Chapter 5

Life and Death

Introduction

Including a chapter on death in a book about the rights of people with mental disabilities may seem unnecessarily morbid. Unfortunately, the intersections between mental disability and death are numerous. Suicidal behaviour is considered to be a symptom of a mental health problem, and suicides can reportedly be reduced if depression and anxiety are treated.¹ Mental disability and death are further related by grossly elevated mortality rates in some psychiatric or social care institutions, with people dying from hypothermia and malnutrition. Deaths sometimes occur during or after incidents of over/mis-medication and the use of physical restraints. The ECHR’s provision on ‘right to life’ is engaged if a State takes inadequate measures to prevent a death in a psychiatric or social care institution. It is also engaged when a State fails adequately to investigate deaths within institutions. These two major topics are the focus of this chapter.

Suicide

European health ministers have recently pledged to address suicide prevention and the causes of harmful stress, violence, depression, anxiety and alcohol and other substance use

¹ See WHO Euro Region Briefing on Suicide Prevention, accessed at http://www.euro.who.int/mental-health.
disorders. The statistics are alarming: from 1950 to 1995 the global rate of suicide increased by 60% and among young and middle-aged people, especially men, suicide is currently a leading cause of death even in developed countries. According to the latest available data, an estimated 873,000 people around the world kill themselves every year, suicide being the thirteenth leading cause of death globally and seventh in the WHO’s European region. The highest rates in the European region are also the highest in the world. Suicide rates vary across Europe, with 5.9 suicides per 100,000 population in Italy, rising to 36.4 in Russia.

The causes of suicidal behaviour are a complex interaction of a number of interrelating factors including psychiatric such as major depression, schizophrenia, alcohol and other drug use, and anxiety disorders; biological factors or genetic traits (family history of suicide); life events (loss of a loved one, loss of a job); psychological factors such as interpersonal conflict, violence or a history of physical and sexual abuse in childhood, and feelings of hopelessness; social and environmental factors, including availability of the means of suicide (firearms, toxic gases, medicines, herbicides and pesticides), social isolation and economic hardship.

Although suicide has been de-criminalized in most European States and therefore people with capacity are free to take their own life, suicide is relevant to the ECHR when a person in a State-run institution such as a prison or psychiatric hospital takes her own life, raising questions of adequate supervision by the State.

Deaths in institutions

Sadly, deaths do sometimes occur in psychiatric institutions. First, people lose their lives in institutions as a result of suicide or homicide. A 2003 Amnesty International report documented one psychiatric hospital in Romania where at least four patients had died following assaults by other patients. These psychiatric incidents reportedly occurred in circumstances in which patients had not been adequately supervised by staff of appropriate number and with appropriate training.

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2 Mental Health Declaration for Europe, WHO European Ministerial Declaration (Helsinki: January 2005), EUR/04/5047810/6, Article 10ix.
4 The United Kingdom’s Mental Health Foundation reports that in the United Kingdom suicides are the second highest cause of death after accidents.
6 WHO Euro Region Briefing on Suicide Prevention, accessed at http://www.euro.who.int/mentalhealth.
7 A suicide attempt, or suicidal ideation are factors which are sometimes taken into account in the decision to detain someone under mental health legislation.