only 4% of patients with a personality disorder lacked decisional capacity. This shows how important is to assess capacity on an individual basis and not to assume that the majority of psychiatric patients lack decision capacity regarding their treatment (Dembo et al., 2018, p.453). Moreover, it is wrong to assume that patients suffering from a mental health issue cannot consent to assisted suicide, because the majority of them have the ability to understand the relevant information connected to assisted death, they are able to appreciate the disorder they have and the medical consequences of their situation and the irreversibility of the decision. If they have also the possibility to reasonable understand their treatment options and communicate their choice, they should have the right to access assisted suicide (Shaw et al., 2018, p.393).

However, there are people with mental conditions such as dementia whose suffering cannot be eased even with optimal medical treatment and psychosocial care. These patients do not primarily experience physical pain, rather they witness a inevitable and increasing loss of their intellectual capacities and are aware that the near future brings them more dependency on others and discomfort. Some of them feel humiliated by the disease they have and carefully take into

consideration their alternatives. So they decide to end their life at a time they determine themselves, before the loss of all their capacity to make autonomous decisions (Gather and Vollmann, 2013, p.446). A study conducted in Sweden emphasized that patients want to have the power over the decision to undergo euthanasia. For them, it is not only about the manifestation of individual autonomy, but it is also about the transfer of power from doctors to patients, increasing the power of the health care system. This was perceived in a positive way by the participants of the study as being in control with one's own death as well as life is valuable to them and it represents a human right (Karlsson et al., 2012, p.37).

Secondly, we need to consider assisted suicide in terms of human rights for it to be possible, as the mentally ill, that can take their own decisions regarding how their life should be lived, have three different ways to formulate their right to suicide. First, the liberty right in which the individual is free to commit suicide, there is no obligation keeping him or her from not doing so. Then, the right to non-interference as others have a duty not to interfere with an individual's suicide. And the last formulation would be the welfare right in which others have the duty to assist the individuals with their suicide. And if we apply it to a right to assisted suicide, there would be: the freedom to commit assisted suicide, the right that keeps others from interfering with the assisted suicide, and the positive right of others to become assisters (Lewis, 2007, p.17). The difference between positive and negative rights can be found in the previous chapter, but this expansion of a certain right is crucial in understanding how self-determination can be applied for people with mental illness that are generally considered a vulnerable group with few to no decision capacity towards the establishment of their rights.

Autonomy has a different normative relevance for people with mental illness, as ground for a right to self-determination that includes the right to decide when to end one's life. In Kantian ethics, autonomy is a fundamental moral value and it represents the basis of our moral obligations towards ourselves as well as towards people around us. It is important to understand that this gives rise to duties and not primarily to rights (Sjöstrand et al., 2013, pp.225–26). For instance, in recent years in Switzerland, assisted suicide (AS) raised more political and public concerns, rather than medical ones. Some institutions started developing their own internal guidelines for allowing assisted suicide or for refusing it. One study exploring physicians' support for AS, in different medical scenarios such as chronic and severe dementia and mental illness, showed that 28% of all physicians interviewed supported AS, and 22% clearly opposed to it. And from the other respondents interviewed, general practitioners and medics from different departments, 40% believed that physicians should be allowed to perform AS. Moreover, the new guidelines on physician-assisted suicide propose circumstances in which this procedure may be ethically justifiable in order to further protect the self-determination of people with mental illness (Hodel et al., 2019, p.622).

Individuals who lack capability to decide for themselves

One reason for providing the option of assisted suicide or euthanasia for mentally ill patients that lack consent is in order to avoid unnecessary pain. A lot of people under strong medication suffered treatable pain unnecessary and a lot of medics all over the EU are still inadequately trained in pain relief techniques. It is argued that the technology of pain management advanced to the point where most pain is now controllable (Gorsuch, 2000, p.691). But if that is the case, why people with severe mental illnesses that cannot consent to their own treatment; are still lacking the option to a dignified death, and end up killing themselves through ways that cause them terrible pain instead? If euthanasia constitutes a relief option for them, it is worth considering it. If we look at dementia, the number of patients requesting euthanasia in the Netherlands has increased in recent years. Patients with dementia are not necessarily incapable of taking decisions, but this section refers to people with severe dementia, unable to consent and understand their reality. Society has a duty to care for patients suffering from this disease and make their lives as painless as possible. It is therefore, morally acceptable for those dementia patients that do not wish to continue their life and choose to die, to have the availability of this option if they so wish (de Beaufort and van de Vathorst, 2016, p.1463).

In the Netherlands, euthanasia or physician-assisted suicide (EAS) is permitted of the criteria for due care is met. This means that if patients go through unbearable and hopeless suffering, they have no realistic alternatives for treatment, they express as well-considered voluntary request, and are properly informed on their situation and prospects for their future life, they are allowed to request assisted suicide. Only after this process has been finalized, another independent physician is consulted and if all the criteria is met, a prudent performance of EAS can proceed (Ruijs et al., 2011, p.393). This shows that if it was possible for people with mental illness that wish to end their life, but have no legal power to consent over their treatment, the process could go on following similar rigorous requirements and analysis from different teams of physicians that best know the situation of their patient and are willing to help them in easing their sufferings even when consent from the patient itself is no legally available. On the other hand, in Belgium euthanasia on the grounds of unbearable suffering caused by a psychiatric disorder or dementia is possible, but it remains a very limited practice. The requests for euthanasia from psychiatric and dementia patients, raised since 2008. This clearly shows that there is need for a more developed practice in EAS if physicians are to respond adequately to these type of delicate requests (Dierickx et al., 2017, p.1).

Another reason for the availability of assisted suicide for psychiatric patients that lack the possibility to consent to their treatment is to avoid unassisted suicide that could impact them both psychologically and physically if the suicide is unsuccessful, and it can certainly affect the witnesses of the act. In Belgium and the Netherlands, some of the mentally ill patients weigh their options well over numerous years and repeatedly express their wish not to continue living. Their suffering and exhaustion become intolerable and their life resumes to meaningless survival. Many prefer EAS out of fear of dying in agony or surviving with the consequences of a

failed suicide attempt. They prefer EAS as it makes them thing at their death as a less lonely, more humane and dignified way for their life to end. This allows them to say goodbye to their loved ones, it makes them feel heard and taken seriously in their willing that often relieves their suffering and strengthens the connection with their caregivers (Vandenberghe, 2018, p.886). For many mentally ill patients the inability to cope with changing circumstances and the increasing dependency can determine them to end their life. For patients with an autism spectrum disorder, refusal of treatment is a common subject which leads physicians to conclude that EAS is the only remaining option. It is therefore more difficult to assess decisional capacity for patients with intellectual disabilities that have been suffering with a life-long disability, but the option of EAS should still be available as a safeguarding option that could prevent a unassisted suicide (Tuffrey-Wijne et al., 2018, p.1).

In recent years, it has been discussed that legalizing assistance in suicide leads to fewer people taking their own lives. This gives people with mental conditions the opportunity to talk about this matter openly, without the fear of legal consequences, it also encourages them to seek professional help and minimize the level of secrecy, fear and rejection feelings that are floating in the air of the contemporary society that is highly unsupportive of debates on assisted suicide. The main Swiss right-to-die society, EXIT proved that the option of physician-assisted suicide is an effective suicide prevention mechanism as people having a certain knowledge of their way out, motivated more than half of them to remain alive and wait for their natural death to occur. Furthermore, assisted suicide keeps people from dying violently and on their own (Albert Jones, 2018, p.306). The possibility to discuss assisted suicide is even harder when physicians have such opposite opinions on the matter. A study conducted on 30 general practitioners established that 16 out of the 30 medics asked, explained that they were open to consider a patient's request for euthanasia, underlying the importance of a careful decision-making process based on finding the balance between the necessity to stop the patient's pain and their personal values (Georges et al., 2008, p.150). Therefore, the key way in which assisted suicide could be discussed as a prevention mechanism against suicide is through physicians that have the widest experience with this kind of sensitive decisions.

