ISSN 2056-3922

International Journal of Mental Health and Capacity Law

Articles and Comment

Casenotes

northumbria UNIVERSITY NEWCASTLE

[2016] IJMHCL pages 71-143

International Journal of Mental Health and Capacity Law

[2016] IJMHCL pages 70–143 ISSN 2056-3922

The International Journal of Mental Health and Capacity Law is a peer reviewed open access journal devoted to the intersection between law, mental health and mental capacity. It builds on the well-reputed Journal of Mental Health Law, with a revised name to reflect its wider focus. It also follows the desire of its predecessor to combine academic articles and commentary with material that is designed to be used by practitioners – lawyers, and medical or social work professionals – in these nuanced areas.

The Editors are keen to receive academic articles, both shorter ones of around 5000 words and longer ones of up to 12,000 words; and practice points, case notes and reports of research of around 5000 words. Submissions should be made via the Journal's website - http://journals.northumbria.ac.uk/index.php/IJMHMCL/index - and comply with the directions given there as to process. Manuscripts should comply either with the Oxford University Standard for Citation of Legal Authorities (http://www.law.ox.ac.uk/publications/oscola.php) or the APA Referencing Style Guide. If you use footnotes, we encourage short footnotes.

Submissions must be original, properly reference any third party material and comply with any copyright limitations. Any possible conflicts of interest must be identified. If an article reflects original research involving human participants, a statement is required that relevant ethical requirements have been met, including an indication as to which body gave ethical approval for the research and the relevant reference number.

All submissions will be peer-reviewed by a double blind peer review process before being accepted for publication; naturally, there will be a process whereby an article may be accepted subject to minor or more major amendments being made. We will endeavour to provide feedback as to why any rejected submission has been rejected.

Contents

Page

Editorial

Articles and Comment

Casenotes

This issue has been edited by:
Dr Daniel Wang (Lead Editor), Alex Ruck Keene, Dr Ruth Fletcher, Dr Catherine Penny and Prof Richard Ashcroft

Editorial assistance has been provided by:
Emma Vogelmann

EDITORIAL
DEPRIVATION OF LIBERTY IN A HEALTH AND SOCIAL CARE CONTEXT: DOLS AND THE WAYS FORWARD

Deprivation of Liberty Safeguards (DoLS) were introduced in England and Wales in 2007 and came into force in 2009 as a response to the European Court of Human Rights decision in the case of *HL v UK*.[1] The Court held that the lack of legal safeguards for incapacitated adults deprived of their liberty in hospitals and care homes, the so-called 'Bournewood gap', was a breach of Article 5 (Right to liberty and security) of the European Convention on Human Rights.

Recent developments have reinforced the importance of discussions about the future of DoLS. First, the House of Lords Select Committee post-legislative scrutiny of the Mental Capacity Act 2005 concluded in 2014 that DoLS, due to their excessive complexity and lack of clarity, are not 'fit for purpose' and called for them to be replaced. Second, the Supreme Court decision in *Cheshire West and Cheshire Council v P*[2]clarified that an incapacitated person, whose care arrangements are the state's responsibility, is to be considered objectively deprived of her liberty if she is subject to continuous supervision and control and is not free to leave. This is the case irrespective of the person's compliance or lack of objection and of the relative normality of the placement or the reason for it. This decision has had a major impact on social and health care bodies, who have been overwhelmed by the consequent increase in the number of applications.[3] Baroness Hale, who wrote the leading opinion in *Cheshire West*, recognized the need for a system that expands the protection to placements outside hospitals and care homes, but that does not need to be as elaborate as DoLS.[4] Considering the findings of the House of Lords Select Committee and the Supreme Court decision in *Cheshire West,* the Law Commission is currently working on proposals to replace DoLS with a system that would suit health and social care providers and users better.

In the context of a general acceptance that legal reforms are necessary, this issue of the IJMHCL brings together research articles and contributions based on relevant experience in legal practice and policy-making to discuss deprivation of liberty in health and social care settings. This issue draws on the 'Rethinking Deprivation of Liberty in a Health and Social Care Context' conference held in London on 30 September, 2015. This conference, convened by the Department of Law at Queen Mary University of London with the support of the Wellcome Trust[5], assembled experts from different jurisdictions to consider alternatives to DoLS. It was convened – in part – to inform the Law Commission's deliberations as to the replacement for DoLS, a project which remains underway as at the date of publication.[6]

---

[1] *HL v UK* (2004) 40 EHRR 761.
[2] *Cheshire West and Chester Council v P* [2014] UKSC 19.
[3] Health and Social Care Information Centre (2015). *Mental Capacity Act (2005) Deprivation of Liberty Safeguards (England): Annual Report, 2014-2015*.
[4] *Cheshire West and Chester Council v P* [2014] UKSC 19 para 57.
[5] Grant number 109046/Z/15/Z.
[6] See Law Commission (2015) *Mental Capacity and Deprivation of Liberty: A Consultation Paper*, Consultation Paper 222, and *Mental Capacity and Deprivation of Liberty: Interim Statement* (May 2016), available at http://www.lawcom.gov.uk/wp-content/uploads/2016/06/mental_capacity_interim_statement.pdf

One of the overarching conclusions that can be drawn from the conference and this IJMHCL issue is that the debate about DoLS – and indeed any regime for the authorising of deprivation of liberty – should be part of a broader conversation about how to reconcile health and social care users' need for care and support with their right to liberty and autonomy. Meeting needs and protecting rights rarely have to be competing objectives.

This edition starts with Eilionóir Flynn's 'Deprivation of Liberty Safeguards and International Human Rights Law: Reconciling European and International Approaches'. The author engages with the question of whether disability-specific forms of deprivation of liberty are in themselves compatible with both the European Convention on Human Rights (ECHR) and the United Nations Convention on the Rights of Persons with Disabilities (CRPD). This article analyses the difficulties for domestic legislation of reconciling Article 5(1)(e) of the ECHR, which authorizes restrictions to liberty based on a mental disability, and Article 14 of the CRPD, which can be interpreted as ruling out any disability-specific form of deprivation of liberty. This sets the scene for Eilionóir Flynn's analysis of the current law in England and Wales and the Law Commission's proposals to replace DoLS.

Gordon R. Ashton offers a critical analysis of DoLS from his personal perspective as a judge of the Court of Protection and as the parent of a social care service user. 'DoLS or quality care', discusses the relation between legal safeguards and the quality of the patients' care. Gordon R. Ashton argues that the former does not guarantee the latter and may even be detrimental to it depending on how they are perceived or applied. A whistle blowing procedure is proposed as an alternative to DoLS.

'Deprivation of Liberty: the position in Scotland', by Laura J. Dunlop Q.C., discusses the response to the 'Bournewood gap' and to *Cheshire West* proposed by the Scottish Law Commission. A decision not to adopt DoLS in Scotland was made in light of the difficulties with its operation in England and Wales. The author, who served on the Scottish Law Commission, discusses the challenges of developing a scheme that is easy to operate, sensitive to different individual circumstances, protective of the liberty of adults with incapacity, and compatible with the jurisprudence of the European Court of Human Rights.

A case-study on the application of the current legal framework for protecting the right to liberty of psychiatric patients is offered by Benjamin Perry, Swaran Singh and David White in 'Capacity Assessment and Information Provision for Voluntary Psychiatric Patients: A Service Evaluation in a UK NHS Trust'. Based on data collected from one mental health trust they suggest that more needs to be done to ensure vulnerable individuals are not being coerced to consent to treatment or are accepted as informal patients without a proper assessment of their mental capacity to consent.

Widening the perspective further, Bo Chen discusses the protection of the rights of persons with mental disabilities in China in '*Xu vs. the Hospital and his Guardian – Involuntary Inpatient Treatment'*. Mental health legislation was introduced in China in 2013 to elevate the threshold for involuntary inpatient treatment there but, as shown in this case note, the application of the law raises questions about the compliance of the Chinese legislation with the CRPD. This case note also highlights the challenges

of implementing legislation that is protective of the right to liberty of people with mental disabilities in a context where social care in the community is insufficient.

We would like to acknowledge the editorial support provided by Emma Vogelmann, the peer reviewers for their careful revision of the articles, and the overall guidance provided by Kris Gledhill as the IJMHCL Editor-in-Chief.

Daniel W. Liang Wang
Queen Mary University of London

Alex Ruck Keene
39 Essex Chambers

Ruth Fletcher
Queen Mary University of London

Catherine Penny
King's College London

Richard Ashcroft
Queen Mary University of London

DISABILITY, DEPRIVATION OF LIBERTY AND HUMAN RIGHTS NORMS: RECONCILING EUROPEAN AND INTERNATIONAL APPROACHES

EILIONÓIR FLYNN*

ABSTRACT

Persons with disabilities are subject to unique forms of deprivation of liberty, often justified by reference to the need to protect their right to life, right to health, and to protect the human rights of others. This paper examines disability-specific forms of deprivation of liberty, particularly those authorised in mental health and capacity law, in light of their compliance with European and international human rights frameworks. It explores the apparent tension between Article 5 of the European Convention on Human Rights, which permits deprivation of liberty of 'persons of unsound mind' in certain circumstances, and Article 14 of the UN Convention on the Rights of Persons with Disabilities, which states that 'the existence of a disability shall in no case justify a deprivation of liberty.' The challenges in attempting to comply with both provisions are illustrated through reference to developments in England and Wales. This paper also seeks to offer a way forward for States Parties to both Conventions, in order to protect the rights of persons with disabilities.

I. INTRODUCTION

This paper seeks to address the perceived conflict in the framing of the right to liberty in both the European Convention on Human Rights (ECHR) and the Convention on the Rights of Persons with Disabilities (CRPD). In particular, my analysis will focus on Article 5 ECHR and Article 14 CRPD, with reference to the case law of the European Court of Human Rights and the standpoint of the UN Committee on the Rights of Persons with Disabilities in General Comment 1 and its Guidance on Article 14. I explore the argument that depriving persons with disabilities of their liberty is necessary to protect their right to life (and to a lesser extent their right to health), and critique this from the standpoint of the CRPD. While the main focus of this paper is on the relevant international standards, I will briefly illustrate their application to domestic law in England and Wales, particularly the Mental Health Act, Mental Capacity Act, the Law Commission's reform proposals and relevant domestic and ECHR case law on the perceived conflict between the right to life and the right to liberty. Finally, I will set out some recommendations for reconciling the perceived conflict in international standards on the right to liberty in domestic and European legal frameworks, in a manner which I believe best respects the human rights of persons with disabilities.

II. ARTICLE 5(1)(e) ECHR – DEPRIVATION OF LIBERTY FOR 'PERSONS OF UNSOUND MIND'

This article sets out the right to liberty under the Convention, stating that: "Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law." An exception is provided for "the lawful detention of persons for the prevention of the

* Eilionóir Flynn (BCL, PhD) is a Senior Lecturer at the School of Law and Deputy Director of the Centre for Disability Law and Policy, National University of Ireland Galway.

spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants."[1]

Bearing in mind that the Convention was adopted in 1950 and came into force in 1953, its language and approach must be placed in the context of its time. While the legal position on deprivation of liberty for these populations in many States Parties to the ECHR has evolved since the treaty text was adopted, the Convention has not kept pace with these developments, nor with the new expressions of the right to liberty in international human rights law, particularly as set out in the Convention on the Rights of Persons with Disabilities. However, before considering the position of the ECHR in light of new developments in international human rights law, it is worth setting out briefly the jurisprudence of the European Court of Human Rights concerning Article 5 as it applies to persons with disabilities.

The European Court has justified the deprivation of liberty of persons of unsound mind on the basis that they may be a danger to public safety[2] but also that should be detained in their own 'best interests' to provide them with medical treatment[3] (usually non-consensual treatment). In *Winterwerp v The Netherlands*, the court clarified that 'unsound mind' means that on the basis of 'objective medical evidence' the person must be found to have 'a true mental disorder … of a kind or degree warranting compulsory confinement.'[4] States are given a wide margin of appreciation by the court to determine who is a person of unsound mind,[5] and the majority of the case law on this provision focuses on people labelled with intellectual and psychosocial disabilities. The court's jurisprudence is heavily reliant on medical evidence of impairment and as a justification for the necessity of detention, and in general, placement in a medical setting or an institution with medical supervision is required by the court where Article 5(1)(e) is engaged.[6] While the court emphasises that such evidence must be 'objective' it has not, to date, significantly challenged the perceived objectivity of such evidence, considering this to form part of the margin of appreciation accorded to states in implementing the Convention.[7]

Persons with disabilities face many different kinds of deprivation of liberty including detention by police, imprisonment, involuntary confinement in hospitals, psychiatric institutions and social care homes. In determining whether a person was deprived of liberty, the European Court will examine whether the individual was free to leave the restricted area, the degree of supervision and control over the person's movements, the extent of isolation or segregation from others and contact with the broader community, as well as the absence of consent to this confinement.[8] In terms of what the Court considers 'valid' consent, the case law has held where a person who is

[1] Article 5(1)(e), European Convention on Human Rights.
[2] *Hutchison Reid v the United Kingdom* (2003) 37 EHRR 211, para. 52.
[3] *Guzzardi v Italy* (1980) 3 EHRR 333.
[4] *Winterwerp v the Netherlands* (1979) 2 EHRR 387, para. 39.
[5] *Plesó v Hungary* App no. 41242/08 (ECHR, 17 January 2012), para. 61; *H.L. v the United Kingdom* (2004) 40 EHRR 761, para. 98.
[6] *L.B. v Belgium* App no 22831/08, (30 July 2013), para. 93; *Ashingdane v the United Kingdom* (1985) 7 EHRR 528, para. 44; *O.H. v Germany* App no 4646/08, (ECHR 24 November 2011), para. 79.
[7] *Rakevich v Russia* App no. 44914/09 (28 October 2003), para. 26.
[8] *Guzzardi v Italy* (1980) 3 EHRR 333, para. 95; *H.M. v Switzerland* (2002) 38 EHRR 314, para. 45; *H.L. v the United Kingdom* (2004) 40 EHRR 761, para. 91; *Storck v Germany* (2005) 43 EHRR 96, paras. 73 and 74; *Stanev v Bulgaria* (2012) 55 EHRR 22, para. 117.

'incompetent' to give consent, the fact that he or she did not object to the deprivation of liberty should not be regarded as equivalent to consent.[9] The nature of confinement as well as the absence of the person's consent, are two significant issues for persons with disabilities – especially those with significant and complex intellectual and psychosocial disabilities – which has generated significant commentary in English case law and subsequent literature, as will be explored further below.

The aim of Article 5 is to ensure that no one is deprived of liberty in an arbitrary manner. In order to guarantee that a deprivation of liberty is not arbitrary, it must be undertaken in a manner that is prescribed in national law, and be compliant with the provisions of the ECHR.[10] With regard to the deprivation of liberty of persons of 'unsound mind', the Court has found that various instances of detention were 'arbitrary' if they were undertaken with no formal authority, or were not subject to judicial scrutiny.[11] Bartlett has further noted that while Article 5 seeks to defend against arbitrary detention, the practice of domestic bodies in many Council of Europe member states in authorising detention on the basis of disability often amounts to simply rubber-stamping the original decisions made by clinicians and social services, and he calls on the court to give clearer guidelines on the robust safeguards required to deter these practices.[12]

However, the Court has not yet considered whether the designation of an individual as a person of 'unsound mind' is itself an arbitrary construct. First, the term 'unsound mind' is relatively imprecise which could lead to arbitrariness. Second, even if 'unsound mind' is interpreted more strictly and linked to a diagnosis of disability or mental illness, the attribution of these labels to individuals have also been shown to be subject to wide socio-cultural variation.[13] For example, Kirk and Kutchins' seminal study[14] on the reliability of psychiatric diagnoses showed that "the ranges of reliability for major diagnostic categories were found to be very broad, and in some cases ranged the entire spectrum from chance to perfect agreement, with the case summary studies (in which clinicians are given detailed written case histories and asked to make diagnoses – an approach that most closely approximates what happens in clinical practice) producing the lowest reliability levels."[15] This research demonstrates the

[9] *H.L. v the United Kingdom* (2004) 40 EHRR 761, para. 91.
[10] *Plesó v Hungary* App no. 41242/08 (ECHR, 17 January 2012), para. 59
[11] *Stanev v Bulgaria* (2012) 55 EHRR 22, para. 145; *Shtukaturov v Russia* (2008) 54 EHRR 27, para. 114.
[12] Peter Bartlett, 'A mental disorder of a kind or degree warranting compulsory confinement: examining justifications for psychiatric detention' (2012) 16(6) *International Journal of Human Rights* 831 at 832.
[13] See for example, Sami Timimi, 'No More Psychiatric Labels: Campaign to Abolish Psychiatric Diagnostic Systems such as ICD and DSM (CAPSID)' (2013) 40(4) *Self & Society* 6; Peter Kinderman, John Read, Joanna Moncrieff and Richard P. Bentall, 'Expert Review: Drop the Language of Disorder' (2013) 16 *Evidence Based Mental Health* 2; Peter Kinderman, 'Mental health law and incapacity: The role of the Clinical Psychologist' (2002) *Journal of Mental Health Law* 179; Henrick Anckarsäter, 'Beyond categorical diagnostics in psychiatry: scientific and medicolegal implications' (2010) 33 *International Journal of Law and Psychiatry* 59; Mark Rapley, Joanna Moncrieff and Jacqui Dillon, *De-medicalizing misery* (Great Britain: Palgrave Macmillan, 2011); Joanna Moncrieff and Sami Timimi, 'The social and cultural construction of psychiatric knowledge: an analysis of NICE guidelines on depression and ADHD' (2013) 20(1) *Anthropology & Medicine* 59; Tanya Marie Luhrmann, 'Social defeat and the culture of chronicity: or, why schizophrenia does so well over there and so badly here' (2007) 31(2) *Culture, Medicine and Psychiatry* 135.
[14] Stuart A. Kirk and Herb Kutchins, 'The myth of the reliability of DSM' (1994) 15(1) *Journal of Mind and Behavior* 71.
[15] Sami Timimi, 'No More Psychiatric Labels: Campaign to Abolish Psychiatric Diagnostic Systems such as ICD and DSM (CAPSID)' (2013) 40(4) *Self & Society* 6 at 8.

potentially arbitrary manner in which diagnostic categories for mental illness are applied.