To sum up, the present chapter explained the right to assisted suicide for two different groups of patients with mental illnesses. The first group, concerns patients that have the capacity to consent to their treatment, they should have access to assisted suicide as they have the autonomy to take these decisions. They should have this option because in some cases, their suffering cannot be diminished even with the optimal medical care. This paper also showed how there is need for us to consider assisted suicide from a human rights perspective. Lastly, autonomy needs be understood differently in the case of mental health as it includes the right to self-determination. The second part of this chapter argued for the right to assisted suicide for people with severe, chronic, and irresolvable mental illness that lack consent to their treatment. The first reason for assisted suicide for this category of patients is avoidance of unnecessary pain and only if the due care criteria is met. The second reason is as a way of unassisted, violent and painful suicide

prevention as assisted suicide, only by existing as an option, can have the power to determine more people to refrain from taking their own lives.

Chapter 5: The Right to Health

At the beginning, it was the adoption of the Constitution of the World Health Organization in 1946 and its following human rights treaties. This slowly but surely encouraged the international community to recognise that the 'enjoyment of the highest attainable standard of health' is a human right. This right does not particularly exist in the ECHR or in other Human Rights Conventions specifically by itself, but it is generally referred to as the right to health and it is included in many clauses that are part of the United Nations and the Council of Europe international human rights instruments that have been supported by many additional instruments and put into practice by different monitoring bodies (Toebes et al., 2014, p.406). The importance of the right to health is therefore crucial for the protection of people with mental illness and it can represent one of the human rights mechanisms opening a door for assisted suicide. As the last chapter explained the connection between mental health and assisted suicide, this chapter will clearly explain how the right to health can protect people with mental illness that wish to have the available option of assisted suicide. This chapter will first show how the right to health indicates the right to be free from non-consensual medical treatment and the right to be free from torture, inhumane or degrading treatment. The chapter then shows how the right to health is a strong ground for non-discrimination and for the states obligations to respect, protect and fulfil human rights.

Firstly, the right to health contains the right to be free from non-consensual medical treatment and for people with mental illness undergoing a certain treatment, it is an essential right. It might be argued that non-consensual interventions can be justified as they foresee an alienation of the pain through which the patient is going. However, this justification is not at all convincing in the case of assisted suicide. If a mentally ill patient decides to die assisted, it cannot be said that it is for his greater good to instead take the medication that is causing him or her, a miserable life (Pugh and Douglas, 2016, p.209). Instead, the same patient should be free from non-consensual medication even if this leads him to his ultimate decision of an assisted death. Without considering consent for people with mental health problems, it is easier to make this group of people more vulnerable and a target for abuses. In the 20th century, non-consensual sterilization was targeting especially people with intellectual disabilities. Only more recently, have the adverse effects on those sterilized against their will been recognized and only in certain jurisdictions. Human rights treaties tried to diminish the sterilization abuses and nowadays there are less abuses on people that lack consent (Rowlands and Amy, 2019, p.233).

There are already some documents supporting consensual medical treatment for mental health patients. For instance, the Mental Capacity Act (2005) for England and Wales aims at supporting autonomy and reducing unfounded paternalism by focusing on how the person arrived at that treatment decision. In practice, even if it can be very difficult to assess, especially with syndromes such as borderline, where the patient is guided more by a mix of beliefs and values, what is the patient's true decision. But the general idea is to focus more on the content of ideas

expressed by the patient, more than on his/hers cognitive abilities (Banner and Szmukler, 2013, p.379). The meaning of personal authority over one's body is central in arguments implying non-consensual psychiatric treatment, including involuntary hospitalization and forced medication. Central integrity is respected when freedom of choice over one's own body and mind exists. Informed consent is the key in respecting others through: keeping the authority to be secure against unauthorized touching, the liberty in acknowledging the value of the freedom, and the general concern of the patient's best interest merged with understanding that individuals are generally the best judges of their own best interests (Cherry, 2010, p.790). Therefore, consensual medical treatment is underlined in the right to health and if for some patients this means respect of the choice for assisted suicide, such option should be available.

Secondly, the right to health implies the right of people with mental illness to be free from torture, cruel, inhumane or degrading treatment or punishment. This argument is better developed in the CPRD as it states in its Article 15, that: 'No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his or her free consent to medical or scientific experimentation.', and 'States Parties shall take all effective legislative, administrative, judicial or other measures to prevent persons with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhuman or degrading treatment or punishment.'(UN, 2007, p.12). The first paragraph of Article 15 prohibits the medical or scientific experimentation without free consent, especially on persons with disabilities, the category from which the mentally ill are part of. The second paragraph of the article obliges states to treat disabled people equally to others in society and to promote the fundamental freedoms of this category of vulnerable people in society (Marchesi, 2017, pp.307–8). Article 15 of CPRD can be very useful for our understanding of how people with mental illness, through assisted suicide can be protected and freed from degrading treatment that the lack of such an option could provide for their situation.

Assisted suicide is an option against torture and degrading treatment that a chronic psychotic patient might experience through his condition. If a person has an attack of acute psychosis and starts to become confused and delusional and intents to commit suicide, it is needed to treat that person as the mental condition prevents exercising a free choice. When the same person is going through a degrading, humiliating, or painful physical condition that changes that person's dignity, the intention to commit suicide becomes a chronic death wish. The decision of the psychiatrist treating this person would become very difficult as the death wish of the patient is based on a permanent condition. The psychiatrist needs to find ways to prevent the patient from harming himself by also avoiding using strong measures that might harm the patient unnecessary (Frati et al., 2014, p.28). The availability of assisted suicide for people that lack decision capacity, as former explained in the previous chapter, comes as a saving mechanism for both the patient and his physician. Looking at a study conducted in the US and the UK, there was a high preference for measures that could permit mentally ill patients to end their life peacefully when their decision-making capacity was compromised (Clarke et al., 2017, p.2).

Thirdly, the right to health implies the protection of people with mental problems from experiencing discrimination. On this matter, numerous concerns have been raised regarding the introduction of mental capacity as a pretext for forceful intervention. Requirements in the assessment of functional capacity to understand the consequences of a certain decision for a patient, because of its flexibility, has turned into the declaration that capacity means agreeing with the psychiatrist, when in reality it is not at all the case. Therefore, the use of mental disability as criteria in establishing if a patient is able or not to go through the process of decision making is by itself discriminatory (Gooding and Flynn, 2015, p.254). The only way to avoid that is to make certain options, such as assisted suicide, available for all mentally ill patients, not just for those capable of taking the final decision. Currently many legal restrictions around Europe are forcing desperate people in their final days to travel to places like Switzerland, Belgium and the Netherlands, in order to get assistance with their choice of a dignified death. So we need to reconsider the current legislation in order to make it more balanced between the protection of vulnerable people and the moral agent of exercising one's rightful capacity for self-determination (Shaw, 2009, p.349).

The right to health serves also to prevent discrimination between people with mental disabilities and other patients such as those being terminally ill. Some critics of assisted suicide claim that giving the power to decide only to competent patients who are terminally ill and choose it voluntarily, would prevent abuses of psychiatric patients. But it is once again essential to stress out that such serious decisions such as assisted suicide need to be taken on a case by case basis as the medical profession has the ability and duty to reliably predict how severe is the mental condition and when assisted suicide can become an option (Coleman, 2010, p.39). If we have a short look around Europe in the states that have legalized euthanasia, we can observe that the qualifying criteria is different from state to state and terminal illness is not always required. In Belgium when a patient is in a state of unbearable physical or mental suffering that cannot be eased, he or she has enough grounds to access euthanasia if they so wish. In both Belgium and the Netherlands, voluntary euthanasia is permissible for children. Where it is lawful, data shows low but growing numbers of deaths by euthanasia. In 2016, the Netherlands registered 4% of deaths due to euthanasia, around 6091 people. Discrimination between mentally ill patients and terminally ill patients is not justified, as various US studies emphasized that pain is not the main reported motivation for physician-assisted suicide, but more the loss of autonomy, dignity and of the power to be able to enjoy life's activities (Kane, 2019, p.200).

Lastly, the right to health denominates a set of obligations. The 1966 International Covenant on Economic, Social and Cultural Rights expresses the view of States; obligations to respect, protect, and fulfill the right to the enjoyment of the highest attainable standard of physicial and mental health. It incorporates both freedoms, such as the right to be free from non-consensual and uninformed medical treatment, as it was previously discussed in this chapter, as well as entitlements. The entitlements build rights such as the right to a system of protection on an equal basis for all, and a system of prevention, treatment and access to essential medicines as well as

access to information and education on health for everyone (Pillay, 2008, p.2005). Some theorists clearly underlined that actions aiming to prevent or reduce harm should be considered first over actions that promote therapeutic beneficence. The ethical principles and values that underline the duties or obligations of government institutions, health care systems or of the judiciary in protecting the right to health of people with mental conditions need to be taken in consideration and prioritized (Kirby, 2019, p.699).

Furthermore, the right to health reveals two important obligations: to protect and to fulfil. In order to protect the right to health for people with mental problems, states are responsible no to violate human rights directly themselves, then, they are bounded to protect their citizens from having their rights violated by other non-state actors, and only after these conditions are respected, states are obliged to ensure that all conditions that enable people to realize their rights are in order (Skempes et al., 2015, p.167). The protection obligation in this case is to make sure psychiatric patients have their rights respected as well as they have access to treatment and to ways that can ease their suffering. The fulfilment obligation of states means establishing the most adequate laws that can realize all the rights expressed above. In the case of mental illness, health professionals underline the importance of guarding the well-being of those affected by mental disorders as well as protecting their family members and carers. Fulfilling the right to health also means respecting the privacy of mentally ill patients, protecting their dignity and confidentiality and actively promoting their safety (Essex, 2014, p.81). The assisted suicide is an option that helps fulfilling these obligations that states have to: respect, protect and fulfil.

To conclude, this chapter explained the importance of the right to health for the protection of people with mental illness. It first established that the right to health contains the right to be free from non-consensual medical treatment and the relevance of this right for mentally ill patients. There have been already documents that support consent of patients on their medical treatment. Then, the chapter underlined how the right to health implies the freedom from torture, cruel and inhumane treatment, and how assisted suicide is an option to avoid the torture and degrading treatment that come with the last stages of chronic psychosis and other serious mental health conditions. The third main point of this chapter was how the right to health can be used in order to protect people with mental illness against experiencing discrimination. This right does not only protect mentally ill patients against discrimination from institutions and people outside their close spectrum, but it also protects them against discrimination that exist between them and terminally ill patients in respect to the accessibility to assisted suicide. Lastly, the right to health expresses a set of obligations that states need to accomplish in order to respect, protect and fulfil the human rights of people with mental disabilities.

Chapter 6: Suicide from a Human Rights Perspective

If the previous chapters were more descriptive and the last one presented the right to health, it is now the time to move to a more analytical perspective by describing suicide from a human rights perspective. In order to do that, this chapter will be looking in two primary cases regarding assisted suicide that were judged at the European Court of Human Rights (ECtHR): Pretty v. the United Kingdom, application number 2346/02 from 29 April 2002, and the case of Haas v. Switzerland, application 31322/07 from 20 June 2011. This chapter will first explain both cases analyzed by exposing the facts of the cases and then the judgments and the decisions of the Court. The last part establishes a comparison between the cases studied with respect to assisted suicide and how it was viewed in both key cases. The margin of appreciation will be discussed first, then the relevance of Article 8 in the way individuals should have the freedom to decide how and when to die was analyzed. The third point of comparison was in connection with Article 3 and with the way that continuing an inhumane and degrading life might constitute torture for people without access to assisted suicide. Lastly, the attitude of the Court in both cases was analyzed.

Preety v. UK

First, the facts of the case present the applicant, a forty-three year old British woman suffering from an incurable disease that weakens her muscles, leading slowly to death. The applicant's condition deteriorated very quickly after her diagnosis in 1999 and the disease was in an advanced stage when she made her application. She was paralyzed from the neck down and had to be fed by a tube. Her intellectual capacities to take decisions were intact. As the final stages of her disease proved to be distressing and undignified, she wished to have a way to control the only important decision that was left to her – when and how she died. She was unable to commit suicide without assistance and in the UK, at that time, assisting someone while he or she is committing suicide represented a crime. The applicant's lawyer requested from the Director of Public Prosecutions, an assurance that her husband would not be prosecuted if he assisted her to die. His request was refused and the Divisional court refused to judicially review the application. The applicant's appeal was dismissed by the House of Lords in November 2001 (Preety v. UK, 2002a). The case then went to the ECtHR having infringed the following rights of the applicant: Article 2 (right to life), 3 (prohibition of torture), 8 (right to respect for private and family life), 9 (freedom of tought, conscience and religion), and 14 (prohibition of discrimination) of the Convention (Preety v. UK, 2002b, para.3), and (Council of Europe, 1953, p.13).

Second, the judgment of this case is particularly important for this paper as it is a central case where assisted suicide was discussed and the applicant lost at the Court of Human Rights, ending her life anyway in a more private and lawful way in Switzerland. The Court established that there was no violation of Article 2 as the obligation of the State was to protect life and this it does not involve a negative aspect deriving from it. An individual is not entitled to self-determination in choosing death rather than life. So there is no right to die deriving from Article

2 (Preety v. UK, 2002b, para.39). There was no violation of Article 3 either as the applicant received proper care form the State medical authorities. As there was no use of lethal force that lead to death for the applicant, the positive obligation of the State under Article 3 does not involve actions to provide improved conditions of care, but it rather sanctions actions determined to terminate life (Preety v. UK, 2002a). There was no violation of Article 8 as preventing the applicant to exercise her choice was not an interference with her private life. Even if Article 8 was applicable in this case, there was no necessity of interference, it was considered that the UK, by refusing the request for assisted suicide, tried to protect the current legislation that protect many vulnerable terminally ill individuals (Preety v. UK, 2002a). Lastly, neither articles 9 nor 14 were breached as the applicant's claims did not involve the manifestation of a religion or belief and there was no discrimination as Article 14 is constructed not to discriminate between those physically capable and those that lack capacity to commit suicide (Preety v. UK, 2002b, para.32).

Haas v. Switzerland

The facts of the case present the applicant that has been suffering for about twenty years from a serious bipolar disorder. His illness made it impossible for him to live in dignity so he asked a Swiss private-law association to help him end his life. He tried to get the prescription of a lethal drug in multiple ways, but they all proved unsuccessful. His case went through more administrative courts until it reached the Federal Court, in 2006 that dismissed his appeals on the fact that there is a distinction between the right to decide one's own death and the real issue of the case – the right to assisted suicide from the State or from a third party. When the case arrived to the European Court, the applicant argued that his right to end his life in a dignified manner had been violated in Switzerland. He was refused because he was not accomplishing the conditions that had to be met in order to obtain the lethal substance as he did not met various psychiatric assessments and the medical prescription could not be issued for him (Haas v. Switzerland, 2011a). His case was built on the violation of Article 8 – the right to respect for private and family life (Council of Europe, 1953, p.11).