The case law of the Court on the definition of 'unsound mind' also references underlying concepts of risk of harm to self or others. Determining when a risk of harm is present is also highly subjective and a potentially arbitrary construct.[16] As Simons and many other scholars have noted, "[n]o evidence-based research supports the proposition that clinicians can accurately predict when, or even if, an individual will commit an act of violence toward oneself or others."[17] To date the Court has not addressed these questions about the arbitrariness of designating an individual to be of 'unsound mind' – however, as will be discussed further below, there is a trend in more recent interpretations of international human rights law to consider detention on the basis of disability to be a form of arbitrary detention, and this is likely to be a matter the court will soon confront in its own jurisprudence.

While there have been advances in the Court's case law on liberty in broadening the scope of locations in which it recognises a deprivation of liberty can occur,[18] and the recognition that a person's acquiescence to a deprivation of liberty does not necessarily constitute valid consent[19] a number of significant challenges remain. First, the Court's case law has not yet addressed whether people with disabilities can be deprived of liberty in their own homes or private residences, although domestic case law in England[20] has determined that such forms of deprivation of liberty do breach Article 5 rights. Second, the Court's jurisprudence on Article 5 generally focuses on whether the correct procedures prescribed in national law have been followed, rather than examining the substantive issue of whether the deprivation of liberty is justified on its merits. The main findings of violations of Article 5 for persons with disabilities to date, including *Stanev*, have therefore been based on procedural irregularities at the national level. As a result, the Court has found relatively few violations of Article 5 in cases of involuntary detention and treatment of persons with psychosocial disabilities.

The Court is of course restricted in its scope here by the wording of Article 5 which includes reference to a 'procedure prescribed by law' and by the wide margin of appreciation accorded to States to determine whether a deprivation of liberty is necessary in an individual case. For these reasons, since the Court's jurisprudence has not yet addressed the core question of whether disability-specific deprivations of liberty are in themselves human rights violations, I will not analyse in further detail the significant body of ECHR case law on Article 5. However, there are possibilities even within the narrow scope of Article 5 for increasing findings of violations under the ECHR – particularly where proportionality tests are used to demonstrate that less restrictive alternatives to detention should be used in order to pursue the State's legitimate aim of protecting the totality of the individual's human rights (including the

[16] Joanna Moncrieff, '"Freedom is more important than health": Thomas Szasz and the problem of paternalism' (2014) 11(2) *International Psychiatry* 46 at 47.
[17] Robert I. Simon, 'The Myth of Imminent Violence in Psychiatry and the Law' (2006) 75 *University of Cincinnati Law Review* 631. See also See Alex D. Pokorny, 'Predictions of Suicide in Psychiatric Patients' (1983) 40 *Archives General Psychiatry* 249; Douglas Mossman 'Assessing Prediction of Violence' (1994) 62 *Journal of Consulting and Clinical Psychology* 783.
[18] *Stanev v Bulgaria* (2012) 55 EHRR 22.
[19] *H.L. v the United Kingdom* (2004) 40 EHRR 761.
[20] *P (by his litigation friend the Official Solicitor) v Cheshire West and Chester Council and another*, *P and Q (by their litigation friend, the Official Solicitor) v Surrey County Council* [2014] UKSC 19.

right to health and the right to life). I will explore this idea further below where I reference the alternatives to detention and forced treatment which are gaining recognition since the entry into force of the CRPD.

In short, the Court's position on the deprivation of liberty of persons of unsound mind has been to accept it as necessary (and not a de facto human rights violation), to tightly control such measures and review the resulting deprivation of liberty to determine its ongoing necessity. This differs significantly from the most recent expression of the right to liberty and security in international human rights law, Article 14 CRPD. However, it is important to state here that the ECHR is permissive towards this kind of deprivation of liberty, rather than requiring all States to guarantee that they will in fact deprive persons of unsound mind of their liberty. This may seem like an obvious point, but it is worth restating. In efforts to reconcile State obligations under European and international human rights law, some commentators, especially those who have incorporated the ECHR into their domestic law, have argued that the ECHR **requires** the deprivation of liberty of certain persons with disabilities.[21] This is simply incorrect. While Article 5 allows for deprivations of liberty for this population it certainly does not require it. Neither does it **require** deprivations of liberty for 'drug addicts and vagrants', and indeed, in most States Parties to the Convention, it is no longer permissible to detain individuals just by labelling them an addict or a vagrant. Therefore, a State Party which has ratified the ECHR may be perfectly compliant with Article 5 if it does not permit the deprivation of liberty of persons of unsound mind who are perceived to be a danger to themselves or others.

This misconception must be addressed in any effort to reconcile the perceived tension between the ECHR and other international instruments such as the CRPD. While it is of course true that the ECHR permits disability-specific deprivations of liberty, whereas the CRPD does not,[22] it is still important to remember that a State can comply with both treaties by having a regime that does not permit any disability-specific deprivations of liberty. Further, many Council of Europe states have ratified both the ECHR and the CRPD. Most of these states take a monist approach to international law so that the CRPD automatically becomes part of domestic law following ratification. Article 5 requires that legislative frameworks on deprivation of liberty 'comply with national law' – and where national law includes the CRPD following ratification or incorporation, this can be used as a justification for states to abolish disability-specific forms of deprivation of liberty in a manner consistent with Article 14 CRPD.

However, the UK has a dualist system, which means of course that the CRPD is not justiciable in domestic courts unless it is incorporated in domestic law, which has not occurred to date. This must be contrasted with the UK position on the ECHR, which has been incorporated in domestic law through the Human Rights Act 1998, and can

[21] See for example, Law Centre Northern Ireland, Submission to the Ad Hoc Joint Committee on the Mental Capacity Bill (Belfast, 2015), available at: <http://www.niassembly.gov.uk/globalassets/documents/ad-hoc-mental-capacity-bill/written-submissions/law-centre-ni.pdf> (last accessed 12 January 2016).

[22] See Philip William Hugh Fennell and Urfan Khaliq, 'Conflicting or complementary obligations? The UN Disability Rights Convention, the European Convention on Human Rights and English law' (2011) 6 *European Human Rights Law Review* 662 and Peter Bartlett, 'A mental disorder of a kind or degree warranting compulsory confinement: examining justifications for psychiatric detention' (2012) 16(6) *International Journal of Human Rights* 831.

be directly argued through the domestic courts. Nevertheless, it is also worth noting that the UK, upon ratification of the CRPD, did not enter any declarations or reservations concerning deprivation of liberty and involuntary treatment under Articles 12, 14 or 25. The UK ratified in 2009, at which point the position of the CRPD Committee on Article 14 and its implied prohibition on all disability-specific forms of deprivation of liberty had been made clear through a number of Concluding Observations,[23] as had the UN High Commissioner on Human Rights' interpretation to the same effect.[24] Therefore, the UK Government should have been aware of the meaning of Article 14, and its failure to enter reservations or interpretative declarations on this matter can be taken as an indication of its intent to comply fully with the requirements of this article.

Even without explicit legislative incorporation, domestic courts in the UK have already referred to the CRPD in 73 cases involving persons with disabilities as a persuasive authority in international law.[25] In two of these cases Article 14 CRPD has been used by domestic UK courts to inform their interpretation of the rights conferred by the ECHR. In *AH v West London Mental Health Trust*, the Upper Tribunal interpreted s 12(2)(a) of the Tribunals, Courts and Enforcement Act 2007 in a way that was consistent with the right in Article 6 of the ECHR (to a fair trial) "re-enforced by article 13 of the CRPD".[26] The result was that a person deprived of their liberty under the Mental Health Act "should have the same or substantially equivalent right of access to a public hearing as a non-disabled person who has been deprived of his or her liberty".[27]

A similar issue was raised in the series of cases starting with *Re X* – in which the Court of Protection[28] and the Court of Appeal[29] grappled with the question of whether an individual, who is the subject of an application for the deprivation of his/her liberty, should be made a party to the relevant Court of Protection proceedings. Ultimately, in a subsequent decision, Mr Justice Charles interpreted the procedural requirements of Articles 13 and 14 of the CRPD as to require independent representation – which he felt could, in the majority of cases, be provided by members of the person's family.[30] Therefore, he found that the CRPD would require the relevant person to be joined as a party to the proceedings only when there was no other way to guarantee their independent representation in court. While these cases only dealt with procedural

[23] See for example Consideration of Reports Submitted by States Parties under Article 35 of the Convention: Concluding Observations, Tunisia, Committee on the Rights of Persons with Disabilities (CRPD), 5th Sess., at 4, UN Doc CRPD/C/TUN/CO/1 (11–15 April 2011); Consideration of Reports Submitted by States Parties under Article 35 of the Convention: Concluding Observations, Spain, Committee on the Rights of Persons with Disabilities (CRPD), 6th Sess, at 5, UN Doc CRPD/C/ESP/CO/1 (19–23 September 2011).

[24] See UN High Commissioner for Human Rights, Annual Report, A/HRC/10/48 (26 January 2009) at [48].

[25] For further analysis of these judgments, see Anna Lawson and Lucy Series, 'The United Kingdom' in Anna Lawson and Lisa Waddington (eds) *Interpreting and Domesticating the UN Convention on the Rights of Persons with Disabilities: A Comparative Analysis of the Role of Courts* (Oxford University Press, 2017) forthcoming.

[26] [2011] UKUT 74 (AAC) at 22 per Carnwath LJ.

[27] Ibid.

[28] *X & Ors (Deprivation of Liberty)* [2014] EWCOP 25 and *Re X and others (Deprivation of Liberty) (Number 2)* [2014] EWCOP 37.

[29] *Re X (Court of Protection Practice)* [2015] EWCA Civ 599.

[30] *NRA & Others* [2015] EWCOP 59 at para 158.

issues and did not address the core content of Article 14 CRPD, they open the door for further consideration of the framing of this right in the CRPD in domestic case law on deprivation of liberty.

Some scholars, such as Minkowitz,[31] have further argued that even where the CRPD does not form part of national law, its content should supersede prior treaties (such as the Hague Convention on the International Protection of Adults) addressing disability-specific issues, including the rights to liberty and security. This argument is based on Article 30 of the Vienna Convention which sets out rules for reconciling 'successive treaties relating to the same subject-matter.' However, the Vienna Convention's primary focus is on the relationship between states parties who have ratified the same treaties, rather than on the obligations a state has to its citizens in implementing its international obligations in domestic law. Nevertheless, the principle it establishes is an important one, and as the CRPD represents the most recent expression of how the right to liberty should be applied to persons with disabilities, as well as a text which was negotiated with significant involvement of persons with disabilities,[32] I believe that states would do well to regard this interpretation as the best means to ensure equal application of universal human rights in the specific context of disability.

III. ARTICLE 14 CRPD – PROHIBITING DISABILITY-SPECIFIC DEPRIVATIONS OF LIBERTY

Article 14(1)(b) CRPD requires States Parties to ensure "that the existence of a disability shall in no case justify a deprivation of liberty." This wording was initially put forward by the Working Group which developed the first draft of the Convention text. During the negotiation of the CRPD, States and civil society debated whether this provision should be framed to ensure that disability could not be the sole or exclusive basis for a deprivation of liberty. Canada, Australia, Uganda, China and New Zealand suggested adding the term 'solely based on disability' and the EU favoured the term 'exclusively based on disability' to this provision. Such an approach would have meant that the existence of a disability combined with the risk of harm to self or others could justify a deprivation of liberty. Many states, including Mexico and South Africa[33] and civil society organisations, including the International Disability Caucus and the World Network of Users and Survivors of Psychiatry[34] strongly opposed the proposal to include the term 'solely' or 'exclusively' in Article 14, and as a result, the final wording is as above.

This wording, and the fact that other options were considered and ultimately rejected, means that Article 14 must be read to prohibit all deprivations of liberty where the existence of disability is a factor in justifying the detention. Although there are scholars who disagree with this interpretation,[35] and some who have argued that an

[31] Tina Minkowitz, 'Comments on CRPD and Hague Convention on the International Protection of Adults', available at <www.chrusp.org> (last accessed 12 January 2016).
[32] Rosemary Kayess and Phillip French, 'Out of Darkness into Light? Introducing the Convention on the Rights of Persons with Disabilities' (2008) 8 *Human Rights Law Review* 1.
[33] Ad Hoc Committee, Third Session, Daily summary of discussions, May 26, 2004; Fifth Session, Daily summary of discussions, January 26, 2005.
[34] Ad Hoc Committee, Fifth Session, Daily summary of discussions, January 26, 2005.
[35] See for example Melvyn Colin Freeman et al, 'Reversing hard-won victories in the name of human rights: a critique of the General Comment on Article 12 of the UN Convention on the Rights of Persons with Disabilities' (2015) 2(9) *Lancet Psychiatry* 844; John Dawson, 'A realistic approach to assessing

assessment of decision-making capability can serve as the basis for detention if it is undertaken in a disability-neutral manner,[36] the majority of the literature published since the Convention entered into force has acknowledged that Article 14 represents a prohibition on forms of detention where disability is one of the grounds for the deprivation of liberty.[37] From the time the CRPD was adopted, this is the interpretation favoured by scholars who were actively involved in the negotiations,[38] as well as the UN Office of the High Commissioner for Human Rights,[39] and the UN Committee on the Rights of Persons with Disabilities,[40] the treaty body responsible for monitoring the Convention. In all dialogues which the Committee has undertaken to date with States Parties, it has urged States to repeal existing laws which provide for preventative detention on the basis of disability, including laws which permit institutionalisation and forced treatment. For example, in the Committee's concluding observations on Australia, it recommended as a matter of urgency that the State "review its laws that allow for the deprivation of liberty on the basis of disability, including psychosocial or intellectual disabilities, repeal provisions that authorize involuntary internment linked to an apparent or diagnosed disability."[41]

The right to liberty and to be free from forced medical interventions in Article 14 is closely connected to the right to legal capacity in Article 12. In the Committee's General Comment on Article 12, it described the relationship between the two articles as follows: "The denial of the legal capacity of persons with disabilities and their detention in institutions against their will, either without their consent or with the consent of a substitute decision-maker, is an ongoing problem. This practice

mental health laws' compliance with the UNCRPD' (2015) 40 *International Journal of Law and Psychiatry* 70.

[36] See George Szmukler, Rowena Daw, and Felicity Callard, 'Mental health law and the UN Convention on the Rights of Persons with Disabilities' (2014) 37(3) *International Journal of Law and Psychiatry* 245.

[37] See for example Bernadette McSherry, 'International trends in mental health laws: Introduction' (2008) 26(2) *Law in Context* 1; Annegret Kampf, 'The Disabilities Convention and its consequences for mental health laws in Australia' (2008) 26(2) *Law in Context* 10; Anna Nilsson, 'Objective and Reasonable? Scrutinising Compulsory Mental Health Interventions from a Non-discrimination Perspective' (2014) 14(3) *Human Rights Law Review* 459; Peter Bartlett, 'The United Nations Convention on the Rights of Persons with Disabilities and the future of mental health law' (2009) 8(12) *Psychiatry* 496; Tina Minkowitz, 'The United Nations Convention on the Rights of Persons with Disabilities and the right to be free from nonconsensual psychiatric interventions' (2007) 34(2) *Syracuse Journal of International Law and Commerce* 405; Arlene S. Kanter, *The Development of Disability Rights under International Law: From Charity to Human Rights* (Routledge, 2014); Anna Nilsson, 'Objective and Reasonable? Scrutinising Compulsory Mental Health Interventions from a Non-discrimination Perspective' (2014) 14(3) *Human Rights Law Review* 459.

[38] See Tina Minkowitz, 'The United Nations Convention on the Rights of Persons with Disabilities and the right to be free from nonconsensual psychiatric interventions' (2007) 34(2) *Syracuse Journal of International Law and Commerce* 405; Tina Minkowitz, 'Why Mental Health Laws Contravene the CRPD–An Application of Article 14 with Implications for the Obligations of States Parties' (2011) *SSRN Working Paper Series*, available at <http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1928600> (last accessed 25 June 2016); Arlene S. Kanter, *The Development of Disability Rights under International Law: From Charity to Human Rights* (Routledge, 2014).

[39] UN High Commissioner for Human Rights, Annual Report, A/HRC/10/48 (26 January 2009) at [48].

[40] UN Committee on the Rights of Persons with Disabilities, Guidelines on Article 14 (adopted September 2015), available at: <http://www.ohchr.org/Documents/HRBodies/CRPD/GC/GuidelinesArticle14.doc> (last accessed 20 January 2016).

[41] UN Committee on the Rights of Persons with Disabilities, Concluding observations on the initial report of Australia, adopted by the Committee at its tenth session (2-13 September 2013) CRPD/C/AUS/CO/1 at para 32(c).

constitutes arbitrary deprivation of liberty and violates articles 12 and 14 of the Convention."[42] Further, this General Comment makes clear that functional assessments of mental capacity cannot be used as justifications for denials of legal capacity which discriminate in purpose or effect against persons with disabilities.[43] This means that the authorization of deprivation of liberty on the grounds that the person lacks mental capacity to consent to a particular living arrangement or medical treatment is prohibited under Article 12 CRPD. Such an interpretation has been critiqued by those in favour of involuntary detention and treatment,[44] but has been warmly welcomed by many disabled people's organisations,[45] scholars actively involved in the drafting of the CRPD,[46] and is also echoed by the UN Working Group on Arbitrary Detention.[47]

The most recent expression of the Committee's interpretation of Article 14 is its guidelines, published in September 2015. While the guidelines do not have the status of a General Comment,[48] they nonetheless represent the most up to date interpretation of Article 14 and give context for how the Committee will address States which come before it. These guidelines make clear that the Committee understands Article 14 to

[42] CRPD/C/GC/1, para 36.
[43] Ibid, paras 12 and 13.
[44] See for example Melvyn Colin Freeman et al, 'Reversing hard-won victories in the name of human rights: a critique of the General Comment on Article 12 of the UN Convention on the Rights of Persons with Disabilities' (2015) 2(9) *Lancet Psychiatry* 844; John Dawson, 'A realistic approach to assessing mental health laws' compliance with the UNCRPD' (2015) 40 *International Journal of Law and Psychiatry* 70.
[45] See for example World Network of Users and Survivors of Psychiatry and Center for Human Rights of Users and Survivors of Psychiatry, *Response to Draft General Comment on Article 12* (New York, 2014) available at: <http://www.ohchr.org/EN/HRBodies/CRPD/Pages/DGCArticles12And9.aspx> (last accessed 30 June 2016); People with Disabilities Australia, the Australian Centre for Disability Law and the Australian Human Rights Centre, *Submission to the Australian Law Reform Commission: Equality, Capacity and Disability in Commonwealth Laws* (Sydney, July 2014), available at: <https://www.alrc.gov.au/sites/default/files/subs/136._org_people_with_disability_australia_pwda__the_australian_centre_for_disability_law_acdl_and_australian_human_rights_centre_.pdf> (last accessed 1 July 2016); Sociedad y Discapacidad, *Submission to the CRPD Committee on the Draft General Comment on Article 12* (Lima, 2014), available at: <http://www.ohchr.org/EN/HRBodies/CRPD/Pages/DGCArticles12And9.aspx> (last accessed 1 July 2016).
[46] Tina Minkowitz, 'The United Nations Convention on the Rights of Persons with Disabilities and the right to be free from nonconsensual psychiatric interventions' (2007) 34(2) *Syracuse Journal of International Law and Commerce* 405; Tina Minkowitz, 'Why Mental Health Laws Contravene the CRPD–An Application of Article 14 with Implications for the Obligations of States Parties' (2011) *SSRN Working Paper Series*, available at <http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1928600> (last accessed 25 June 2016); Arlene S. Kanter, *The Development of Disability Rights under International Law: From Charity to Human Rights* (Routledge, 2014).
[47] UN General Assembly, Report of the Working Group on Arbitrary Detention: United Nations Basic Principles and Guidelines on the right of anyone deprived of their liberty to bring proceedings before a court (New York, 4 May 2015) WGAD/CRP.1/2015.
[48] A General Comment is an authoritative interpretation of the text of a treaty provision by its monitoring body, but is not legally binding on states who ratify the treaty in the same way that the treaty text is binding. For more detail on the legal status of General Comments, see Helen Keller and Leena Grover (2012): 'General Comments of the Human Rights Committee and their Legitimacy,' in Helen Keller, Geir Ulfstein and Leena Grover (eds), *UN Human Rights Treaty Bodies: Law and Legitimacy*, (Cambridge University Press, 2012), 116-198; Phillip Alston, 'The historical origins of the concept of "General Comments" in human rights law', in Laurence Boisson de Chazournes and Vera Gowland-Debbas (eds), *The International Legal System in Quest of Equity and Universality: Liber Amicorum Georges Abi-Saab* (Martinus Nijhoff, 2001), 775.

include an absolute prohibition of detention on the basis of 'perceived or actual impairment.' The Committee's guidelines also go further than previous interpretations of Article 14, for example, that put forward by the UN High Commissioner for Human Rights, who had suggested in 2009 that it would be in conformity with the CRPD to have disability-neutral laws on preventative detention.[49] Bartlett interprets the High Commissioner's perspective to mean that the use of 'dangerousness' or some other facially neutral criteria for preventative detention might be permissible under CRPD.[50] However, the Committee has now moved away from talking about disability-neutral criteria for detention in its Guidelines on Article 14. Instead, it states that "[t]he involuntary detention of persons with disabilities based on risk or dangerousness, alleged need of care or treatment or other reasons tied to impairment or health diagnosis is contrary to the right to liberty, and amounts to arbitrary deprivation of liberty."[51]

However, this perspective is not shared by all UN human rights treaty bodies. The Human Rights Committee published General Comment 35 just a few months before the CRPD Committee's Guidelines on Article 14. In this general comment, the Human Rights Committee states that "The existence of a disability shall not **in itself** justify a deprivation of liberty but rather any deprivation of liberty must be necessary and proportionate, for the purpose of protecting the individual in question from serious harm or preventing injury to others. It must be applied only as a measure of last resort and for the shortest appropriate period of time, and must be accompanied by adequate procedural and substantive safeguards established by law."[52]

This position is in direct conflict with the CRPD, but appears closer to the position of the ECHR. However, the Human Rights Committee's approach also conflicts with more recent developments in the UN Working Group on Arbitrary Detention, which revised its Basic Principles in May 2015. This document references "the State's obligation to prohibit involuntary committal or internment on the ground of the existence of an impairment or perceived impairment, particularly on the basis of psychosocial or intellectual disability or perceived psychosocial or intellectual disability, as well as [the] obligation to design and implement de-institutionalization strategies based on the human rights model of disability."[53] Therefore, while there is a discrepancy between the interpretations of the universal right to liberty at the international level, it is clear that the two most recent expressions of this right as applied to disabled people – by the CRPD Committee and the Working Group on Arbitrary Detention, favour an absolute prohibition of disability-specific deprivations of liberty.

[49] UN High Commissioner for Human Rights, Annual Report, A/HRC/10/48 (26 January 2009) at 48.
[50] Peter Bartlett, 'The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law' (2012) 75(5) *Modern Law Review* 752.
[51] UN Committee on the Rights of Persons with Disabilities, *Guidelines on Article 14* (adopted September 2015), available at: <http://www.ohchr.org/Documents/HRBodies/CRPD/GC/GuidelinesArticle14.doc> (last accessed 20 January 2016) at para 14.
[52] CCPR/C/GC/35, para. 19.
[53] WGAD/CRP.1/2015, para. 56.

IV. LIFE VS LIBERTY – A FALSE HIERARCHY OF HUMAN RIGHTS?

Many different justifications for deprivation of liberty in order to protect other human rights are offered by those in favour of maintaining disability-specific deprivations of liberty. Typically, these arguments centre on the notion that the detention is necessary in the 'best interests' of the person and is defensible from a human rights perspective if it is done with the goal of protecting the individual's right to life or health, or the right to life of others.[54] Those who support detention on the basis of the right to health argue the necessity of detention to provide needed but unwanted care and treatment, to restore the person's capacity to take autonomous decisions, to protect the person from self-harm or from exploitation and abuse by others. However, I do not find these justifications for detention particularly convincing, given the significant body of literature which establishes that where a person is engaging or at risk of self-harm, care and support can be provided by non-coercive means, even in situations of acute crisis and distress.[55]

In cases of harm to others, along with Minkowitz,[56] Kanter,[57] O'Mahony and Gooding[58] I support the proposition that these should be addressed through the criminal justice system, with the appropriate reasonable accommodations and support to enable the person to effectively participate in the process. Where the person is exposed to, or at risk of harm from others who seek to abuse or exploit her, I contend that it is a disproportionate response to deprive the victim of abuse of her liberty, and that instead, responses should focus on the perpetrator of abuse.[59] Given these findings, the purported justification of deprivation of liberty that appears to hold the most legitimacy to me concerns the right to life. Some scholars have argued that at a

---

[54] See for example, Jos Dute, 'European court of Human Rights. ECHR 2014/6 Case of Arskaya v. Ukraine, 5 December 2013, no. 45076/05 (fifth section)' (2014) 21(2) *European Journal of Health Law* 204.

[55] See for example Shery Mead, *Intentional Peer Support: An Alternative Approach* (Community Mental Health Services, 2014); Coral Muskett, 'Trauma-informed care in inpatient mental health settings: A review of the literature' (2014) 23(1) *International Journal of Mental Health Nursing* 51; John Gleeson, Henry J. Jackson, Heather Stavely and Peter Burnett, 'Family intervention in early psychosis' (1999) *The recognition and management of early psychosis: A preventive approach* 376; Jolijn Santegoeds, 'The Eindhoven Model and Family Group Conferencing: An Alternative to Forced Psychiatry' (Conference of State Parties to the CRPD, New York, July 2013); Gideon Jong, Gert Schout and Tineke Abma, 'Prevention of involuntary admission through family group conferencing: a qualitative case study in community mental health nursing' (2014) 70(11) *Journal of Advanced Nursing* 2651; Swedish National Board of Health and Welfare, "A New Profession is Born – Personligt ombud, PO," Västra Aros, Västerås, November 2008, 10, available at: <http://www.personligtombud.se/publikationer/pdf/A%20New%20Proffession%20is%20Born.pdf> (last accessed 1 July 2016); Deborah Gold, '"We Don't Call It a 'Circle'": The Ethos of a Support Group' (1994) 9(4) *Disability and Society* 435; Jaakko Seikkula and Mary E. Olson, 'The open dialogue approach to acute psychosis: Its poetics and micropolitics' (2003) 42(3) *Family process* 403.

[56] Tina Minkowitz, 'Why Mental Health Laws Contravene the CRPD–An Application of Article 14 with Implications for the Obligations of States Parties' (2011) *SSRN Working Paper Series*, available at <http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1928600> (last accessed 25 June 2016).

[57] Arlene S. Kanter, *The Development of Disability Rights under International Law: From Charity to Human Rights* (Routledge, 2014) at 252.

[58] Piers Gooding and Charles O'Mahony, 'Laws on unfitness to stand trial and the UN Convention on the Rights of Persons with Disabilities: Comparing reform in England, Wales, Northern Ireland and Australia' (2016) 44 *International Journal of Law, Crime and Justice* 122.

[59] Anna Arstein-Kerslake and Eilionóir Flynn, 'The General Comment on Article 12 of the Convention on the Rights of Persons with Disabilities: a roadmap for equality before the law' (2016) 20(4) *The International Journal of Human Rights* 471.

European level, Article 2 ECHR imposes a substantive obligation on States to initiate a deprivation of liberty if necessary to protect the right to life of the person or others.[60] In this sense, a jurisprudence of a 'hierarchy of rights' is often referred to, with the right to life trumping the right to liberty. I will now explore this claim in more detail with reference to ECHR case law.

It is important at the outset of this analysis to clearly distinguish between state obligations to protect the right to life of those at risk of suicide, and those at risk of being killed by others. Two ECtHR cases to date have dealt with a threat to life posed by private individuals (one of which involved a diagnosis of mental illness), and three have dealt with the risk to life posed by suicide. I will first address the cases involving risk to life by third parties and then turn to the risk to life posed by suicide. It was established in *Osman v UK*[61] that the right to life in Article 2 ECHR includes a positive obligation on States 'to take appropriate steps to safeguard the lives of those within their jurisdiction.' This obligation on the authorities is of a general nature, however it becomes a more specific and operational obligation where 'the authorities knew or ought to have known at the time of the existence of a real and immediate risk to the life of an identified individual or individuals from the criminal acts of a third party and that they failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk.'[62]

In this case, a teacher, Mr. Paget-Lewis had shot and killed Mr. Ali Osman (whose son, Ahmed was also wounded in the shooting). Mr. Paget-Lewis had been suspended from work following a psychiatric evaluation at the time of the shooting. However, the Court found that in this case that the applicants had failed to show that the authorities knew or ought to have known that the lives of Mr. Osman and his son were at real and immediate risk from the teacher. Therefore, the Court found that there was no violation of Article 2 by the UK. This is an important ruling as the Court did not suggest here that the authorities should have involuntarily detained or forcibly treated Mr. Paget-Lewis in order to prevent the killing of Mr. Osman. In particular, the steps taken by the school authorities, including informing the police of their concerns about Mr. Paget-Lewis and suspending him from teaching duties pending an investigation into alleged unprofessional behaviour with Ahmed Osman, were found by the Court to be proportionate to protect the right to life in Article 2 ECHR.

However, in *Kayak v Turkey*,[63] the Court found that the authorities had failed to protect the right to life of a 15 year old who was stabbed to death in the playground of the boarding school he attended. The attack was carried out by another student who was 18 years old at the time, using a bread knife stolen from the school canteen. In this case, the Court held that the authorities had failed in their duty to ensure supervision of the school premises. Supervision of the premises was deemed by the court to be an operational obligation which was a proportionate response to the risk of danger posed to students. The Court reiterated that school authorities had an essential role to play in the protection of the health and well-being of pupils – having regard to their

[60] See for example Sascha Mira Callaghan and Christopher Ryan, 'Is there a future for involuntary treatment in rights-based mental health law?' (2014) 21(5) *Psychiatry, Psychology and Law* 747.
[61] *Osman v UK* (1998) 29 EHRR 245 at para. 115. See also *L.C.B. v United Kingdom* (1998) 27 EHRR 212, para. 36.
[62] Ibid, para. 116.
[63] *Kayak v Turkey* App no 60444/08, (ECHR 12 July 2012).

particular vulnerability due to their age – and a primary duty to protect them against any form of violence to which they might be subjected while under the school's supervision. While the school staff could not be expected to watch each pupil all the time, movements inside and outside the school required heightened surveillance. One of the distinguishing features of this case compared to Osman v UK is that the killing happened on school property, as opposed to at the applicants' home. Therefore, in cases where persons with psychosocial disabilities pose a risk to the lives of others, the Court has not required preventive detention or forced treatment to be used, but has rather required States to take appropriate steps to protect potential victims where a threat to their lives is, or should be, known to the relevant authorities.

I now turn to consider the ECHR cases involving a threat to life from suicide. In *Reynolds v UK*,[64] the Court found that the National Health Service had failed in its operational duty to protect David Reynolds' right to life. He had reported hearing voices telling him to kill himself and was admitted to hospital as a voluntary patient. The staff reported that he seemed calmer a few hours after his admission and was assessed as a low suicide risk. At one point during the evening he was found walking outside the unit and encouraged by staff to come back inside, which he did. Later that evening he broke the glass and jumped out of the window in his room on the sixth floor and subsequently died. The applicant, his mother, successfully argued that the National Health Service had violated her son's right to life under Article 2 ECHR, as they were aware of the risk to his life by suicide and did not take appropriate steps to respond to that risk.

However, while the Court recognised that a violation had occurred, it did not provide further detail in this case about what kinds of steps should have been taken by the authorities to preserve Mr. Reynolds' right to life. It must be emphasised that the Court did not suggest that Mr. Reynolds should have been involuntarily detained or treated against his will in order to preserve his life. Further, the Court did not draw a link between David Reynolds' right to life under Article 2 and his right to liberty under Article 5 or suggest that one right took priority over the other. The applicant had not raised the question of whether Mr. Reynolds' rights to liberty were violated while he was a voluntary patient; therefore, the Court did not comment on this issue.

A violation of the right to life in Article 2 was also found in another case involving a hospital death, *Arskaya v Ukraine*. In this case, a 42 year old man died after refusing surgical intervention for a lung condition. The man, S, had refused surgery as he was 'in fear for his life' and was described by clinicians as euphoric and emotionally unstable during the 11 days he spent in the hospital from his initial admission until his death. The Court held that Article 2 "obliges the national authorities to prevent an individual from taking his or her own life if the decision has not been taken freely and with full understanding of what is involved … It follows that one of the central issues in determining the validity of a refusal to undergo medical treatment by a patient is the issue of his or her decision-making capacity."[65]

Essentially, this decision implies that S's treatment refusal should not have been respected, and that his legal capacity to consent to treatment should have been

[64] *Reynolds v the United Kingdom* App no 2694/08, (ECHR 13 March 2012).
[65] App no. 45076/05 (ECHR 5 December 2013), para. 69.

removed and vested in a third party, such as a guardian. However, S was not attempting or requesting to leave the hospital, and did consent to less intrusive medical treatment, but consistently refused surgery. The Court did not consider whether his right to liberty had been infringed in this case. Nevertheless, if the hospital staff had refused to respect S's treatment decision regarding the bronchoscopy, as the Court found they should have done, and forced him to undergo treatment against his will in order to save his life, this would inevitably involve a restriction of his right to liberty, at a minimum, during the surgery. In this sense, the Court has implied, without specifically referring to Article 5, that the right to life supersedes other human rights, including the rights to liberty and autonomy, in situations where the person's life is at risk due to a physical illness and he or she is deemed to lack the decision-making capacity to provide informed consent or refusal of treatment.