The judgment of the case showed that the right of an individual to decide how and when his life should end if it comes from his free will was one aspect of the right to respect private life. But the present case concerned a different problem, of the State had the positive obligation under Article 8 to make sure the applicant can procure without prescription, the substance enabling him to die without the risk of failure and without any pain. As the members states of the Council of Europe have not yet reached an agreement regarding assisted suicide and other rights that could give an individual the autonomy of choosing how and when to die. Even if assisted suicide has been decriminalize in some states, including Switzerland, the majority of States militate for the protection of the individual's life more than towards his right to end it. The Court than gave states a wide margin of appreciation (Haas v. Switzerland, 2011a). The Court understood the will of the applicant to end his life painlessly, in a dignified manner but it had to agree with the Swiss law of the existence of a medical prescription in order to obtain lethal drugs. The Court

recognized the legitimacy of such a prescription in order to prevent abuse and impulsive decisions (Haas v. Switzerland, 2011b, para.16 (6.3.4)).

Comparison

The first reason of comparison is the implication of the margin of appreciation that states have which was applied in both cases in connection to Article 8. In Pretty v. UK, it has been argued that states have the option to change their personal status in relation to a matter of concern, in order for it to fit with their identity. Some states, do not afford this reservations, therefore, there is no consensus between states regarding the margin of appreciation (Preety v. UK, 2002b, para.15). In Haas v. Switzerland the Court recognized that it is in the attributes of the State to enjoy a certain margin of appreciation when there are different interests at stake, and when the problem involves unchangeable, serious requests such as assisted suicide (Haas v. Switzerland, 2011b, para.53). When we compare the two cases, we can see that in the first case, an appeal for a negative right to assisted suicide in the UK was impossible. The second case involved a positive obligation to the state to provide the lethal substance for the applicant, which would therefore be established under Article 8 in Switzerland, where assisted suicide is partly legalized (Tiensuu, 2015, p.255). Therefore, both cases contain a certain margin of appreciation. In Pretty v. UK, the State has taken the obligation to protect life more than anything else which gives it a narrow margin, and in Haas v. Switzerland, where the legislation permits the prescription of lethal drugs, but where the applicant could not obtain such a prescription, the state has a wide margin of appreciation on the matter of assisted suicide.

The second reason of comparison is Article 2. In Pretty v. UK, the applicant sustained that Article 2 does not protect life itself, but the right to life. As the aim of this article is to protect individuals from third parties such as the State, it also recognizes that it is the individual's choice whether or not to live. Therefore, Article 2, protects the right of an individual to self-determination in relation to his life or death. So the article acknowledges that a person may refuse life-saving or life-prolonging medical treatment and may decide to commit suicide. Even if most people want to live, it is worth recognizing that some want to die and Article 2 protects both rights. The right to die is not a mirror of the right to life, but the effect of it and the State has a positive obligation to protect both (Preety v. UK, 2002b, para.4). This argument appears in the second case as well. In Haas v. Switzerland, the Federal Tribunal noted that Article 2 obligates states to implement appropriate procedures that certify that the decision of an individual to end his or her life corresponds to his or hers free will. One way for states to implement these procedures is by requiring a psychiatric assessment and a medical prescription whenever an assisted suicide is in question. In this way abuses are controlled and the freedom to choose how to live or end one's life, available under Article 2, can be done according to one's autonomic decision (Harmon and Sethi, 2011, p.361).

The third comparison can be made regarding Article 3. In Pretty v. UK, the applicant recognized that Article 3 implies both a negative obligation not to expose individuals to inhumane and

degrading treatment and a positive obligation to protect individuals from torture. She emphasized that the State had the positive obligation to protect her from the suffering that continuing her life in her condition would cause her. The fact that the State did not cause her present health condition was not the central matter. What was important was that the UK had the obligation to act in relief of her present situation (Sanderson, 2002, p.944). It is important to observe that in the second case, Article 3 is not part of the applicant's case as this article does not oblige the State to create a legal basis for other ways for an individual to have access to assisted suicide, rather than the legal ones already existing in that state (Haas v. Switzerland, 2011b, para.16 (6.2.2.)). Here is essential to understand that the positive obligations to protect people against torture is a very important right and if for some people living their life in the current conditions given by their mental or physical state represents torture, and assisted suicide would be their only solution against an inhumane and degrading condition, then the State clearly has the obligation to facilitate the assisted suicide.

Lastly, it is worth mentioning the attitude of the Court in the two cases. In the first case, the Court agreed with the United Kingdom in safeguarding and protecting the life of the applicant. As the country's legislation does not support assisted suicide, it is easily understandable the way the judgment of the Court gave more liability and justice to the State even if the European Judges appeared to fully understand the applicant's wish to end her life. The most impacting conclusions are drawn from the fact that there are people such as Ms. Preety that inevitably succeeded to end their life in a private institution or in a different country. This underlines the important of assisted suicide and the human rights that this *right to die* implies. In the absence of making assisted suicide more accessible for people in true need of it, we will have even more private actors regulating what the States have no power to regulate due to different constrains in the good case, but the bad case future scenario, predicts even more violent and painful suicides. On the other hand, we agree with the judgment of the Court in the second case as the applicant was a citizen of Switzerland, a country where assisted suicide is possible under certain conditions. The fact that the applicant did not comply with these conditions and could not get a prescription for a lethal drug shows us two things: one, that it was the applicant's problem that he could not comply the conditions needed for such a prescription, and two, it shows us that such as system that partly decriminalized suicide is working, which gives us hope for the future of decriminalized assistance in suicide.

This chapter analyzed two key cases from the ECtHR, Pretty v. UK and Haas v. Switzerland to better establish how suicide is seen from a Human Rights perspective. After the two cases were explained by outlining their facts and judgments by the Court, their most relevant facts were compared. The first comparison outlined the margin of appreciation that states were given in connection to Article 8 and how the wide margin of appreciation helps State stick to their identity and admit or go against assisted suicide. The second comparison point was Article 2 and the freedom to choose how to live or end one's life that should be done autonomously. Next, Article 3 was discussed and the importance to protect people against torture, and if the life of

these people represents torture due to their mental or physical condition, and they see assisted suicide as their only solution, the State is positively obliged to make this solution available for them. The last comparison was made between the attitudes of the Court in the two cases. The first case was marked by the refusal of the Court to admit the applicant's request to not legally punish her husband if he assisted her to commit suicide. The second case helps us understand that the applicant did not obtain a prescription for a lethal drug as this could have caused an abuse which determines that decriminalizing assisted suicide can work.

Chapter 7: End of Life and the ECHR

In the previous chapter, the analysis presented two of the key cases where assisted suicide was reviewed by the European Court of Human Rights (ECtHR). This chapter will analyze two other cases in which suicide happened but out of different circumstances. In both Koch v. Germany and Fernandes de Oliveira v. Portugal suicide is a disputed issue. Both cases are very important as they present the two arguments for assisted death, autonomy and relief of suffering. Moreover, through the following analysis we will emphasize that patients' autonomous choices should be more valued in health care because of their aim in establishing what patients really wish. It is possible to believe, following an adequate line of reasoning, that an autonomous person would not choose a life of meaningless suffering. This thesis tries to underline that mental suffering is not precisely different from physical pain in the end-of-life context (Cholbi and Varelius, 2015, pp.73–74). Therefore, mentally ill patients have no reason to endure suffering and human rights mechanisms are the first ways that can bring relief. The present chapter at first summarizes the facts and the judgments of both cases and then draws a comparison between the two. First the positive obligations of states are mentioned, then the obligation to protect the life of vulnerable people in society based on Article 2. The comparison also sustains the importance of the respect of private and family life for people willing to have an assisted suicide. Ultimately, the decision of the Court in the two different cases is analyzed.

Koch v. Germany

The facts of the case present the applicant who went to the Federal Institute for Pharmaceutical and Medical Products to get an authorization so that he could obtain a lethal dose of a drug for his wife. His wife suffered from a complete quadriplegia and wanted to commit suicide in her own home in Germany. The institute refused to give him this authorization, so the applicant and his wife had their administrative appeal discharged. The following year, both went to Switzerland, where the wife was able to commit suicide, with the help of an association. The applicant unsuccessfully tried to obtain a declaration that proved that the Institute's decisions had been unlawful. He appealed to the administrative court of appeal and then, to the Federal Constitutional Court, but all his appeals were declared inadmissible. Because the German courts refused to examine the merits of the application, the case went to the European Court of Human Rights. The main article that was mentioned by the applicant was Article 8 (Right to respect for private and family life) because the way in which the German State handled the issue was considered to violate the private life of the victim and her husband (Koch v. Germany, 2012a).

The judgment of the case underlines the specific details that helped the Court reach a decision. The first important detail is that the applicant claimed a violation of his own rights. The applicant and his wife were married for 25 years and had a very strong connection. He was by her side through her suffering and supported her in her wish to end her life. Another important detail is that the couple traveled to Switzerland where the wife of the applicant was able to die assisted. The application was a joint one, but after his wife died, the applicant changed the domestic

proceedings in his own name. The Court decided that there was a violation of Article 8, as the private life of the applicant was directly affected as the Federal Institute refused to grant a lethal dose to his suffering wife. But as the right to private and family life is a non-transferable right, the Court declared the case inadmissible. On the other hand, even if the Court agreed with the Federal Institute's refusal as it was legitimate in compliance with Article 8, they had to sanction the State, as the German Federal Constitutional Court refused to examine the merits of the case without any legitimate aim (Koch v. Germany, 2012a, para.a,b).

Fernandes de Oliveira v. Portugal

The facts of the case present the suicide of a mentally ill man whom, after being voluntarily admitted to a psychiatric hospital for treatment, committed suicide. The applicant, the mother of the man in question, blames the State for negligence, as her son, after multiple attempts to commit suicide managed to escape the hospital and jumped in front of a train. The applicant tried to receive compensation for her son's death, as the hospital could have monitored him more carefully as the medical staff was aware of his previous attempts (Fernandes de Oliveira v. Portugal, 2019). The applicant complained under Article 2 (the right to life) of the Convention arguing that the negligence of the psychiatric hospital led to the death of her son. Moreover, she argued that under Article 6 (right to a fair trial) the proceedings of her case lasted too long (Fernandes v. Portugal, 2019, para.3). In 2017 a judgment at one of the Chambers at the European Court declared the application admissible as the judges unanimously held that there had been a violation of both substantive and procedural aspects of Article 2. Shortly after, the Government of Portugal requested the referral to this case to the Grand Chamber in accordance with Article 43 (referral to the Grand Chamber) of the Convention so the ECtHR started judging the case (Fernandes v. Portugal, 2019, para.4), (Council of Europe, 1953, p.24).

The judgment of the case shows that the positive obligation of the State to be up to date with the regulation regarding the security of the psychiatric institution was respected according to the Mental Health Act. The medical facility had an open regime that encouraged the patient to move around freely (Fernandes de Oliveira v. Portugal, 2019, para.(a)). This was strengthened by the fact that the son of the applicant was admitted to this medical facility on a voluntary basis. These facts influenced the Court's decision as the patient had all tools needed for his treatment. Therefore, the court argued that there was no violation of Article 2 of the Convention. Furthermore, the Court argued that there was no positive obligation of Portugal to take preventive measure, as it is very difficult to know the existence of a real and immediate risk in cases as the present one. It was essential for the Court to consider the previous mental health history of the applicant's son to establish the gravity of his mental distress and to observe if the authorities could have predicted his suicide. The Court finally concluded that in cases such as the present one, it is an impossible task to completely prevent a suicide. The Court ultimately states that there was no violation of the structural part of Article 2, but there was a violation of the procedural part of the article because the procedure lasted more than eleven years (Fernandes de Oliveira v. Portugal, 2019, para.(b)).

Comparison

Firstly, the positive obligations of states appear in both cases. In Koch v. Germany, the Court argued that the State had no obligation under Article 8 to facilitate the assistance needed for a suicide in dignity and it remained unclear for the applicant if his wife had a substantial right to an assisted suicide in her condition (Koch v. Germany, 2012b, para.33). In the second case, the positive obligations are strongly visible in Article 2. It is essential to understand that Portugal was positively obliged to take the preventive optional measures to protect the applicant's son, independent of his voluntary or involuntary admission. Even if the patient was voluntarily hospitalized, the State had to protect him (Fernandes v. Portugal, 2019, para.90). The two cases are important in understanding positive obligations of states in treating people with mental illness. In Koch v. Germany, the wife of the applicant deserved more consideration towards her case from the responsible institutions of the State. Her health condition and her autonomous wish resulted for the option of assisted suicide, and the state failed to respect her right to privacy. And in the second case, the applicant's son was deprived of his right to life, by the fact that the State failed to accomplish its positive obligation to protect him and his mental health under Article 2.

Secondly, the right to life contained under article 2 embodies an obligation to safeguard and protect those most vulnerable in society. There are two different of the same argument. In Fernandes de Oliveira v. Portugal, the first obligation of the State under Article 2 is to protect vulnerable people from the negligence of institutions. This can be achieved through different ways of assessment that certify if certain institutions complied with the regulations designed to protect the human rights of the people these institutions have in their care. And the second obligation is to protect vulnerable individuals from other individuals or from themselves (Fernandes v. Portugal, 2019, paras106–108). And in the present case the State failed both obligations. Moreover, the State has a positive obligation to ensure the practical and effective exercise of a right once granted (Black, 2014, p.118). And if a State cannot protect its citizens from harming themselves in practice, then it does not protect their right to life. Assisted suicide is only one way through which people that already took the decision to end their life, would be doing it through a medical, safe and painless procedure, not by jumping in front of the train as it happened in Fernandes v. Portugal.

Thirdly, the importance of respecting private and family life under article 8 is portrayed in Koch v. Germany. The German authorities refused to give the lethal drug needed for the applicant's wife to be able to self-determinedly end her life. Moreover, the Court recognized that this particular case raised multiple fundamental questions about autonomy in end-of-life decisions which are of general interest for many individuals, not only for the applicant and his wife. The fact that the Court recognized that there has been a violation under Article 8 for the applicant, as he accompanied his wife till her last moments and he was directly affected by the State's refusals and long bureaucratic proceedings, is the first step towards introducing assisted suicide in the debate of human rights (Dute, 2013, p.81). Article 8 is strongly connected with assisted suicide, as the way and the time of one's death is a personal matter that should be possible if a person

suffering from a medical condition that creates a degrading state, wishes to die and end his or her suffering. It has been argued that the decriminalization of assisted suicide in some jurisdictions such as the Dutch one, created room for abuse cases in which lethal injections were given without the patient's consent (Koch v. Germany, 2012b, para.42). But here it is a totally different matter as consent is the first issue analyzed and if there is consent, there cannot be abuse cases. But when assisted suicide is not possible, the abuse from the State authority in persuading someone to live a miserable life is more common.

Lastly, the judgment of the Court can be compared in the two cases. In the Koch v. Germany the margin of appreciation is the most interesting point because even if Germany had a wide margin, as assisted suicide is still a strongly debated issue in the majority of Member States, the Court still recognized the violation of Article 8 for the applicant. Only four States examined the allowance of physicians to prescribe a lethal drug in order to enable a patient to end his or her life. This gives all states a wide margin of appreciation, so they can examine the merits of certain cases involving assisted death as free as they find suitable. But because in the present case, the domestic courts did not fulfill their obligation to examine the merits of the applicant's claim, their refusal was sanctioned (Koch v. Germany, 2012b, paras70–72). This action gives us a lot of hope as this case underlines the positive obligations of states when assisted suicide is under question. The second case, Fernandes v. Portugal, rises serious concerns on how states fail their obligations to provide health care to vulnerable people such as psychiatric patients. More States should enforce their commitment to suicide prevention, especially regarding people under State supervision and even more with institutionalized psychiatric patients (Fernandes v. Portugal, 2019, para.56). We should once again pay attention to how assisted suicide is a method to prevent suicide for institutionalized patients such as the son of the applicant in the discussed case.