In *Keenan v UK*, the Court also found that the State has a particular operational duty to protect the right to life of prisoners whose confinement places them at greater risk to their life, including the risk of suicide. Mark Keenan had assaulted two prison guards after a change in psychiatric medication which he said made him feel unwell. As punishment for the assault, he was placed in solitary confinement, where he hanged himself. Nevertheless, the Court found that in this case, the State had upheld its operational duty under Article 2 since "on the whole, the authorities responded in a reasonable way to Mark Keenan's conduct, placing him in hospital care and under watch when he evinced suicidal tendencies."[66] While this decision was made in the context of a prison environment, it can also be interpreted to provide guidance to other national authorities, including healthcare professionals, on reasonable steps to be taken where there is a real and identified risk to life by suicide.

Since in this case, the detention followed a criminal conviction and had occurred in accordance with the law, no separate consideration was made of whether the applicant's placement in a cell on the prison's punishment block violated his right to liberty under Article 5 ECHR. However, the Court did find that the way in which Mark Keenan had been treated by prison staff did amount to inhuman or degrading treatment or punishment, and recognised a violation of his rights under Article 3 ECHR. In particular, it is worth noting here that the Court also stated that "there are general measures and precautions which will be available to diminish the opportunities for self-harm, without infringing on personal autonomy"[67] and that it would need to be determined on a case by case basis whether other, more restrictive measures should be taken. This implies that approaches which respect autonomy must be taken first, before the national authorities can resort to any more coercive measures which might violate other rights protected by the ECHR, including the right to privacy in Article 8.

Finally, it must be noted that the European Court has clearly stated that the right to life in Article 2 does not imply a corresponding right to choose to end one's life, or to avail of assisted suicide. In *Pretty v UK*, the court held that no such right could be found in Article 2, 3 or 8 of the ECHR.[68] However, it also held that the legalisation of assisted suicide in a State Party to the Convention would not necessarily violate the operational duty to respect the right to life in Article 2.[69] It is significant that the Court has found

[66] *Keenan v the United Kingdom* (2001) 33 EHRR 38 para. 99.
[67] Ibid, para. 90.
[68] *Pretty v the United Kingdom* (2002) 35 EHRR 1 paras 39-40.
[69] Ibid, para. 41.

that in specific situations where a person's life is at risk from his own actions or the actions of others, the State has an obligation to intervene to protect life, in a manner that might compromise the other human rights protected under the Convention. At this point, it is worth considering how these distinct international obligations – under the CRPD and ECHR have been interpreted in domestic case law in England to date, with a view to providing recommendations for reform.

V. UK INTERPRETATIONS OF INTERNATIONAL OBLIGATIONS ON THE RIGHTS TO LIFE AND LIBERTY

The UK's approach to protecting the rights to life and liberty of persons with disabilities is more heavily reliant on the ECHR than on the CRPD, as disability-specific deprivations of liberty are still permitted through various legislative frameworks, primarily – in England and Wales – the Mental Health Act 1983 and the Mental Capacity Act 2005.[70] Before exploring the implications of these Acts in terms of human rights compliance and their interpretation in case law, it is worth briefly setting out the UK's position on domestic incorporation of human rights norms. As noted above, the ECHR has a particularly high status in the hierarchy of laws, being incorporated into domestic law through the Human Rights Act 1998. This legislation places an obligation on all public bodies (including providers of health and social care services) to comply with the ECHR in carrying out their functions. The 1998 Act also ensures that individual litigants can allege a violation of human rights protected in the ECHR in domestic courts, and that courts are empowered to make findings about the compatibility of domestic legislation with the ECHR.

The UK ratified the CRPD in 2009 and did not enter any interpretative declarations or reservations with respect to Article 14 on the right to liberty. However, in its Initial Report to the UN Committee on the Rights of Persons with Disabilities, the government maintains that "No one in the UK can be deprived of his or her liberty because he or she is disabled. If there are situations when it is necessary to detain a person who has a mental disorder, strict safeguards are in place to ensure that the needs of the individual are taken into account and respected."[71] The report then goes on to describe the various legal frameworks for civil commitment in the mental health system, the deprivation of liberty safeguards system in the Mental Capacity Act and the detention of offenders in the criminal justice system. This report fails to make the link between the CRPD requirement that disability shall 'in no case' be even one of the grounds for deprivation of liberty with the existing domestic legislation permitting deprivation of people with learning disabilities, mental health experience, dementia and other cognitive disabilities in the UK.

As is the case in most countries, legislation in England and Wales provides for the deprivation of liberty of persons with disabilities for the purpose of involuntary psychiatric treatment in the Mental Health Act 1983, and in situations where the person concerned is unable to consent to their living arrangement or medical treatment under the Mental Capacity Act 2005. The Mental Health Act 1983 allows for deprivation of

[70] Other regimes exist in Northern Ireland and Scotland, which are not discussed here.
[71] Office for Disability Issues, *UK Initial Report on the UN Convention on the Rights of Persons with Disabilities* (London: 2011), at para 132 available at <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/345120/uk-initial-report.pdf> (last accessed 26 January 2016).

liberty for involuntary psychiatric treatment in hospital where a person is deemed to have a 'mental disorder' – i.e. a 'disorder or disability of the mind.'[72] This term can include persons with learning disabilities where 'that disability is associated with abnormally aggressive or seriously irresponsible conduct.'[73] In addition to the existence of a mental disorder, the person can only be admitted for involuntary treatment under the Mental Health Act where 'it is necessary for the health and safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section and appropriate medical treatment is available for him.'[74] This provision was extended in the Mental Health Act 2007 to allow for compulsory treatment orders to be used outside a hospital setting in the community, a development which has been subject to significant critique by a number of commentators for its negative impact on the rights and freedoms of service users.[75]

In 2009, the Mental Capacity Act was amended to introduce legislative safeguards for disability-specific deprivations of liberty as a result of the *HL v UK*[76] decision from the European Court of Human Rights. This judgment found that there was a gap in the legal framework for voluntary patients in the mental health system who, like HL, are not in fact free to leave, and had not provided valid consent to their confinement. In this case, the European Court found that HL 'lacked capacity' to consent to his detention and treatment. In response, the Deprivation of Liberty Safeguards were introduced to give a legislative basis to ensure that all health and social care providers obtain authorisation for any deprivation of liberty proposed for adults who 'lacked capacity.' The safeguards provide that such deprivations must only be used for individuals who by reason of an impairment of, or disturbance in the functioning of the mind or brain, fail to pass a functional assessment of mental capacity.[77] In addition, the deprivation of liberty must be in the relevant person's best interests, must be necessary to prevent harm to the person, and be proportionate to the likelihood and seriousness of that harm. The safeguards aim to ensure that deprivations of liberty are independently authorised by local authorities, only occur in approved settings such as hospitals and care homes, are regularly reviewed, and subject to legal challenge – including through the assistance of an independent mental capacity advocate.

There is an extensive body of scholarly work on the effectiveness and human rights implications of the Deprivation of Liberty Safeguards, which is impossible to capture in any depth in this present article. However, it is worth noting that the recent explosion of interest in this topic at a national level has stemmed from two domestic developments – an inquiry undertaken by the House of Lords on the Mental Capacity Act and the Supreme Court decision in *Cheshire West*.[78] In particular, it is worth

[72] Section 1(2) Mental Health Act 1983 as amended by section 1, Mental Health Act 2007.
[73] Section 1(2A) Mental Health Act 1983 as amended by section 2, Mental Health Act 2007.
[74] Section 32, Mental Health Act 2007.
[75] See for example David Pilgrim, Bernice Pescosolido and Anne Rogers, *The Sage Handbook of mental health and illness* (Sage Publications, 2011); Simon Lawton-Smith, John Dawson and Tom Burns, 'Community treatment orders are not a good thing' (2008) 193(2) *The British Journal of Psychiatry* 96; Tom Burns and John Dawson, 'Community treatment orders: how ethical without experimental evidence?' (2009) 39(10) *Psychological medicine* 1583.
[76] *H.L. v the United Kingdom* (2004) 40 EHRR 761.
[77] Sections 4A and 4B, Mental Capacity Act 2005 as amended by sections 5(2) and 56, Mental Health Act 2007 and S.I. 2009/139, article 2(b) with article 3.
[78] *P (by his litigation friend the Official Solicitor) v Cheshire West and Chester Council and another*, *P*

highlighting that the House of Lords described the Deprivation of Liberty Safeguards as 'not fit for purpose' and found that better implementation would not be sufficient to redress the fundamental problems identified.[79] It recommended a comprehensive review of this aspect of the legislation incorporating widespread consultation and the provision of adequate time for parliamentary scrutiny. Work is currently underway at the Law Commission to review the legislation and develop recommendations for reform, described in further detail below.[80]

In respect of *Cheshire West*, the most important aspect of the decision for the present argument was Baroness Hale's ruling that the right to liberty must be a universal one[81] – and its content and related obligations should not therefore be varied for different population groups, such as persons with disabilities. This case involved three adults with learning disabilities who experienced various restrictions in their movements and/or would have been prevented from leaving the places where they lived (one litigant lived in adult foster care and the other two in care homes). The leading judgment written by Baroness Hale acknowledged that none of the litigants had made any efforts to leave, and that these placements were in their 'best interests' but nevertheless recognised that they were de facto deprived of their liberty under Article 5 ECHR, although the deprivations were justified under Article 5(1)(e) and did not give rise to a violation of the individuals' human rights.

Baroness Hale cited the CRPD in support of her argument about the universal nature of human rights for persons with disabilities, and acknowledged that the ECHR should be read 'in light of' the CRPD, and has indeed already begun to influence Strasbourg jurisprudence since the decision of *Glor v Switzerland*.[82] The positive developments in the ECHR jurisprudence which serve to align the court's position closer to the CRPD in cases involving deprivation of liberty and denial of legal capacity have been noted by Lewis[83] and Series,[84] among others. While the court can clearly continue to develop its jurisprudence in this direction, it will inevitably confront the stumbling block that Article 5(1)(e) justifies disability-specific forms of deprivation of liberty, whereas Article 14 CRPD does not, as discussed above. However, for states struggling to comply with both standards, as I argued above, moving away from the kind of detention permitted by the ECHR and towards the standard enshrined in the CRPD can certainly be undertaken, even where the CRPD is not directly applicable in domestic law. Justifications for moving away from the ECHR and towards the CRPD include the fact that the CRPD is the most recent expression of how international human rights norms

and Q (by their litigation friend, the Official Solicitor) v Surrey County Council [2014] UKSC 19.

[79] House of Lords Select Committee on the Mental Capacity Act 2005, *Mental Capacity Act 2005: post-legislative scrutiny* (London: 2014), available at <http://www.publications.parliament.uk/pa/ld201314/ldselect/ldmentalcap/139/139.pdf> (last accessed 1 February 2016).

[80] Law Commission, Mental Capacity and Deprivation of Liberty: A Consultation Paper (London: 2015) available at <http://www.lawcom.gov.uk/project/mental-capacity-and-deprivation-of-liberty/> (last accessed 4 January 2016).

[81] *P (by his litigation friend the Official Solicitor) v Cheshire West and Chester Council and another, P and Q (by their litigation friend, the Official Solicitor) v Surrey County Council* [2014] UKSC 19.

[82] App. No.13444/04, (ECHR 30 April 2009).

[83] Oliver Lewis, 'Advancing legal capacity jurisprudence' (2011) 6 *European Human Rights Law Review* 700.

[84] Lucy Series, 'Legal capacity and participation in litigation: recent developments in the European Court of Human Rights' in Gerard Quinn, Lisa Waddington and Eilionóir Flynn (eds) *European Yearbook of Disability Law Volume 5* (Intersentia: 2015), 107.

should apply to the lived experience of persons with disabilities,[85] and that its drafting involved unprecedented levels of participation of persons with disabilities,[86] including those with intellectual and psychosocial disabilities, who are arguably best placed to determine how deprivations of liberty, even when undertaken in the name of protection, care and treatment, affect their enjoyment of all human rights.

Much more can be read about domestic developments on deprivation of liberty in the UK in other articles within this volume, and in previous work by Stavert,[87] Penny and Exworthy,[88] and others. The ECHR dimensions of these developments have been explored in some detail – but the *Cheshire West* case does not raise questions of whether the right to liberty might be compromised in order to protect the right to life, or to protect other fundamental human rights, and so will not be discussed in further detail in this article. However, before considering further the case law on deprivation of liberty in England, it is worth briefly exploring the most up to date developments from the Law Commission's work on reforming the Deprivation of Liberty safeguards.

The Law Commission's Consultation Paper published in 2015 proposed the replacement of the existing Deprivation of Liberty Safeguards scheme with a new tiered system of 'protective care.'[89] This comprised of 'supportive care' for persons deemed to lack mental capacity to decide where to live but whose living arrangement did not amount to a deprivation of liberty; 'restrictive care' for those who lacked capacity and whose living arrangement did involve a deprivation of liberty, and a separate scheme for deprivation of liberty in hospitals and palliative care.[90] However, in May 2016, the Commission published an interim statement following receipt of submissions to its consultation process, indicating a shift away from this approach towards a more streamlined scheme for authorizing deprivations of liberty. According to this statement the Law Commission's revised proposals will only cover restrictive care and treatment and not include a separate hospital scheme. The Commission's interim statement proposes that "[t]he responsibility for establishing the case for a deprivation of liberty will be shifted onto the commissioning body (such as the NHS or local authority) that is arranging the relevant care or treatment, and away from the care provider. … The required evidence would include a capacity assessment and objective medical evidence of the need for a deprivation of liberty on account of the person's mental health condition."[91]

---

[85] Janet E. Lord and Michael Ashley Stein, 'The Domestic Incorporation of Human Rights Law and the United Nations Convention on the Rights of Persons with Disabilities' (2008) 83 *Washington Law Review* 449.

[86] Rosemary Kayess and Phillip French, 'Out of Darkness into Light? Introducing the Convention on the Rights of Persons with Disabilities' (2008) 8 *Human Rights Law Review* 1.

[87] Jill Stavert, 'Deprivation of Liberty and Persons with Incapacity: The Cheshire West Ruling' (2015) 19(1) *Edinburgh Law Review* 129.

[88] Catherine Penny and Tim Exworthy, 'A gilded cage is still a cage: Cheshire West widens "deprivation of liberty"' (2015) 206(2) *The British Journal of Psychiatry* 91.

[89] Law Commission, *Mental Capacity and Deprivation of Liberty: A Consultation Paper* (London: 2015) available at <http://www.lawcom.gov.uk/project/mental-capacity-and-deprivation-of-liberty/> (last accessed 4 January 2016).

[90] Ibid.

[91] Law Commission, *Mental Capacity and Deprivation of Liberty: Interim Statement* (London: 2016), available at <http://www.lawcom.gov.uk/wp-content/uploads/2016/06/mental_capacity_interim_statement.pdf> (last accessed 27 June 2016) at para 1.38.

This seems to suggest that deprivation of liberty will, under the new proposal, only be authorised based on the person's 'mental health condition' and not on other criteria such as the person's 'best interests'. However, the existing scheme operates under the Mental Capacity Act, which uses 'best interests' as the test by which decisions are made on behalf of a person who is deemed to lack capacity, and the Commission's suggestion that the process of depriving a person of liberty include a capacity assessment seems to indicate that 'best interests' standards will still play a role in this process. The use of the language 'mental health condition' in this proposal is suggestive of 'mental disorder' – the existing standard under the Mental Health Act, which includes both a diagnosis of mental illness and risk of harm to self or others. This proposal is not entirely clear in its current formulation – but seems to indicate a fusion of the approaches in existing capacity legislation with the regulation of involuntary detention under the Mental Health Act.

Further, the Commission states that since it will abandon its previous proposal for a separate hospital scheme, "there should be no additional mechanism inserted into the Mental Health Act to cater for compliant incapacitated patients."[92] This term covers those who, like HL in the *Bournewood* case, are admitted to psychiatric hospital without objecting, but who are deemed incapable of providing informed consent. The Commission notes that "if such patients are to be admitted to hospital (general or psychiatric) for purposes of assessment and treatment for mental disorder, their admission should be on the basis of the existing powers of the Mental Health Act."[93] This seems to suggest that patients who cannot provide informed consent to treatment must be treated as involuntary patients under the Mental Health Act, regardless of whether or not they object to their detention and/or treatment. While further clarification will be provided when the Law Commission publishes its final recommendations and draft bill in December 2016, it appears that the position in domestic law will continue to authorise deprivations of liberty for persons with disabilities based either on a diagnosis of mental illness or disability or determination of lack of mental capacity, consistent with ECHR jurisprudence but in contrast to the requirements of Article 14 CRPD.