To conclude, this chapter analyzed two cases involving suicide at the ECtHR, Koch v. Germany and Fernandes de Oliveira v. Portugal in order to better understand how the end of life is perceived through the European Convention of Human Rights. After the two cases were successfully summarized according to their facts and judgments, a comparison was made between the two of them. The first observation showed the positive obligations that arise for states in protecting people with mental illness. The second correlation was Article 2 as it contains the obligation to protect vulnerable people in society, especially those that already took the decision to end their life and would be allowed to do it in medical and painless way if assisted suicide was a more common option. Then, the importance of Article 8 is described as the idea of more consent which equals less abusive cases is introduced. The last comparison is between the judgment of the first and the second case which once again underlines the way in which assisted suicide is a way of suicide prevention especially for institutionalized patents.

Chapter 8: Detention and Suicide

All people are entitled to have their rights protected under the European Convention of Human Rights. When some of these people are deprived of their liberty by states, the situation is a bit more complicated as states have a duty to care for their detainees, especially in regard to suicide prevention (Thoonen and Duijst, 2014, p.121). Another important factor is the test that determines if authorities ought to have known the risks detained people faced. Assessing a suicide risk is a difficult task in all situation, but in detention facilities, determining if a person is going to commit suicide becomes very challenging and needs more attention and care from State's authorities (Thoonen and Duijst, 2014, pp.144–45). The first part of this chapter will present the facts and the judgments of two important cases: Renolde v. France and Centre of Legal Resources (CLR) on behalf of Valentin Campeanu v. Romania. Then, there will be a comparison between the two cases that will first discuss the violation of Article 2 and 3 in both cases. The last part of the comparison will discuss the connection between detention and suicide, followed by an analysis of the judgment of the European Court of Human Rights in both cases.

Renolde v. France

The facts of the case present the applicant, the brother of the victim who complained about the fact that his brother committed suicide in his cell because of the negligence of the State authorities. The victim was suffering from psychiatric disorders and when he was transferred to another prison, he tried to commit suicide. He got medication for his acute delirious episode, and he was put in care in a cell on his own. It all started when he assaulted a guardian and as a consequence, he was put in a punishment cell for 45 days. Before his lawyer was able to request a psychiatric assessment to establish more details about his mental condition, he was found hanged in his cell. In the aftermath of his death, a preliminary investigation concluded that there were no substances in his body which indicates he did not take his prescribed medication. The investigation team concluded that the victim was fit for punishment and he did not take his medication as a result of his own decision not to follow his treatment. The measures taken by the prison authorities decreased the safety of the victim and the care he received was inadequate. After the judges refused to answer the case, the applicant arrived at the European Court with allegations under Article 2 (the right to life) and Article 3 (freedom of torture and inhumane treatment) (Renolde v. France, 2008).

The judgment of the case presents two important articles of the Human Rights Convention. In connection to Article 2, the authorities had an obligation to safeguard the life of the applicant's brother as they knew from the moment of the first suicide attempt that the victim was suffering from acute psychotic disorders and that he was capable to harm himself. Despite the fact that the victim was not under an immediate threat, he should have been closely monitored for any possible unexpected deterioration of his condition. The authorities needed to make sure that the victim was well enough to remain in detention. Moreover, there was no evidence of even a discussion of his possible admission to a psychiatric hospital on the basis of his mental condition.

The authorities failed to safeguard the patient and to provide the necessary treatment corresponding to his serious condition, and they have him the maximum penalty on the disciplinary board, the 45 days in detention at only three days after his first suicide attempt. The isolation deprived him from his activities and aggravated the suicide risk. The Court concluded that there was a violation of Article 2 as the authorities failed to comply their positive obligations to protect the applicant's brother's right to life. The serious disciplinary punishment attracted the Court to decide that there was a violation of Article 3. The punishment imposed in the detention facility was very severe and long which affected the physical and moral health of the applicant's brother. As he was already suffering from distress, his lawyer requested a psychiatric assessment before him going to the punishment cell and this was not concretized in time. Therefore, the penalty imposed on the victim was not compatible with the standard of treatment required in cases where a mentally ill person is involved and this constituted inhuman and degrading treatment and punishment which is against the European Convention of Human Rights (Renolde v. France, 2008)

Centre of Legal Resources on behalf of Valentin Campeanu v. Romania

The facts of the case present the application which was made by a non-governmental organization (NGO) on behalf of a young Roma man who died in 2004 at 18 years old. At birth, Mr. Campeanu was placed in an orphanage, and from early childhood, he was diagnosed with HIV and with a severe mental disability. When reaching adulthood, he had to be placed in a specialized institution, many of them refused to accept him due to his medical record. After finally being admitted to a psychiatric hospital after being diagnosed with a hyper-aggressive behaviour, a team of monitors found him alone in an unheated room poorly dressed. The hospital failed to provide him with the most basic treatment and care and Mr. Campeanu died. A 2004 report by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) showed that around 109 patients died in suspicious circumstances in that same psychiatric hospital. The Committee also found that some of the patients were not given sufficient care and there was a lack of human and material resources at the hospital and there were deficiencies in food and living conditions such as heating. The NGO argued that there was a violation of Article 2 (the right to life), Article 46 (binding force and execution of judgments) and Article 34 (individual applications).

The judgment of the case portrays how article 34 was relevant even if the NGO had no close link and no personal interest in the victim. The exceptional circumstances of the case and the serious allegations brought to the State authorities made it admissible to the Court, even if the NGO has no power of attorney over the victim, which died before the application was admitted. The Court established that the victim, which was in the State's care, had died due to negligence and he never received the legal support and advice needed to improve his situation. Regarding Article 2, the Court concluded that there has been a violation as his acceptance to the institutions needed to support him were based on which of them was willing to receive him, not on where he was able to receive the medical care and support needed. The transfers from one institution to the other

took place without a proper diagnosis and aftercare which affected Mr. Campeanu's actual health state and he lacked his most basic medical needs. The authorities failed to protect Mr. Campeanu which was already in a vulnerable state and endangered his health condition by placing him in a psychiatric hospital that lacked heating, proper food and had a shortage in medical staff and medication, therefore, the authorities failed to protect Mr. Campeanu's life (Campeanu v. Romania, 2014a).

Comparison

The first area of comparison between the two cases is the way violation of Article 2 can be prevented if states respect their obligation to protect people with mental health problems. One way to fulfil this protection is by physicians that can engage the client in a review of issues and options he or she might have, evaluating their capacity to make decisions. Is such evaluations are conducted, physicians have no grounds to hospitalize people involuntarily as they can decide for themselves and as their families know of their intentions to die. Even if the same client is counselled permanently in trying to achieve the highest quality of life possible, for the longest time possible, he or she might still decide to end their life, and as their autonomy and self-determination need be respected, States are obliged to fulfil their obligation to relief the pain of people suffering in society (Werth and Richmond, 2009, pp.205–206). In Renolde v. France, Article 2 included the obligations of detention institutions such as prisons to provide effective medical and psychological services for mentally ill detainees. If there are no activities of suicide prevention and no right diagnosis and no proper treatment according to the mental disorder, is administered, the prison population has always to suffer and the risk of suicides increases considerably (Renolde v. France, 2009, para.55). A similar violation of the right to life happened in Campeanu v. Romania as the victim, suffering from HIV and from a severe mental health condition was transported from one State institution to another without the respect of the minimum conditions needed for the protection of life (Campeanu v. Romania, 2014b, para.79). If states continue to fail their obligation to protect life through the massive negligence and poor conditions their institutions offer, the future of human rights is a very dark one and the protection of people with mental health illness will be permanently under threat.