I will now turn to two important domestic cases where the House of Lords and Supreme Court, respectively, considered whether a deprivation of liberty should have occurred in order to preserve an individual's right to life, in accordance with the provisions of the ECHR. In the first case,[94] Carol Savage had been detained under the Mental Health Act 1983. After three months of detention, she left the hospital without permission and walked to a nearby train station where she jumped in front of a train and was killed. Her daughter sued the NHS trust which managed the hospital under the Human Rights Act for failure to protect her mother's right to life under Article 2 ECHR. The Trust appealed to the House of Lords, arguing that Article 2 obligations should not apply to its staff in this case. However, the House of Lords dismissed this appeal, finding that the health service does have an operational duty under Article 2 ECHR to protect the lives of patients detained under the Mental Health Act. The judgment set out that the operational obligation arose only if members of staff knew or ought to have known that a particular patient presented a "real and immediate" risk of suicide. In those

[92] Ibid, at para. 1.45.
[93] Ibid.
[94] *Savage v South Essex Partnership NHS Foundation Trust and MIND (Intervener)* [2008] UKHL 74.

circumstances Article 2 ECHR required them to do all that could reasonably be expected to prevent the patient from committing suicide. This decision was partly based on the jurisprudence of the European Court of Human Rights in respect of the duties on prison staff to take steps to prevent prisoners from committing suicide.[95] If the hospital staff in this case were found to have failed to take reasonable steps, not only would they and the health authorities be liable in negligence, but the House of Lords held that there would be a violation of the operational obligation under Article 2 ECHR to protect the patient' right to life.

The question of whether the hospital staff knew or ought to have known of an immediate risk to Carol Savage's life, and whether they took all reasonable steps to prevent it, was referred back to the trial judge in the High Court. In this subsequent decision, Mackay J found that there was a real and immediate risk to Carol Savage's life, and that the staff had failed to take reasonable steps to prevent her from committing suicide, stating "all that was required to give her a real prospect or substantial chance of survival was the imposition of a raised level of observations, which would not have been an unreasonable or unduly onerous step to require of the defendant in the light of the evidence in this case."[96] However, it is interesting to note that in the earlier House of Lords judgment on this case, Lord Rodger commented that "Runwell Hospital could have kept Mrs Savage in a locked ward, instead of an open acute ward, could have subjected her to checks on her whereabouts every 15 minutes instead of the 30 minute checks that were prescribed at the time of her fatal absconding on 5 July 2004, and, no doubt, could have imposed other restrictions that would have made it virtually impossible for her to abscond. However the hospital were, in my opinion, entitled, and perhaps bound, to allow Mrs Savage a degree of unsupervised freedom that did carry with it some risk that she might succeed in absconding. They were entitled to place a value on her quality of life in the Hospital and accord a degree of respect to her personal autonomy above that to which prisoners in custody could expect."[97] In this case, Mrs. Savage had already been deprived of her liberty in a manner permitted by Article 5(1)(e) ECHR, but the trial judge's ruling suggests that further restrictions on her liberty, in the form of more frequent observations, should have been imposed as a result of the real and immediate risk to her life.

In the second case, Melanie Rabone,[98] a voluntary patient, committed suicide during a period of leave from hospital. She was admitted to hospital as an emergency following a suicide attempt and was assessed by the hospital as at high risk of a further suicide attempt. Although she was admitted as a voluntary patient she was informed that if she attempted or demanded to leave, she would be reassessed for involuntary detention under the Mental Health Act. After three weeks in hospital, she expressed a strong desire to be allowed home for a weekend visit. Her parents were concerned about whether she was well enough to return home, but her consultant agreed to two days leave. On the afternoon of the second day, Melanie told her mother that she was going to visit a friend, and hanged herself in a nearby park. Lord Dyson JSC held that

[95] *Keenan v the United Kingdom* (2001) 33 EHRR 38. See also *Slimani v France* (2006) 43 EHRR 49 and *Kilinc v Turkey* App No 40145/98 (ECHR 7 June 2005)
[96] *Savage v South Essex Partnership NHS Foundation Trust* [2010] EWHC 865 (QB) at para. 89.
[97] *Savage v South Essex Partnership Foundation Trust and MIND (Intervener)* [2008] UKHL 74 at para. 13.
[98] *Rabone v Pennine Care NHS Foundation Trust* [2012] UKSC 2.

there was a real and immediate risk to her life by suicide and that the hospital staff had failed to take reasonable steps to uphold their operational duty to protect her life. In this context, the House of Lords found that making Melanie an involuntary patient would have been a reasonable step to protect her right to life, stating "if she had insisted on leaving the hospital, the authorities could and should have exercised their powers under the [Mental Health Act] to prevent her from doing so".[99] Lord Dyson JSC further held that "the decision to allow Melanie two days home leave was one that no reasonable psychiatric practitioner would have made."[100]

This case sets a troubling precedent in domestic jurisprudence – and has been interpreted by Callaghan, Ryan and Kerridge to mean that people with mental illness should be pre-emptively detained as a means of suicide prevention.[101] These authors suggest that one approach to this problem would be to only detain psychiatric patients who lack the mental capacity to make a decision to leave; in keeping with the European Court decision in *Arskaya*.[102] However, at present, a lack of mental capacity is not a basis for detention or involuntary treatment under the Mental Health Act in England and Wales, although legislation to introduce a mental capacity-based system of detention and treatment has been enacted in Northern Ireland.[103] A lack of mental capacity is however one of the conditions for detention in accordance with the Deprivation of Liberty Safeguards under the Mental Capacity Act (England and Wales). In my view, none of these approaches are sufficient to protect the totality of the individual's human rights, either under the ECHR or the CRPD, and further efforts must be made to bring domestic law into compliance with international human rights standards, as I explore in the following section.

VI. TOWARDS A HUMAN RIGHTS-COMPLIANT SOLUTION AT DOMESTIC AND EUROPEAN LEVELS

As I have argued above, deprivation of liberty on the basis of a determination of either 'unsound mind' or lack of mental capacity is highly subjective and value-laden, and should therefore fall foul, in my view, of the requirement in both the ECHR and international human rights law that deprivations of liberty must not be arbitrary. Significant empirical research evidence shows that functional assessments of mental capacity are just as subjective and value laden as determinations of risk of harm to self or others.[104] While there are scholars who disagree with these findings, and argue

[99] Ibid at para. 34.
[100] Ibid at para. 43.
[101] Sascha Callaghan, Christopher Ryan and Ian Kerridge, 'Risk of suicide is insufficient warrant for coercive treatment for mental illness' (2013) 36(5) *International Journal of Law and Psychiatry* 374.
[102] App no. 45076/05 (ECHR 5 December 2013).
[103] Mental Capacity Act (Northern Ireland) 2016. For a critique of this Act's compliance with the CRPD, see Eilionóir Flynn, 'Mental (In)Capacity or Legal Capacity? A Human Rights Analysis of the Proposed Fusion of Mental Health and Mental Capacity Law in Northern Ireland' (2013) 64(4) *Northern Ireland Legal Quarterly* 485.
[104] See for example, Derek Morgan and Kenneth Veitch, 'Being Ms B: B, autonomy and the nature of legal regulation' (2004) 26 *Sydney Law Review* 107; Peter Kinderman, 'Mental health law and incapacity: The role of the Clinical Psychologist' (2002) *Journal of Mental Health Law* 179; Joanna Moncrieff, '"Freedom is more important than health": Thomas Szasz and the problem of paternalism' (2014) 11(2) *International Psychiatry* 46; Bruce J. Winick, 'The Side Effects of Incompetency Labeling and the Implications for Mental Health' (1995) 1 *Journal of Psychiatry, Public Policy and Law* 42; Sheila Wildeman, 'Protecting rights and building capacities: Challenges to global mental health policy in light

that there is an increasing coherence in the methods and findings of functional assessments of mental capacity,[105] the critique of these approaches by critical psychiatrists,[106] users and survivors of psychiatry,[107] disabled people's organisations[108] and human rights scholars[109] serves as a basis for challenging this perspective.

The criteria of risk of harm forms the current basis for decisions to detain patients under the Mental Health Act 1983, and this approach has been criticised by Callaghan, Ryan, and Kerridge for its vagueness and the difficulty in determining the extent of risk that should warrant detention.[110] Further, as these authors acknowledge, deprivations of liberty are not guaranteed to be effective in suicide prevention. The literature also demonstrates that less invasive responses to the risk of suicide can be far more effective than approaches involving force or coercion.[111] These alternatives are often trauma-based approaches, many of which have been developed by the people with

---

of the Convention on the Rights of Persons with Disabilities' (2013) 41(1) *The Journal of Law, Medicine & Ethics* 48.

[105] See for example Ruth Cairns et al., 'Reliability of mental capacity assessments in psychiatric in-patients' (2005) 187(4) *The British Journal of Psychiatry* 372; Jessica Wilen Berg, Paul S. Appelbaum and Thomas Grisso, 'Constructing competence: formulating standards of legal competence to make medical decisions' (1996) 156(9) *American Journal of Psychiatry* 345; Thomas Grisso and Paul S. Appelbaum, *Assessing competence to consent to treatment: A guide for physicians and other health professionals* (Oxford University Press, 1998).

[106] See for example Peter Kinderman, 'Mental health law and incapacity: The role of the Clinical Psychologist' (2002) *Journal of Mental Health Law* 179; Joanna Moncrieff, '"Freedom is more important than health": Thomas Szasz and the problem of paternalism' (2014) 11(2) *International Psychiatry* 46; Bruce J. Winick, 'The Side Effects of Incompetency Labeling and the Implications for Mental Health' (1995) 1 *Journal of Psychiatry, Public Policy and Law* 42.

[107] See for example World Network of Users and Survivors of Psychiatry and Center for Human Rights of Users and Survivors of Psychiatry, *Response to Draft General Comment on Article 12* (New York, 2014) available at: <http://www.ohchr.org/EN/HRBodies/CRPD/Pages/DGCArticles12And9.aspx> (last accessed 30 June 2016).

[108] See for example, People with Disabilities Australia, the Australian Centre for Disability Law and the Australian Human Rights Centre*, Submission to the Australian Law Reform Commission: Equality, Capacity and Disability in Commonwealth Laws* (Sydney, July 2014), available at: <https://www.alrc.gov.au/sites/default/files/subs/136._org_people_with_disability_australia_pwda__the_australian_centre_for_disability_law_acdl_and_australian_human_rights_centre_.pdf> (last accessed 1 July 2016); Sociedad y Discapacidad, *Submission to the CRPD Committee on the Draft General Comment on Article 12* (Lima, 2014), available at: <http://www.ohchr.org/EN/HRBodies/CRPD/Pages/DGCArticles12And9.aspx> (last accessed 1 July 2016).

[109] See Committee on the Rights of Persons with Disabilities, General Comment No. 1 – Article 12: Equal Recognition Before the Law, UN Doc. No. CRPD/C/GC/1, adopted at the 11th Session (April 2014); UN Committee on the Rights of Persons with Disabilities, Guidelines on Article 14 (adopted September 2015), available at: <http://www.ohchr.org/Documents/HRBodies/CRPD/GC/GuidelinesArticle14.doc> (last accessed 20 January 2016); UN General Assembly, Report of the Working Group on Arbitrary Detention: United Nations Basic Principles and Guidelines on the right of anyone deprived of their liberty to bring proceedings before a court (New York, 4 May 2015) WGAD/CRP.1/2015.

[110] Sascha Callaghan, Christopher Ryan and Ian Kerridge, 'Risk of suicide is insufficient warrant for coercive treatment for mental illness' (2013) 36(5) *International Journal of Law and Psychiatry* 374.

[111] See for example Shery Mead and Mary Ellen Copeland, 'What recovery means to us: Consumers' perspectives' (2000) 36(3) *Community mental health journal* 315; Shery Mead, David Hilton and Laurie Curtis, 'Peer support: a theoretical perspective' (2001) 25(2) *Psychiatric rehabilitation journal* 134; Douglas Noordsy, William Torrey, Kim Mueser, Shery Mead, Chris O'Keefe and Lindy Fox, 'Recovery from severe mental illness: an intrapersonal and functional outcome definition' (2002) 14(4) *International Review of Psychiatry* 318.

lived experience of emotional distress within the user and survivor movement.[112] For example, Muskett's review of the global literature on trauma-informed care in mental health demonstrates that hospitals and services which used these approaches – including de-escalating crisis situations with peer support, counselling, and talking therapies which acknowledge the person's distress without medicalising the experience, reported a marked decrease in the use of coercive practices such as restraint, seclusion and involuntary admission.[113] There is also significant evidence on the effectiveness of non-coercive practices for people experiencing extreme distress, self-harm, challenging behaviour and mental health crisis through methods such as family group conferencing,[114] the use of personal ombuds,[115] circles of support[116] and open dialogue,[117] which have been written about extensively in the literature on Article 12 CRPD.[118]

Given the decision in *Rabone*, the findings of the Law Commission and the current implementation of the Mental Capacity Act, it is unlikely that the domestic legal framework in England and Wales will move away from disability-specific deprivation of liberty in the near future. However, it is possible that the case law could develop in a more progressive direction, if the courts begin to recognise that less restrictive alternatives to detention are more proportionate and effective responses to the risk to life posed by suicide than a deprivation of liberty and imposition of non-consensual treatment. When specifying the kinds of measures that should have been taken by state actors, including health professionals, to fulfil their operational obligation to

[112] See for example Shery Mead, *Intentional Peer Support: An Alternative Approach* (Community Mental Health Services, 2014).

[113] Coral Muskett, 'Trauma-informed care in inpatient mental health settings: A review of the literature' (2014) 23(1) *International Journal of Mental Health Nursing* 51.

[114] John Gleeson, Henry J. Jackson, Heather Stavely and Peter Burnett, 'Family intervention in early psychosis' (1999) *The recognition and management of early psychosis: A preventive approach* 376; Catherine Love, 'Family group conferencing: Cultural origins, sharing, and appropriation – A Maori reflection' in Gale Burford and Joe Hudson (eds), *Family group conferences: New directions in community-centered child and family practice* (Transaction Publishers, 2007) 15; Jolijn Santegoeds, 'The Eindhoven Model and Family Group Conferencing: An Alternative to Forced Psychiatry' (Conference of State Parties to the CRPD, New York, July 2013); Gideon Jong, Gert Schout and Tineke Abma, 'Prevention of involuntary admission through family group conferencing: a qualitative case study in community mental health nursing' (2014) 70(11) *Journal of advanced nursing* 2651.

[115] See Swedish National Board of Health and Welfare, 'A New Profession is Born – Personligt ombud, PO,' Västra Aros, Västerås, November 2008, 10, available at: <http://www.personligtombud.se/publikationer/pdf/A%20New%20Proffession%20is%20Born.pdf> (last accessed 1 July 2016).

[116] See Deborah Gold, '"We Don't Call It a 'Circle'": The Ethos of a Support Group' (1994) 9(4) *Disability and Society* 435; Bruce Uditsky, 'Natural pathways to friendships' in Angela Novak Amado (ed) *Friendships and Community Connections for People With and Without Developmental Disabilities* (Paul H Brooks, 1993).

[117] Jaakko Seikkula and Mary E. Olson, 'The open dialogue approach to acute psychosis: Its poetics and micropolitics.' (2003) 42(3) *Family process* 403-418; Birgitta Alakare Seikkula and Jaakko Jukka Aaltonen, 'Open dialogue in psychosis II: A comparison of good and poor outcome cases' (2001) 14(4) *Journal of Constructivist Psychology* 267.

[118] See for example Piers Gooding, 'Navigating the "flashing amber lights" of the right to legal capacity in the United Nations Convention on the Rights of Persons with Disabilities: responding to major concerns' (2015) 15(1) *Human Rights Law Review* 45; Fiona Morrissey, 'The United Nations Convention on the Rights of Persons with Disabilities: A New Approach to Decision-Making in Mental Health Law' (2012) 19 *European Journal of Health Law* 423, Bernadette McSherry and Ian Freckelton, 'Where to from here for coercive care?' in Bernadette McSherry and Ian Freckelton, (eds) *Coercive Care: Rights, Law and Policy* (Routledge, 2013) at 283.

protect the right to life, domestic courts could for example refer to the need for access to crisis peer support in the community. Courts could also require healthcare professionals to demonstrate that alternatives to coercion such as family group conferencing and open dialogue were attempted in order to protect the person's right to life while also respecting the individual's right to healthcare based on informed consent, and the right to enjoy legal capacity on an equal basis with others, as set out in Articles 25 and 12 of the CRPD.

Finally, it is important to emphasise that the European Court has not explicitly followed the approach of the UK Supreme Court in *Rabone*. While the European Court has established in *Arskaya* that refusal of medical treatment should not be respected unless the patient had the necessary decision-making capacity, this decision was reached in a case concerning medical treatment for a physical health condition, not forced psychiatric treatment, and in *Rabone*, the decision to grant home leave was not connected to an assessment of the patient's decision-making capacity. In *Reynolds*, the European Court had the opportunity to consider whether a voluntary patient in the mental health system should have been detained in order to protect his right to life. The applicant in *Reynolds* referenced the *Rabone* decision in his submission, which meant that it was open to the European Court to follow this line of reasoning, and to suggest what kinds of measures (including detention) would have been reasonable for the hospital staff to take in order to fulfil the operational obligation under Article 2.

The European Court did not suggest that *Reynolds* should have been detained in these circumstances, although it did find that a violation of the operational duty to protect the right to life had occurred. However, the Court has in previous cases outlined what measures should be taken in respect of prisoners who are at risk of suicide as discussed above[119] and so would have been at liberty to reiterate those here or develop new guidelines on necessary measures. Therefore the Court's decision to remain silent on this matter in Reynolds can be interpreted as a deliberate one. The reluctance of the Court to specify what might constitute reasonable steps in these situations may also be attributable in part to its remit as an international court, and the judges may well have felt that domestic authorities are better positioned to determine what reasonable measures would be.

While the European Court cannot ignore Article 5(1)(e) and cannot therefore find a de facto violation of Convention rights where individuals have been lawfully involuntarily detained under mental health or mental capacity laws, it can state whether a deprivation of liberty is a proportionate response to a real and immediate risk to life by suicide. To date, it has not made such a statement, even where invited to do so in *Reynolds v UK*. As suggested above in respect of the domestic courts in England, it would also be encouraging to see the European Court's jurisprudence include more references to the alternative, peer-driven community-based supports for emotional distress, crisis and suicide prevention, as examples of less restrictive measures which can be undertaken in order to respect the operational obligation to protect the right to life. Such an approach would be in keeping with the Court's statement in *Keenan v UK* that the first response of state authorities should be to take precautions to diminish self-harm which do not infringe on personal autonomy.

[119] *Keenan v the United Kingdom* (2001) 33 EHRR 38.

This would align with the Court's jurisprudence on institutionalisation of persons with intellectual and psychosocial disabilities, such as its decision in *Stanev v Bulgaria*[120] that the imposition of partial guardianship on the applicant and his subsequent placement in a social care home violated his right to liberty under Article 5. In that decision, the Court held that "the objective need for accommodation and social assistance must not automatically lead to the imposition of measures involving deprivation of liberty."[121] It follows therefore that less restrictive measures, including appropriate community support, must be made available to persons with disabilities, to replace the current system of disability-specific deprivations of liberty, justified on the basis of the perceived need for care and protection of the person. The Court is prepared to accept in these cases that support and care can be provided in a manner that does not infringe the rights to autonomy, privacy and liberty protected in the ECHR. Further elaboration on the kinds of proportionate measures to be taken in response to a crisis would be most welcome as the Court's jurisprudence in this field continues to develop.

VII. CONCLUSION

There has been an increasing tendency for the European Court to cite the CRPD in its jurisprudence since its decision in *Glor v Switzerland*,[122] as discussed above. In order to bring the ECHR case law closer to CRPD compliance, it is open to the Court to find that a deprivation of liberty imposed because the person has been deemed to be of 'unsound mind', constitutes arbitrary detention, although given the trajectory of the Court's case law to date, such a move seems unlikely in the near future. Perhaps a more likely outcome would be for the court to find that a particular deprivation of liberty, while lawful under Article 5, constitutes a breach of the Article 8 right to privacy and respect for home and family life.

In my view, there is still potential for both the ECtHR and domestic courts in the UK to find disability-specific deprivations of liberty in violation of Article 8 and 14 ECHR, even where such provisions may be consistent with Article 5 ECHR. A specific deprivation of liberty may not amount to a violation of Article 5 but amount to an unjustified interference with the right to privacy under Article 8 and may also constitute disability-based discrimination prohibited by Article 14. The Article 8 approach to disability-specific forms of deprivation of liberty is particularly attractive where it can be demonstrated that less intrusive measures could have been used to provide care and support to the person – for example to continue living independently in the community with the social support and access to healthcare that the person might need.

Restrictions on Article 8 rights are permitted where they are "in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic wellbeing of the country, for the prevention of disorder or crime,

[120] (2012) 55 EHRR 22.
[121] Ibid, at para. 153.
[122] App. No.13444/04, (ECHR 30 April 2009). The CRPD is increasingly cited by the Court in its decisions involving persons with disabilities as part of the international human rights law context which can guide the Court, particularly in cases of institutionalization and denial of legal capacity. See for example *Seal v the United Kingdom* (2012) 54 EHRR 6; *Jasinskis v Latvia* App no 45744/08 (ECHR 21 December 2010); *Kiss v Hungary* (2013) 56 EHRR 38; *Kiyutin v Russia* (2011) 53 EHRR 26.

for the protection of health or morals, or for the protection of the rights and freedoms of others." However, research evidence demonstrates that a majority of mental health deprivations of liberty are based on 'danger to self' rather than 'danger to others'[123] which means that the restrictions concerning public safety, prevention of crime, and protection of the rights of others, would not apply in such cases. Further, the Mental Capacity Act does not provide for deprivation of liberty to be undertaken on the basis of risk of harm to others – but only where such detention is in the person's 'best interests.' This kind of deprivation of liberty could only then be justified on the basis of protection of the person's health according to the ECHR. As I have argued above, where danger to others applies, the appropriate response in my view is to engage the criminal justice system for persons with disabilities on an equal basis with others, with the necessary reasonable accommodations to ensure effective participation in the justice system. In keeping with Szmukler, Daw, and Callard,[124] I do not believe that a mere finding of 'danger to others' is an ethically acceptable ground for imposing pre-emptive detention or forced treatment, although I also dispute their purported solution of a mental capacity assessment to determine whether or not forced treatment and detention should apply.

As the evidence base on alternatives to coercion in mental health care continues to grow, courts may increasingly ask hard questions of healthcare providers about the necessity of coercion and forced treatment and its long-term outcomes for individuals – in terms of both their health and the protection of their human rights. This approach could certainly lead to a greater willingness on the part of the courts to recognise disability-specific detention and forced treatment as human rights violations, reading the ECHR in a manner more consistent with the CRPD. Such an approach can be substantiated by finding that disability-specific detention and forced treatment also constitute disability-based discrimination under Article 14 ECHR. The UK Supreme Court has already held in *AM v Secretary of State for Work and Pensions*[125] that inconsistency of domestic provisions with international law, including unincorporated treaties such as the Convention on the Rights of the Child and the CRPD, can form part of the assessment of objective justification in determining whether discrimination has occurred contrary to Article 14 ECHR. Building on this ruling, it is possible to argue that there is further scope in domestic courts to rely on the CRPD in finding disability-specific deprivations of liberty to constitute disability-based discrimination under Article 14 ECHR.

This approach could also be replicated in the European Court of Human Rights, where cases like *Korbechev and Sergeyeva v Russia*,[126] *Kiyutin v Russia*[127] and *Glor v Switzerland*[128] demonstrate the court's willingness to find disability-based discrimination to violate Article 8 in conjunction with Article 14 where the discrimination

[123] See for example Cornelis L. Mulder, Gerrit T. Koopmans and Jean-Paul Selten, "Emergency psychiatry, compulsory admissions and clinical presentation among immigrants to the Netherlands" (2006) 188(4) *The British Journal of Psychiatry* 386; Hans Joachim Salize and Harald Dressing "Epidemiology of involuntary placement of mentally ill people across the European Union" (2004) 184(2) *The British Journal of Psychiatry* 163.

[124] George Szmukler, Rowena Daw and Felicity Callard, 'Mental health law and the UN Convention on the Rights of Persons with Disabilities' (2014) 37(3) *International Journal of Law and Psychiatry* 245.

[125] [2015] UKSC 47.

[126] App no 16899/13 (ECHR 29 March 2016).

[127] App no 2700/10 (ECHR 10 March 2011).

[128] App. No.13444/04, (ECHR 30 April 2009).

does not meet a proportionality test in pursuance of a legitimate aim. Such an approach would seem to be a natural extension of the court's case law on adult guardianship and deprivation of liberty in psychiatric hospitals and care homes, which has emerged since the decision of *Stanev v Bulgaria*.[129] It would also begin to address the Court's stated intention to read the ECHR in light of prevailing international human rights standards which are accepted by States Parties to the Convention – almost all of which, including the UK, have also ratified the CRPD. Finally, this would begin to clarify how countries which have ratified both the ECHR and the CRPD could ensure compliance with both conventions, which fully respect the totality of rights of persons with disabilities, especially those with intellectual, psychosocial and cognitive disabilities who are more likely to experience violations of their right to liberty in the name of protection.

[129] (2012) 55 EHRR 22. See also *D.D. v Lithuania* App no 13469/06 (ECHR 14 February 2012) *MS v Croatia* App no 36337/10 (ECHR 25 April 2013); Zagidulina v Russia App no 11737/06 (ECHR 2 May 2013); *Shtukaturov v Russia* (2012) 54 EHRR 27; *Salontaji-Drobnjak v Serbia* App No 36500/05 (ECHR 13 October 2009); *Ivinović v Croatia* App no 13006/13 (ECHR 18 September 2014); *Hadzimejlic and others v Bosnia Herzegovina* App no 3427/13 (ECHR 3 November 2015).

DoLS or Quality Care?

GORDON R. ASHTON OBE, LL.B*

I. INTRODUCTION

A comprehensive mental capacity jurisdiction was established for England and Wales on 1st October 2007 when the Mental Capacity Act 2005 was implemented. Shortly prior to this the 'Bournewood Gap' was identified when the European Court of Human Rights held that there was a breach of the human rights of adults who lacked capacity and were deprived of their liberty by the state.[1] A legal procedure was required to authorise this and in consequence our legislation was amended to introduce Deprivation of Liberty Safeguards (commonly referred to as DoLS) with effect from 1st April 2009.[2] These applied only to adults resident in hospitals and care homes and were found to be insufficient when the Supreme Court held that some adults in community settings were also being unlawfully deprived of their liberty.[3] A further procedure was urgently required and Sir James Munby as President of the Court of Protection set up the *Re X* streamlined, paper-based judicial authorisation procedure to cope with the thousands of anticipated applications.[4] It is to these two different procedures that I refer in this article.

II. A PARENT'S PERSPECTIVE

I first encountered the 'Bournewood Gap' before it was even identified. Our son Paul was a strapping lad over 6 feet tall with no physical impairments, but he had grown up with severe learning disabilities and challenging behaviour that made him increasingly difficult to manage. We were determined to achieve a life for him that was not dependent on our household which he was likely to outlive. We made strenuous attempts to settle him in various care homes and communities (I became a founder of one and a trustee of several) but they could not cope with his behaviour and ultimately he was sectioned under the Mental Health Act for the purpose of moving him to a health authority unit shared with two other young adults (although the section was then discharged!). We had never resorted to the use of drugs but he was soon drugged so heavily that he could barely stand or converse with us on our visits. Ultimately he died there in 2004 at the age of 28 years due to inadequate supervision – there should have been at least two carers but on that morning for some reason there was only one and he choked to death on his breakfast.

---

* Retired district judge and nominated judge of the Court of Protection. Gordon Ashton draws on his experience as a parent and a judge to consider the relevance of deprivation of liberty safeguards in the context of the care of adults who lack capacity to make their own decisions but need constant supervision, and then outlines his perspective as a potential consumer of the mental capacity jurisdiction.

1 *HL v UK* (2004) 40 EHRR 761, overturning the decision of the House of Lords in *R v Bournewood Community and Mental Health NHS Trust ex parte L* [1999] AC 458, [1998] 2 FLR 550.

2 Mental Health Act 2007 which inserted clause 4A and B and Schedules A1 and 1A in the Mental Capacity Act 2005.

3 *P v Cheshire West and Cheshire Council and another; P and Q v Surrey County Council* [2014] UKSC 19, concerning the living arrangements of P, MIG and MEG.

4 *Re X and others* (Deprivation of Liberty) [2014] EWCOP 25.

How does this relate to Deprivation of Liberty Safeguards?

As parents we were not concerned that our son's liberty was being restricted – we would have been appalled if this had not been so. What concerned us was whether the care arrangements were the best that could reasonably be achieved for our son. We learnt that this depended on the dedication of carers and the implementation rather than wording of the care plan. This justifiably stated that he should not leave the flat unless accompanied by two responsible adults, but there were seldom two adults available and when my wife wished to take him for a walk there was no-one to accompany them. So the reality was that he was confined to a small flat with two others needing continuous supervision.

Would the DoLS or *Re X* procedure have given our son more freedom or saved his life? No, because the former only addresses the justification for deprivation of liberty[5] whereas the latter would have found the care plan acceptable on the face of it. This might have created an opportunity not otherwise available for us to ventilate our concerns about the quality of his lifestyle, but the reality was that no other options were then available and the courts could not oblige the authorities to fund something better.

There is now uncertainty as to whether safeguards should apply to care at home where there is some involvement of the local authority. During the years that we looked after our son we would have found it laughable if anyone had suggested that we were depriving him of his liberty in view of his irrational behaviour and lack of awareness, and would have felt threatened and undervalued if intrusive reports had to be prepared and reviewed at intervals. Of more importance was the extent to which we were providing him with opportunities that would not otherwise have been available to him, and as parents we looked to the authorities for support not policing. I found myself in sympathy with the initial attempt of Sir James Munby to head off the looming disaster by adopting the 'relative normality' approach whereby arrangements that were normal or perhaps inevitable for such an individual did not amount to a deprivation of liberty.[6]

III. A DISTRICT JUDGE'S PERSPECTIVE

I never aspired to be a judge, but after 28 years in general legal practice my activities outside the office motivated by the struggle with our son displeased my partners so much that I applied to be a District Judge. I had been a deputy for some years and also a part-time chair of the Social Security Appeals Tribunal, but was also a member of the Law Society's Mental Health & Disability Committee, lecturing to lawyers and charities on disability issues and writing my first book, *Mental Handicap & the Law* the publication of which in 1992 coincided with my appointment. Not only did life on the Bench give me more time for these activities but I also found that the judiciary lacked awareness of the need to make reasonable adjustments for people with physical, sensory and mental impairments. Thus began my long association with the Judicial Studies Board (now the Judicial College) and their Equal Treatment Advisory Committee through which I provided information and training to judges on disability issues.

[5] See *Hillingdon London Borough Council v Neary* [2011] EWHC 1377 (COP).
[6] *Cheshire West and Cheshire Council v P* [2011] EWHC Civ 1257, overturned by the Supreme Court. It is the existence of a deprivation that is relevant, not the reason for it.

When human rights 'came home' with the passing of the Human Rights Act 1998 I complained that the Court of Protection as then constituted under the Mental Health Act was not compliant because apart from the Master it was run by nominated officers with the courtesy title of 'Assistant Master' who lacked the independence of a judge. Also a court that sat only in London was not accessible to elderly and disabled people in the north of the country. Shortly thereafter I was appointed a Deputy Master to hear cases at my court in Preston, Lancashire and subsequently I was involved in setting up the new Court of Protection under the Mental Capacity Act 2005.

How does this relate to Deprivation of Liberty Safeguards?

As a nominated Judge of the Court of Protection I inevitably became involved in deprivation of liberty situations although challenges under the DoLS procedure were initially reserved to High Court Judges. It seemed to me that if a care plan was in the best interests of an incapacitated person, any deprivation of liberty would be justified so I concentrated on the former and treated DoLS as a parallel path that would only concern the Court if there was a specific challenge. The problem then became that one was restricted to that which the relevant authority was prepared to fund. In many cases the Court seemed impotent to achieve its view of best interests especially when only one care option was available. In one of my final cases where I had expressed unresolved concerns I threatened to invite the press to the next hearing on the basis that the court of public opinion may be more powerful than my own role.

Yet despite my extra-judicial experience I did not feel best placed to decide what care provision would be in the best interests of the incapacitated person, and had to remind myself that my judicial role was not to dictate that such provision be provided but merely to ensure that decisions made for the individual were in his or her best interests. In that respect the incapacitated person was in the same position, no better and no worse, than any other person in seeking adequate care provision. One can only choose from that which is, or might be, available. However, the DoLS amendment extended the judicial role to determining whether any deprivation of liberty was in the best interests of the individual and that widened the powers of the Court considerably because a refusal to accept the extent of the deprivation obliges the provider to reconsider the care arrangements.

IV. A RETIRED LAWYER'S PERSPECTIVE

I am now retired and living with my wife of almost 45 years who has Parkinson's disease. We are apprehensive about the future together and then perhaps for one of us alone. If we cannot cope due to physical or mental infirmity we shall become dependent on others, a situation we have not faced since childhood and do not relish. We do not wish to be a burden to our daughters or to be kept alive by medical care if the quality of our lives cannot be preserved. We may even become consumers of the mental capacity jurisdiction! I became responsible for my mother who spent her last years in a nursing home and died there in 2013 at the age of 97 years. I knew that she was receiving the best care available because I had arranged it for her. These experiences made me painfully aware that it is for the benefit of such persons, and not the lawyers, that the jurisdiction exists. I find myself reflecting on what has been

achieved, less defensive of the Court of Protection and more willing to identify its failings.

How does this relate to Deprivation of Liberty Safeguards?