The second comparison can be done in relation to Article 3 and in how the negligence of states can inhumanly treat people in society, especial those that are institutionalized. In Renolde c. France, the medical records of the victim showed how his acute psychotic disorders influenced his tragic death. When he was transferred to the second prison, he was already having delusional moments, as one of the prison's guards stated, observing him having dialogues with himself at night (Renolde v. France, 2009, para.40) Despite all this facts, the prison still decided to send him for 45 days in a punishment cell without any prior psychiatric examination so the degrading and punishment regime that was waiting for Mr. Renolde contributed to his decision to commit suicide. In Campeanu v. Romania the consequences of the torture and inhumane treatment that the victim was exposed to in the multiple poor equipped institutions he was dragged through, brought his death and constituted a violation of Article 3. The same Article entitled the patient to

respect as a human being, without discrimination (Campeanu v. Romania, 2014b, para.55). But being a Roma man, being HIV positive and having a severe mental illness, showed how the Romanian health care and social care systems discriminated the patient multiple times and how the obligation of the Romanian State to protect its citizens against torture and degrading punishments was not fulfilled, with the result of the death of the patient and grave violations from the State to a mentally ill patient.

The next parallel between the two cases constitutes a basis of understanding of the connection between detention and suicide. In many places of the world, suicide is a leading cause of death in prisons. In France, for instance, suicide of prisoners represents more than 100 deaths per year; this means approximately half of the total deaths in prison. Suicide rates in prisons are seven times higher than in the community and are among the highest in Europe. Reducing prison suicide is a joint priority of both the health care system and of the justice ministry. The two systems need to permanently collaborate in order to prevent the risks leading to suicide (Chan Chee, 2019, p.112). To prevent suicide in prisons, periodically psychiatric tests should be conducted for the inmates and mental health awareness should be a priority. When these factors are accomplished, if prisoners have a specific request for assisted suicide, it should be an available option in order to prevent hanging or violent actions with the purpose to terminate life. In the first case, suicide prevention was mandatory as the victim was in a risk to commit suicide prior to his punishment. The risk of his suicide should have been constantly assessed by both specialized medical and custodial staff, close and constant observation of the victim, especially of the ways he avoided taking his medication was necessary, but because all of these measure to prevent his suicide, lacked, the Court established the State was responsible for the victim's suicide (Renolde v. France, 2009, para.64 (58)). In the second case, if the option of an assisted suicide was available for the victim, many torturing commutes from one institution to another might have been avoided. As the CRT reported that the hospital hosting the victim had a history of dubious deaths of its patients, it was once again emphasized that the negligence of institutions brings agony to patients instead of lighting their suffering (Campeanu v. Romania, 2014b, para.47).

The last comparison evaluates the decision of the Court in the two cases. In Renolde v. France, the Court proves very responsible in considering all the details of the case and in establishing the two severe violations in the case of a prisoner with a mental illness. The violation of the right to life is given by the fact that the prison facility and staff failed to prevent the victim from taking his own life after the evidence that he did not take his medication accused the facility of negligence for a vulnerable person in a poor mental health condition. The violation of Article 3 adds to the negligence of the State's institution as the prison gave the victim a large punishment of 45 days alone in a detention room that worsened the mental and physical health of the victim, leading to his suicide. The prison's internal decisions constituted torture and ill treatment and were among the factors directly causing the victim's death. In CLR on behalf of Valentin Campeanu v. Romania the Court proved to be trustworthy by accepting the case in the first place,

even if the representative NGO had no direct connection to the victim or other necessary interests that the regulation asked for in order for such a case to be admitted at the European Court of Human Rights. But due to the austere violations of Articles 2 and 3 of the Convention, the Court accepted the case and strongly sanctioned the Romanian state for its discriminative policy and negligence regarding its health and social systems. The two judgments represented an amazing starting point of discussion on the risks that detention facilities or State's institutions bring for people that are mentally ill. Both cases raised awareness on important topics such as suicide prevention and protection of mentally ill patients which are crucial in the fight of assisted suicide decriminalization.

This chapter created a parallel between a case where a mentally ill victim committed suicide in prison and a second case in which a mentally ill patient died due to institution's negligence. The two cases serve for a better understanding of the state's positive obligations towards the respect of the human rights of people with mental illness. After the two cases have been described following the line of their facts and judgments, a comparison was designed. The first point to compare was the violation of Article 2 in both cases as the continuous failure of states to protect human rights for mentally ill patients leads to numerous lost of lives. The second point of the analysis was meant to prove how State's negligence can violate Article 3, by inhumanly treating institutionalized people. The obligation to prevent people from experiencing torture and degrading treatment in State's institutions is exclusively that State's responsibility and it should be severely sanctioned by European Human Rights institutions. The next point of discussion was the connection between detention and suicide in the light of the fact that suicide is not only a problem of people that are free to take their own decisions, but it can happen to everyone, including to institutionalized people. The State has the positive obligation to lighten people's suffering not to increase it through degrading treatment. Lastly, the decision of the Court in both cases was debated as suicide prevention and the protection of mentally ill patients is essential when decriminalized suicide assistance is discussed.

Chapter 9: Methodology

The subject of the present thesis is divided into two different parts. The first part represents a critical review of the existing literature on the topic of mental health, human rights and assisted suicide, and the second part is an analysis of six different cases that strengthen the idea of the decriminalization of assisted suicide for people with mental illness. Chapter two explains the importance of mental health and what human rights are associated with it and then it shows four of the contemporary challenges on the matter. Then, the next chapter introduces the positive obligations of states and the negative ones, illustrating the importance of both for understanding what assisted suicide means for states that are signatories of the European Convention of Human Rights. Chapter four emphasizes how mental health and assisted suicide are interrelated. It does that by showing that not only mentally ill patients that are capable to consent to their medical treatment should have access to assisted suicide, but also those patients suffering from severe psychiatric conditions that lack the capacity to consent to their medical treatment but that deserve a painless end of life. The last chapter part of the literature review, presents the right to health and how it constitutes the basis of non-discrimination and obliges states to respect, protect and fulfill their duties in caring for people suffering from a mental illness in society. It is important to mention that the right to health not only serves in protecting people with mental illness in general, but it helps in avoiding discrimination between patients who can consent and those who cannot consent to their own treatment when it comes to how and when their life will end. The chapters mentioned bellow serve to the understanding of how human rights can be used for the protection of people with mental illness and how ethical debates such as assisted suicide are an important part of the permanently changing society in which we live.

The next part of the thesis, presents three chapters, each making a different comparison between two key cases that argue for the human rights of people with mental illness. In chapter six, suicide from a human rights perspective is discussed. The two cases explained here serve to introduce the wide margin of appreciation that States have, which most of the times constitutes a challenge in determining what positive or negative obligations a State has. Article 8 is then introduced as assisted suicide is a matter of the private life of an individual and should be protected. This chapter also introduces some key points of Article 3 that are directly connected to self-determination in end-of-life decisions. The last point, which in each chapter expresses the critical view of the author, assesses the judgments of the European Court of Human Rights in both cases. The next chapter presents the way in which the end of life is viewed from the perspective of the Human Rights Convention as there are no specific rights that protect either people with mental illness per se or the option of assisted suicide. Both matters are derived from the cases that were judged by the Court during many years. The two cases picked in this chapter are suitable in establishing the positive obligations of states in protecting and assisting their citizens that already took the decision to end their life. Then Article 2 is analyzed once again, but this time in the view of the protection of vulnerable people's lives. The chapter also contains the importance of Article 8 for all members of the family containing a mentally ill person, not just

for the person itself. The last part, expresses once again, a critical view on the Court's decision. Chapter eight gives the details of the connection between detention and suicide, in order to emphasize that suicide is not only the thought of people that are part of the community, but this pressing problem passes through the minds of some of the institutionalized people as well. This chapter, through the two cases chosen, analyzes Articles 2 and 3 and the thin wire that connects detention to suicide, and then ends with the last critique of the judgment of the Court.