Should I have been concerned about deprivation of liberty when I visited my mother and found her sitting in her room alone or 'confined to bed'? My thoughts related more to the quality of her care and whether the staff were being kind to her because she needed guidance and support rather than freedom. I would have been angry at the intrusion and waste of resources if people unknown to me had wished to carry out a fruitless annual enquiry as to whether she was unlawfully being deprived of her liberty. I do not worry about being deprived of my own liberty in the event that I become infirm and lack capacity just as long as good quality care is provided by people who treat me with respect and create opportunities for me to enjoy some activity. Being cared for by uncaring persons but with more freedom than one could cope with would be a worse fate than being excessively restricted by persons providing loving even though misplaced care.

V. CONCLUSION

Entrenched human rights are necessary to preserve a free society but the framers of the European Convention could hardly have anticipated that they would be applied with such intensity in these situations. The Human Rights Act 1998 made the Mental Capacity Act 2005 necessary but has it now become a threat to this jurisdiction? Of course the incapacitated individual is vulnerable to inappropriate confinement, and we need judicial procedures to prevent people from being wrongly declared as incapable and then deprived of their liberty. Enforceability of human rights then becomes important, but the obsession of lawyers with the prospect of deprivations of liberty in every case results in a clash of objectives with too much emphasis being placed on personal freedom and too little on the need for support or supervision. The cost of this in terms of financial and professional resources is enormous and in times of austerity inevitably depletes the budget for the delivery of care. How much of our limited resources are we to devote to that issue when the real question is whether the care plan and the way it is being implemented is in the best interests of the individual?

The underlying problem with a rights based approach is that it focuses solely on rights and life is not like this. With rights come responsibilities to oneself, one's family, one's carers and society. None of us have total freedom to exercise our rights as we need to be heedful of the needs of others. Those who lack decision-making capacity are unlikely to be mindful of these natural constraints. Why should they be treated as released from them in the decision-making process and thereby become entitled to have everything their own way? The person who constantly says 'I know my rights' provokes other people to keep their distance which is not in the best interests of that person. This brings us back to the delicate balance between empowerment and protection. There are times when we need to be protected from ourselves and the constraints of our normal personal relationships often have this outcome. If we lack the capacity to recognise and respond to those constraints we would surely expect that they would be applied externally in any decision-making process. The notion that I should have a supporter who ascertains what I want so that this can be demanded on my behalf is not one to which I would wish to subscribe. If as a result of a lack of

awareness or judgment I wished to give all my money away I would not expect this to be the decision made on my behalf even though if I did not lack capacity I would have the legal right to do so. A supporter may recognise this but in seeking to exert influence would perhaps be going beyond the true role of a supporter and would be moving towards a 'best interests' approach to decision-making without the safeguards of the statutory criteria.

I have no wish to condemn the procedures that we have without offering a viable alternative. I would sooner concentrate on the enforceability of human rights where appropriate than universal enforcement. Otherwise the emphasis in care provision for those lacking capacity becomes minimum restriction rather than maximum support. I favour a whistle-blowing procedure to protect those who may be deprived of more liberty than is necessary, but with someone in authority capable of responding by making a reference to the Court of Protection for judicial scrutiny. There should be widespread public knowledge of this procedure as part of the culture of care so that relatives and concerned persons may blow the whistle, and a designated local official to monitor the care of those who have no such contacts. Resources would then be reserved for those who needed protection.

During the past 25 years I have campaigned for this jurisdiction, participated with the Law Commission to achieve it and then worked in the judicial system to implement it. Has my dream become a nightmare? I respect the impeccable logic of the Appeal Courts in applying the broad principles of international Conventions but wonder whether in days of austerity our society can afford to deliver such an idealistic approach. It seems out of touch with the reality of life as an involuntary carer faced with expectations but insufficient support from the authorities, whose right to personal freedom must not be overborne by the similar right of the one cared for. I conclude this contribution with the words that I have used in many of my lectures over these years: "The structure is there but it all depends on how we, the lawyers and other professionals, implement the legislation – *pragmatic or legalistic*?"

CAPACITY ASSESSMENT AND INFORMATION PROVISION FOR VOLUNTARY PSYCHIATRIC PATIENTS: A SERVICE EVALUATION IN A UK NHS TRUST

BENJAMIN IAN PERRY*, SWARAN PREET SINGH**, DAVID HEDLEY WHITE***

ABSTRACT

A. BACKGROUND

Since the *Cheshire West* judgement, yearly applications for the Mental Health Act (MHA) and Deprivation of Liberty Safeguards (DoLS) have increased, though many patients are still admitted informally. To ensure lawfulness, informal admissions must be capacitous, informed, and without coercion. If fully capacitous consent is not obtained, then there is a risk of "de facto" detention and deprivation of liberty. Deprivation of liberty is only lawful through appropriate legal frameworks (DoLS for incapacitous, non-objecting hospital inpatients, or MHA otherwise). Use of such legal frameworks might be hampered by the perceived stigma associated with them, though this may not be in the best interests of the patient.

B. AIMS AND OBJECTIVES

We aimed to examine the assessment of capacity and provision of adequate information required for an informed voluntary psychiatric admission, and any evidence of possible coercion into informal admission. We postulate variable use of legal frameworks designed to empower patients and prevent illegal deprivation of liberty.

C. METHODS

A retrospective randomized sample (n=50) was obtained from psychiatric admissions between May 1st and August 31st 2015 to Coventry & Warwickshire Partnership NHS Trust. Clinical notes were evaluated for demographics, assessment of capacity and the provision of adequate information surrounding admission, and for the presence of documentation pertaining to a 'de facto detention' during the first week of admission.

D. RESULTS

Seventeen patients (34%) were detained on admission. At one week, nine further patients were detained. Eight of these patients were detained within 72 hours of voluntary admission. Capacity assessment was documented in 54% of these patients. The provision of adequate information was poor, at just 26%. None of the nine patients later detained within the first week were provided the required information on admission. Documentation pertaining to a 'de facto detention' was present in 21% of voluntary patients' notes at admission, and 24% at 24 hours. After 24 hours, the prevalence and frequency decreased over the first week.

* Division of Mental Health and Wellbeing, University of Warwick, UK and Coventry and Warwickshire Partnership NHS Trust, UK

** Division of Mental Health and Wellbeing, University of Warwick, UK and Birmingham and Solihull Mental Health Foundation NHS Trust, UK

*** Coventry and Warwickshire Partnership NHS Trust, UK

E. CONCLUSION

Both capacity assessment and provision of adequate information to allow an informed decision for voluntary admission were poorly documented. As none of the patients detained during the first week of admission were provided adequate information pertaining to the admission, it is not possible to discount the possibility of coercion into admission in this subgroup. The presence of documentation pertaining to 'de facto detention' was common, and may point toward a potential illegal deprivation of liberty. Our findings suggest that more needs to be done to ensure vulnerable individuals are not subject to illegal deprivation of liberty whilst under psychiatric care.

I. INTRODUCTION

Those with severe mental illness may be vulnerable, and are at risk of coercive hospital admission (Hoge et al, 1997). Once they remain as an inpatient, they are also at risk of deprivation of liberty (Poulson, 2002). To help prevent potential exploitation, legal frameworks are in place to empower and protect those patients most vulnerable due to their mental disorder, potentially due to impaired capacity or insight. The Convention for the Protection of Human Rights and Fundamental Freedoms, Article 5 states that all human beings have the right to liberty and security of person (Art 5(1), Council of Europe, 1950), save in certain circumstances, which include a mental disorder (Art 5(1)(e), Council of Europe, 1950) meeting the Winterwerp criteria. These criteria include 'reliable demonstration of unsound mind by an objective medical professional; of a nature or degree warranting hospital inpatient stay; and persistent (Winterwerp v Netherlands, 1979).

When a mentally disordered person is deprived of their liberty, it must be in accordance with a process set down in law, and the person must have speedy access to a Court (Art 5(4), Council of Europe, 1950). Currently, in England and Wales, there are three ways in which a mentally disordered patient can be lawfully detained in hospital should this be deemed necessary; via the Mental Health Act (MHA) (1983, as amended 2007), via the Deprivation of Liberty Safeguards (Mental Capacity Act 2005 as amended 2007, Schedule A1) (DoLS) or by order of the Court of Protection (CoP), as outlined in table 1. Each of these is a due legal process, with the necessary patient-orientated safeguards such as the right to appeal or second opinion.

Mental Health Act (1983) (MHA)	Deprivation of Liberty Safeguards (2009) (DoLS)	Inherent Jurisdiction of the High Court (Court of Protection (CoP))
Section 2 (assessment order) lasts up to 28 days Sections 3&37 (treatment order) last up to 6 months, but second opinion required to administer treatment after 3 months	Allow detention of incapacitous, compliant patients in hospitals or care homes Introduced following "Bournewood judgment"	Reserved for complicated cases where MHA or DoLS cannot be used

Emergency holding powers (Section 5) for patients already in hospital, last up to 72 hours For application, 'MHA assessment' carried out involving psychiatrist uninvolved with the case, a doctor who knows the patient and approved mental health practitioner[a] Includes right to appeal and a second opinion Those on treatment sections subject to section 117 aftercare[b]	Include the right to appeal by patient or 'relevant representative' to Court of Protection To be detained in *hospital* the patient must be fully compliant with all aspects of care (if not the MHA must be used instead).	

Table 1: legal deprivation of liberty in England and Wales at a glance

a Approved mental health practitioner might be from a range of backgrounds, for example general practitioner or social worker.

b The duty of Health and Social Services to provide funding for continued patient care.

The nature of what constitutes 'deprivation of liberty' has been repeatedly re-examined over the last few decades, leading to the three means of lawful detention as described above. This began with the 'Bournewood' Case (R. v Bournewood Community and Mental Health NHS Trust, 1997, EWHC Admin 850), in which a man (HL) with severe learning difficulties was an "informal" psychiatric inpatient. He was compliant with care and treatment, and for this reason, the hospital decided not to apply the MHA, which was the only legal means for detention available to them at that time. His carers argued that he was "unlawfully detained" because he was not allowed to leave the ward or to have his carers visit him, and sought a judicial review of the hospital's decision.

The High Court decided that HL was not unlawfully detained, because he had not attempted to leave and had therefore not been forcibly restrained. At the Court of Appeal, it was decided that the patient had been unlawfully detained, and should have been detained under the MHA (R v Bournewood Community and Mental Health NHS Trust, 1997, EWCA Civ 2879).

On further appeal in the House of Lords (R. v Bournewood Community and Mental Health NHS Trust, 1998, UKHL 24) the decision was overturned again. The House of Lords said that for there to be unlawful detention there must be actual rather than potential restraint. They were also worried that if the Court of Appeal decision were to stand, tens of thousands of informal patients would be detained under the MHA, with considerable financial costs and excessive stigmatization.

However, this case was then brought to the European Court of Human Rights (HL v UK 45508/99, 2004, ECHR 471), which made the final judgment that the distinction between 'actual' and 'potential' restraint was irrelevant, and that HL *had* been deprived of his liberty. Furthermore he had been kept in hospital under the common law "doctrine of necessity", which the Court said was not a "procedure set down in law" required under Article 5. DoLS arose out of this judgment; the Mental Capacity Act (2005) was amended to include DoLS. (Mental Capacity Act 2005 as amended 2007, Schedule A1). DoLS created a legal process for the detention of passively compliant, incapacitous patients, and introduced various safeguards for such patients.

More recently, important judgments have occurred in high profile court cases such as '*P v Cheshire West'* and '*P & Q v Surrey County Council',* involving vulnerable individuals residing outside of hospital. The Supreme Court (P v Cheshire West 2014), in its ruling on the above cases, defined what constitutes a deprivation of liberty, in what it called the "acid test". If a person is under "constant supervision and control" and he or she is "not free to leave at any time", then the person is, by definition, deprived of their liberty. Baroness Hale, in the leading judgment, said '*a gilded cage is still a cage*', meaning that even if all agree that a patient's care and treatment is in their best interests, the patient is still being deprived of his liberty.

These cases have major implications for those working in a mental health setting. For example, applications under the MHA have risen year on year, perhaps in part due to concerns over potentially unlawful deprivation of liberty (Care Quality Commission, 2014). Even more concerning is that since the "Cheshire West" ruling by the Supreme Court, DoLS applications in England increased tenfold, from 13,700 in 2013-14 to 137,540 in 2014-15 (Health and Social Care Information Centre, 2015).

Nonetheless, many patients *are* still admitted informally (i.e. not admitted under a legal framework). Severity of mental illness aside, there may be other reasons for this. Firstly and perhaps most significantly, a capacitous patient may be strictly consenting to have their liberty deprived, though this may be hard to envisage. Secondly, MHA assessments carry a financial burden. Thirdly, detention under the MHA carries stigma. Though there have been improvements (Thornicroft et al, 2013), mental illness is adversely portrayed in the media (Weinrich, 2014), and public perception of those with mental illness remains negative (Schomerus, 2012). Even when discharged from the MHA, patients may be met with foreign travel restrictions, insurance premium increases, and increased difficulty in obtaining employment (Stuart, 2006).

This is despite the Mental Health (Discrimination) Act (2013), which aimed to combat the stigma attached to having been detained under the MHA. It removed the blanket ban on such individuals participating in jury service, amended rules that might remove individuals as directors of public or private companies 'by reason of mental health', and removed legislation under which a Member of Parliament would automatically lose their seat if they are detained under the MHA for greater than six months. These are all positive steps in the reduction of the potential societal disadvantage that might be experienced by patients with mental illness.

The MHA has numerous safeguards to protect patients. In addition to the right to appeal, to a second opinion about treatment, and to advocacy, it notably includes an important role for the Approved Mental Health Professional (AMHP). The AMHP is an

independent mental health professional, but *not* a doctor, with special training and expertise in mental health and law. The role of AMHPs is "to provide an independent decision about whether or not there are alternatives to detention under the Act, bringing a social perspective to bear on their decision, and taking account of the 'least restrictive option and maximising independence' guiding principle" (MHA Code of Practice, Department of Health, 2015). The AMHP makes the final decision about detaining a patient under the Act ("making an application") albeit supported by two medical "recommendations".

Despite advances in combatting stigma, and despite the safeguards built into the MHA to protect patients, some suggest that detention under the MHA should be used only when a patient in a psychiatric hospital is actively trying to leave. A guiding principle of the MHA is the "least restrictive" principle – "where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained" (MHA Code of Practice, Department of Health 2015). Some argue that keeping a patient informal is the 'least restrictive' option, an option that carries the least possible harm. Some go further and argue that mental health professionals, with their ability to detain individuals, are 'suborned as agents of social control' (Mullen, 2005).

As mentioned, an informal (voluntary) patient should make a fully informed decision to be admitted. Without this there is a risk of coercion into admission and a subsequent unlawful deprivation of liberty.

In 2014, the Royal College of Psychiatrists (R.C.Psych.) published a response following '*P v Cheshire West'* and '*P & Q v Surrey County Council'*, outlining a list of nine pieces of information a patient should have in order to consent to admission, some of which are outlined in figure 1.

That the person will be expected to remain on the ward, most likely for at least 24 hours

The possibility of having some personal items confiscated, and personal searches

That the nursing staff must be informed of plans when the person requests to leave the ward

That the nursing staff may refuse to agree to allow the person to leave the ward.

Fig. 1 Examples of information to be provided to patients as outlined in R.C.Psych. document

The response also reiterates the concept of 'de facto detention'. That is, the patient remains 'voluntary' in the full knowledge that they would be detained if they attempted to leave. Such an admission runs a serious risk of representing an unlawful deprivation of liberty, removes access to the safeguards of the MHA (for example appeal to a tribunal), and could be construed as paternalistic.

Other authors have examined extra-legal deprivation of liberty in other legal jurisdictions; in Denmark (Poulson, 2002) and the USA (Hoge et al, 1997). We could find no similar recent work in England and Wales.

In light of Cheshire West and the changing definition of 'deprivation of liberty', we wished to examine voluntary admissions for the risk of 'de facto detention'. We suspected that some 'voluntary' patients may not be giving fully informed consent to

admission, and that mental health professionals may still be reluctant to use the MHA, despite the safeguards it offers for both patients and professionals.

II. AIMS AND OBJECTIVES

The aim of the study was to examine the possibility of coercion into 'voluntary' admission in psychiatric patients.

The objectives were firstly to ascertain whether capacity to consent for admission was adequately assessed, and whether those patients admitted as voluntary were provided with sufficient information to be able to make an informed decision to come into hospital.

Secondly, the study examined the demographics and prevalence of psychiatric diagnoses of admitted patients, and the prevalence of use of the MHA for newly admitted patients during the first week of admission. We hypothesize that a 'quick switch' from informal to formal admission soon after admission may reflect an initial coercion into informal admission.

Thirdly, we assessed whether informal patients may have been subject to a 'de facto detention' during the first week of admission.

III. METHODS

A. Study location & trust policy

The study was completed at Coventry and Warwickshire Partnership NHS Trust, United Kingdom, during the four-month period between May 1st – August 31st 2015. Adult inpatient mental health services in the trust comprise of three acute psychiatric units, The Caludon Centre in Coventry (112 beds), St. Michaels Hospital in Warwick (41 beds), and The Pembleton Unit in Nuneaton (12 beds) with adult rehabilitation services provided at multiple sites (40 beds), for a catchment area of around 850,000 people. As with most mental health trusts in the UK currently, the trust is close to or meeting inpatient capacity at all times.