Limitations

The limitations to the literature review were strong as the present thesis tried to keep away from first giving details on the mental health conditions of the people it was referring to, this was done in order not to confuse technical details on the different mental health conditions. Then, the definition of assisted suicide was not precisely stated as this thesis is a European study and because different countries use different definitions, they were all put under the umbrella of assisted suicide. These definitions include: euthanasia, physician-assisted death (PAD), euthanasia or physician-assisted suicide (EAS). Another limitation was the lack of data that shows the connection between assisted suicide and mental health, especially when it comes to those mentally ill patients that lack consent to their medical treatment. Lastly, the literature stayed away from choosing a specific country or geographical area and tried to keep its arguments in the European Sphere as the Member States of the European Convention on Human Rights have very different views on assisted suicide, and only very few of them have started to decriminalize it or to even open the debate on the protection of people with mental health conditions that might consider committing suicide. Unfortunately, for some countries in Europe, even suicide is still a sensitive subject and little awareness exists and only few prevention mechanisms are functional.

There were certain limitations worth mentioning for the cases analysis as well. The first one was the lack of knowledge on the legislation of the countries discussed in the cases mentioned. National jurisdictions are crucial in establishing which countries can agree to what human rights. In countries such as the Netherlands, where assisted suicide is partly decriminalized, the national laws makes it possible for people to have access to end their life in dignity, and at the same time, the same laws can prevent abuses and regulate more who has access to assisted suicide and under what conditions. In jurisdictions such as the Romanian one, where assisted suicide is not at all mentioned and mental health is not a priority, violent and unassisted suicides are more frequent and people are more unaware of their options to relief their pain. The last downside of this thesis is that there is little knowledge about the human rights implementation mechanisms available in every country that signed the European Convention. Because the civil society in every country has a different way of acting on the protection of the human rights of people with mental illness, there is a very little possibility for quantifying common ways in the decriminalization of assisted suicide as this topic is a very controversial and debated one.

Chapter 10: Conclusion

After introducing the topic in the first chapter, the second one presents the vulnerabilities of mental health that can be used to shape future public policy. A more inclusive society for mental health is desired for a reinforcement of the most important human rights. The role of expressing the most urgent issues concerning mental health is to explain the chosen topic and its connection to human rights. One problem identified in this chapter is the depravation of liberty for people with mental illness which can lead to inhuman and degrading treatment. Then another problem identified was the institutional corruption that produces abuses for the institutionalized mental health patients. Then, there is the global neglect in mental health care which creates stigma and violations of different articles of the Convention. If states do not act immediately, goals such as suicide prevention will be very difficult to achieve as mental health is an increasingly common issue of our contemporary society. Lastly, the need for more autonomy in decision making towards end of life scenarios was discussed.

Chapter three underlined the difference between the positive obligations of states and the negative ones. The positive obligations are used when states need to take certain actions in order to protect the human rights of their people. States also have the positive duty to understand that each obligation creates one or more different sub-rights such as personal autonomy or the right of people with mental health problems to self-determination. Then the positive obligations of states should be more applicable Europe even if all states have their own restrictive national legislations. Another strong point of this chapter was finding the negative obligations that serve the assisted suicide argument. The first negative obligation of states in not to interfere with a person's human right and when a physician refuses to alienate a patient's pain due to cultural, religious or personal beliefs, he or she might violate the human rights of that patient. Then, states have the negative obligation not to take actions with the purpose of interfering with an individual's self-determination and this leads us to assisted suicide as a possibility to respect an individual's autonomy. Another negative obligation is not to interfere with the alternatives that could be available to a patient's life treatment. By respecting this, the States does not interfere with the wish of a mentally ill patient and with the moral judgment as well as with the professional opinion of physicians and other experts on the field. Finally, states have the negative obligation not to interfere with the medical progress and human rights development as assisted suicide, in some cases, might prove the only way to relief the anguish of a mentally ill patient.

The fourth chapter expresses the right to end of life decisions for the two distinct groups or vulnerable mental ill people. The first part argues that people with mental illness that have the option to consent to their treatment should be able to do so in relation to assisted suicide as well. The reasons for that are that euthanasia is a mechanism to alienate suffering that cannot be minimized even with a proper medical care. Moreover, considering assisted suicide from a human rights perspective is essential in understanding its challenges. Autonomy is another key issue presented in this chapter as decisional people are entitled to their self-determination. The

next important part of this chapter, and a very controversial one, is the right to assisted suicide for people that are mentally ill and that lack the capacity to consent to their own medical treatment. One reason for this argument is that assisted suicide might be the only possible solution to avoid unnecessary pain after all other possible measure to heal an individual had already proved ineffective. Another strong point expressed here is that assisted suicide is a strong way to prevent unassisted and painful suicides because just the knowledge that there might be an alternative to one's current situation can be enough for this person to choose life.

Chapter five argues that the right to health is very useful in protecting the mentally ill. The first point expressed here is that the right to health contains the right to be free from forced medical treatment as this is crucial for mentally ill patients that sometimes the only thing they have under control is their consent in day to day situations. The right to health also supports the same dispositions of Article 3 as it prevents people with mental illness from experiencing degrading treatment when they are institutionalized. Assisted suicide constitutes an option of avoiding life-long medical treatments such as sedation and other medical procedures that transform the life of a severe mentally ill patient. Another way in which the right to health can be used is to protect psychiatric patients from experiencing discrimination and this will be best illustrated in the legal cases discussed in the next chapters. Lastly, the right to health is a primary guardian to the obligations that States need to take in order to respect, protect and fulfill with the most pressing human rights of people with mental disabilities.

Chapter six explains the connection between suicide and human rights by analyzing two key cases from the European Court of Human Rights: Preety v. UK and Haas v. Switzerland. The first part of this chapter gives the requiring details of each of the two cases, following their facts and their judgments and then it delivers a comparison between the two. The first important feature is the wide margin of appreciation that states have in connection to assisted suicide as very few of them legalized it in their national jurisdictions. The second feature is the rights that Article 2 guards in relation to the right to life and to what kind of life. The next comparison point was the violation of Article 3 that can be useful in the assisted suicide debate, as keeping a person from committing suicide can constitute inhumane and degrading treatment, especially if it is against the person's free will. The last point described in this chapter is the judgment of the Court and its importance in the process of better understanding assisted suicide as well as about the ways in which this can be achieved through the European Convention of Human Rights.

Chapter seven argues for the possibility of ending life in dignity with the use of human rights. For this, there have been two other analyzed cases, Koch v. Germany and Fernandes de Oliveira v. Portugal. The way the cases were chosen was in order for them to be against as many different states as possible. And even if the cases chosen are quite different between each other, this thesis tried to tackle the connections and similarities between them. This chapter analyzed the two cases, ending with a critique for the Court's judgment. The most important ideas hit were the positive obligations of states in human rights protection. Then the debate of Article 2 as it serves

in protecting vulnerable people and the consequence of this article for people who already firmly decided to take their own life whether their jurisdictions permit it or not. Another strong point of this chapter is once again, Article 8 as the respect of private and family life encourages people to be more open about their situation and avoid abuses from institutions or from those around them persuading them towards a certain medical treatment or future decision. The critique recognizes the way States have the responsibility to promote suicide prevention and how the Court articulates this duty.

The last chapter interprets two important cases which best explain the connection between detention and suicide having as central motif, the negligence of State's institutions. The cases debated are Renolde v. France and Centre of Legal Rsources on behalf of Valentin Campeanu v. Romania. The comparison between them first shows the violation of Article 2 but this time showing the failure of states to keep two men alive in their institutions. The next debate point was the violation of Article 3 which shows the way careless staff working in State's institutions can facilitate harmful treatment for those institutionalized. Another strong point of this comparison was the expression of the idea that suicide is not only experience by people that are free to take their own decisions, but these ultimate ideas cross the minds of people in care of State's institutions as well. Lastly, the thesis ends with another critical discussion on the Court's decision in both cases. And right at the end a discussion on the methodology used, as well as on the limitations encountered while conducting this study, is initiated.

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