The MHA Code of Practice (Department of Health, 2015) states that when a patient needs to be in hospital, informal admission is usually appropriate when a patient who has the capacity to give or to refuse consent, is consenting to admission. However, there is no trust guideline currently outlining whether this should be assessed by nursing staff, or by the admitting doctor. There is no national or Trust guideline outside of the aforementioned publication by the Royal College of Psychiatrists on ensuring patients admitted informally are given adequate information on what an admission will be like, including the "rules" of the institution.

B. Eligibility Criteria

All patients admitted to adult inpatient mental health services, both acute and rehabilitation, in the Coventry and Warwickshire Partnership Trust between May 1st 2015 – August 31st 2015 featured as the sampling frame. There were no specific inclusion criteria for diagnosis or length of admission to help prevent selection bias.

C. Ethics

The study was approved by Coventry and Warwickshire Partnership Trust as a service evaluation and as such did not need formal ethical approval from an NHS Research Ethics Committee. Data was collated in an anonymized format from routine clinical records, by the lead author.

D. Method

A sample size of 50 was achieved via the randomization function of Microsoft Excel from a spreadsheet containing details of all patients that met eligibility criteria outlined above. The sample size was chosen based upon guidance from the National Audit Office (National Audit Office, 2001). Clinical notes were analysed by the authors, firstly, for the diagnosis (either provisional or established) alongside demographic information including age, sex and length of admission. Documentation pertaining to the admission was analysed for evidence that a) capacity to consent to admission was assessed at the time of admission, and b) information surrounding the reality and rules of an admission were appropriately explained to the patient.

Next, the clinical notes were assessed (either from consultant ward round notes, nursing observations or clinical assessment by doctor) at specified frequencies (0hrs, 24hrs, 48hrs, 72hrs, 1 week) from admission for legal status, any change in such, and any evidence of a 'de facto detention' as documented in the clinical notes of informal patients. This was assessed by the presence of documentation such as 'if the patient tries to leave the ward, for section 5(2)'. Descriptive statistics were used to illustrate findings.

E. Results

i. Demographics

The sample included a roughly even split amongst sexes (24m, 26f). Mean age was 46.28 (statistical range 64).

ii. Diagnosis on admission

Figure 2 outlines the spread of diagnoses (established or main differential) amongst study subjects. The majority (46%) of admitted patients included in the study were diagnosed with psychotic illness. This broadly mirrors other published literature on psychiatric admission statistics (Thompson et al, 2004).

Diagnosis	*n*
Schizophrenia and related diagnosis	23
Depression/Suicidal Ideation	11
Bipolar Affective Disorder	9
Personality Disorder	3
Substance Misuse	2
Anorexia	1
Organic Illness	1

Fig 2. Diagnosis on admission amongst study participants

iii. Length of Admission

Length of admission is outlined in figure 3. The majority of patients in the sample were discharged from hospital within six weeks.

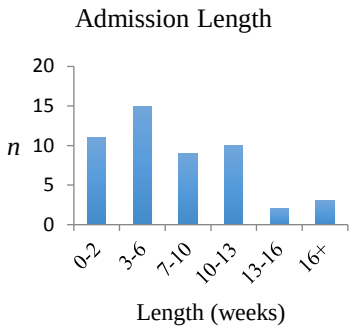

Fig 3. Length of admission amongst study subjects

iv. Legal Status and discharges

Seventeen patients (34%) were detained on admission. At seventy-two hours, a further eight patients had been detained. Three patients were discharged home during the first seven days. At seven days, one further patient had been detained (56% total of remaining admitted patients). No patients were discharged from the MHA during the first seven days. DoLS were not used in our sample.

v. Capacity assessment and information provided on admission

A formal capacity assessment was documented in twenty-seven patients (54%), though this was higher in patients detained on admission (82% of detained patients). Only thirteen (39%) of informal patients had a capacity assessment documented.

Information pertaining to the reality and rules of an inpatient admission was provided to thirteen patients (26%). Again, this was more common for detained patients (59%) than patients admitted informally (10%).

None of the nine patients detained during the first week of admission had documented evidence that information relating to the reality and rules of a mental health inpatient admission had been explained.

vi. 'De facto detention'

As visible in table 2, the presence of documentation pertaining to 'de facto detention' was prevalent during the first week of admission. Prevalence was highest either at or soon after admission, and gradually declined in frequency and prevalence over the first week.

Time	0hr	24hr	48hr	72hr	1wk
N	7	7	5	4	2
total voluntary	33	29	26	23	21
%	21	24	19	17	10

Table 2: 'De Facto detention'

IV. DISCUSSION

In this study, admissions into acute mental health beds were assessed for the possibility of coercion into voluntary admission. We present several findings of note. Firstly, capacity assessment and the provision of information pertaining to the reality of a mental health inpatient stay were poorly recorded, especially amongst patients admitted informally. Capacity assessment and the provision of information were better, though still lacking, in patients admitted under the MHA. This may be an issue of poor documentation, rather than an absence of seeking and gaining valid informed consent. However, we cannot exclude the possibility that some admissions were subject to

coercion into informal admission. These results echo those from previous pre-Cheshire West work (Poulson et al, 2002; Hoge et al, 1997), suggesting that coercion into admission and extra-legal deprivation of liberty are still commonplace in the mental health population. It is possible that this is a reflection of an inherent wish of professionals to avoid endowing patients with the potential weight of stigma that might still be attached to the use of the MHA, as previously mentioned.

It may be true that had a larger number of voluntary patients had the reality of inpatient admission explained to them, some might have refused admission. In this case, the difficult but nonetheless vital decision of 'what to do next' (i.e. could the patient be managed in the community with maximal community support available) could have been addressed. It seems plausible that better performance on information-giving in the "sectioned on admission" group stems from the formal, legal nature of such an admission.

None of the patients detained during the first week of admission had information on the 'reality of inpatient admission' explained to them when they were admitted. It seems plausible that their detentions under the MHA occurring at such a short frequency from admission reflects an initial coercion into admission, which was then challenged by the patient.

Finally, there was a reasonably high prevalence of 'de facto detention' in our sample. This contradicts guidance provided by the Royal College of Psychiatry. Interestingly, the highest prevalence of 'de facto detention' appeared either at admission or soon after admission, which provides further evidence that a subset of patients may have been inappropriately admitted as voluntary patients, when perhaps the severity of their mental state may have impaired their capacity or judgment making ability. A quick comparison of the rates of conversion from voluntary to legally detained reveals that more voluntary patients were subject to a 'de facto detention' than were converted to formal detention under the MHA at all measured time points, suggesting that a proportion of patients subject to a 'de facto detention' remained informal. This raises the possibility that this subset of patients may therefore have been subject to an extra-legal deprivation of liberty.

V. LIMITATIONS

There are several important considerations to make when viewing these results. Firstly, the sample size is relatively small which may limit generalizability, and increase the risk of type II error. A further study conducted on a larger sample size would help to improve the power of the study and therefore strengthen any conclusions drawn from it.

Secondly, we have used a switch from informal to formal admission within the first week as a surrogate marker for the possibility of an initial coercion into admission, though this may not be the case. It is wholly possible that a patient with the necessary information about their admission may capacitously agree to come in voluntarily and then change their mind, or even become more unwell necessitating use of legal frameworks. However, it is noticeable that in our sample, all of the informal patients later detained within the first week had documented evidence that information about the admission had been provided to them.

Thirdly, our work does not feature anyone admitted under DoLS. Future work may consider stratified sampling to ensure a representative sample of patients detained under DoLS.

Fourthly, the retrospective nature of the study relies purely on documentation quality in the generation of results. The findings are therefore wholly reliant on detailed, accurate documentation, and it is therefore possible that our results do not accurately reflect actual practice. Thus, a prospective study might be a more effective means in accurately assessing suitability for formal detention under a legal framework.

Fifthly, it is possible that patients bearing longer psychiatric histories, with multiple previous admissions, may be given less information on admission than a patient suffering their first psychiatric episode. The presence of previous admissions was not assessed in the study, and may be pertinent for future work. However, some might argue that even in such cases, assumptions should not be made and patients should still be offered the relevant information.

Finally, we are unable to prove whether any discrepancy in use of the MHA for newly admitted patients is a result of differing beliefs around best practice, or around the stigma associated with formal detention under a legal framework. Our findings might therefore pave the way for further qualitative work, which may try to capture any inherent cultural beliefs that may exist within the healthcare system.

VI. CONCLUSION

It is vital that all patients admitted to inpatient mental health services as voluntary patients make a free decision to be admitted, and are deemed capacitous to make the decision. They must be provided with enough information for the decision to be considered informed. Without this there is a risk of coercion and extra-legal deprivation of liberty.

Furthermore, the provision of information and assessment of capacity must be adequately documented, so that professionals and organizations can defend themselves against allegations of unlawful deprivation. Our findings suggest that currently, these standards are not being adhered to.

With these findings considered, a guideline, pro forma or flow-chart to guide staff into adhering to best practice and the documentation of such might help. Based upon these findings, the specified trust has now incorporated a pro forma into policy, to be completed by the admitting clinician, ensuring that the patient has capacity to consent to admission and has been provided with adequate information on the likely reality of an inpatient stay.

The stigma faced by patients with mental illness is real, and may well be amplified by a history of detention under the MHA. This may weigh heavy on the minds of those professionals tasked with decisions surrounding legal frameworks in the admission of acutely unwell psychiatric patients. Whilst our findings highlight the possibility of coercion and extralegal deprivation of liberty in voluntary patients, it is likely that the

professionals involved believed they were acting in the patient's best interests. Yet, there is evidence that stigma around mental health issues is dissipating, albeit slowly, and as such, misgivings about using the MHA may be misplaced. Equally importantly, the law is evolving with respect to deprivation of liberty issues and this cannot be ignored. The MHA exists to protect patients and has safeguards to empower them. Without these safeguards in place, patients are disempowered, unprotected and arguably more stigmatized. We argue that more education about capacity law and the MHA is required for all mental health professionals, in order to improve practice and ultimately lessen stigma.

Acknowledgements

The authors would like to extend sincere thanks for the help and guidance of Alex Keene, Barrister and Honorary Research Lecturer at University of Manchester, and Kris Gledhill, Barrister and Associate Professor at AUT Law School, Auckland.

References

Care Quality Commission (2014). *Mental Health Act Annual Report 2013/14*. [online] Available at: http://www.cqc.org.uk/content/mental-health-act-annual-report-201314 [accessed 1 Feb 2016].

Council of Europe (1950). *The Convention for the Protection of Human Rights and Fundamental Freedoms*. Rome: Council of Europe.

Department of Health (2015) *Statutory guidance. Code of Practice: Mental Health Act 1983.* London. The Stationery Office.

Health and Social Care Information Centre (2015). *Mental Capacity Act (2005) Deprivation of Liberty Safeguards (England) Annual Report, 2014-15.* [Online] Available at: http://www.hscic.gov.uk/catalogue/PUB18577/dols-eng-1415-rep.pdf [accessed 11 Jul 2016].

HL v UK (2004) 40 EHRR 761

Hoge, S. K., Lidz, C. W., Eisenberg, M., Gardner, W., Monahan, J., Mulvey, E. & Bennett, N. (1997). *Perceptions of coercion in the admission of voluntary and involuntary psychiatric patients*. International journal of law and psychiatry, 20(2), 167-181.

Mental Health Act (1983, as amended 2007). London: HMSO.

Mental Health (Discrimination) Act (2013). London: HMSO.

Mullen, P. E. (2005). *Facing up to our responsibilities: Commentary on... The Draft Mental Health Bill in England: without principles*. The Psychiatrist, 29(7), 248-249.

National Audit Office (2001) *A Practical Guide To Sampling.* Available at: https://www.nao.org.uk/wp-content/uploads/2001/06/SamplingGuide.pdf [accessed 12 Oct 2016].

Poulsen, H. D. (2002). *The prevalence of extralegal deprivation of liberty in a psychiatric hospital population*. International journal of law and psychiatry, 25(1), 29-36.

P v Cheshire West and Chester Council; P and Q vs Surrey County Council (2014). UKSC 19.

R. v Bournewood Community and Mental Health NHS Trust Ex p. L [1997] EWCA Civ 2879

R. v Bournewood Community and Mental Health NHS Trust Ex p. L [1998] UKHL 24

R. (L) v Bournewood Community and Mental Health NHS Trust (1997) EWHC Admin 850

Royal College of Psychiatrists (2014). *Mental Capacity Act - Update following P v Cheshire West and P & Q v Surrey County Council cases.* [online] Available at: http://www.rcpsych.ac.uk/policyandparliamentary/mentalhealthlaw/mentalcapacityact.aspx [accessed 1 Feb 2016].

Schomerus, G., Schwahn, C., Holzinger, A., Corrigan, P. W., Grabe, H. J., Carta, M. G., & Angermeyer, M. C. (2012). *Evolution of public attitudes about mental illness: a systematic review and meta-analysis*. Acta Psychiatrica Scandinavica, 125(6), 440-452.

Stuart, H., 2006. *Mental illness and employment discrimination*. Current Opinion in Psychiatry, 19(5), pp.522-526.

Mental Capacity Act (2005 as amended 2007) (Schedule A1). London: HMSO.

Thompson, A., Shaw, M., Harrison, G., Ho, D., Gunnell, D. and Verne, J., 2004. *Patterns of hospital admission for adult psychiatric illness in England: analysis of Hospital Episode Statistics data*. The British Journal of Psychiatry,185(4), pp.334-341.

Thornicroft, A., Goulden, R., Shefer, G., Rhydderch, D., Rose, D., Williams, P. & Henderson, C. (2013). *Newspaper coverage of mental illness in England 2008-2011*. The British Journal of Psychiatry, 202 (s55), s64-s69.

Weinreich, N. K. (2014). *Transforming Media Messaging about Mental Illness through News, Entertainment and Social Media.* In 2014 National Conference on Health Communication, Marketing, and Media (August 19-21). CDC.

Winterwerp v Netherlands (1979) 2 EHRR 387

DEPRIVATION OF LIBERTY: THE POSITION IN SCOTLAND

Laura J Dunlop*

I. INTRODUCTION

In Scotland, the principal legislation providing for adults who lack capacity is the Adults with Incapacity (Scotland) Act 2000. This Act was based on work by the Scottish Law Commission (SLC), culminating in the publication in 1995 of a Report on the topic.[1] In 2009, during a consultation to devise the SLC's eighth programme of law reform, representations were received suggesting inclusion of a project on deprivation of liberty in the context of adult incapacity.[2] Between 2010 and 2014, the SLC therefore undertook such a project. The central issue was whether people with cognitive disability who were considered to require restriction of their freedom of action for their own protection, but were unable to consent to such arrangements, were deprived of their liberty in terms of Article 5 of the European Convention on Human Rights when the arrangements were implemented and, if so, how such deprivations should be authorised.

In this article, I shall refer to 'Bournewood' or 'the Bournewood issue' as shorthand for the litigations which propelled the issue forward over the period 1997 to 2005, these being *R v Bournewood Community and Mental Health NHS Trust ex parte L*[3] and *HL v UK*.[4] I shall begin with the legal landscape in Scotland in relation to the Bournewood issue, both in terms of the legislation which governs decision-making and the case-law which has addressed the circumstances of specific individuals. I shall then chronicle the progress of the law reform project, and set out the recommendations made, with some explanation of the underlying thinking. Finally, I shall offer some reflections on the way forward in relation to these issues for people in Scotland.

II. INITIAL RESPONSE IN SCOTLAND TO BOURNEWOOD

If the formal response to Bournewood in England and Wales is seen as the introduction of the Deprivation of Liberty Safeguards by way of amendment of the Mental Capacity Act 2005, the initial response to Bournewood in Scotland was very different. The only alteration to Scottish legislation in relation to informal detention was the inclusion in the Mental Health Care and Treatment (Scotland) Act 2003 of section 291,[5] which provides:

> 291 Application to Tribunal in relation to unlawful detention
> (1) This section applies where, otherwise than by virtue of this Act or the 1995 Act, a person ("the patient")–
> (a) has been admitted to a hospital; and

---

* QC, DUniv, LL.B, DipLP, Scottish Law Commissioner 2009 to 2014.

[1] Scottish Law Commission, *Incapable Adults* (Scot Law Com No 151, 1995).

[2] The Eighth Programme can be viewed on the SLC website www.scotlawcom.gov.uk

[3] [1999] 1 AC 458 (HL).

[4] (2005) 40 EHRR 32.

[5] At the time of introduction of the Bill, when the provision formed section 202, para 326 of the Policy Memorandum commented '(T)he Tribunal is, by way of section 202 of the Bill, given jurisdiction to consider applications by persons ("informal patients") in respect of whom no authority to detain applies but who may contend that they are *de facto* being unlawfully detained'.

(b) is being given treatment there primarily for mental disorder.

(2) A person mentioned in subsection (4) below may apply to the Tribunal for an order requiring the managers of the hospital to cease to detain the patient.

(3) On an application under subsection (2) above the Tribunal shall–
(a) if satisfied that the patient is being unlawfully detained in the hospital, make the order mentioned in subsection (2) above; or
(b) if not satisfied about the matter mentioned in paragraph (a) above, refuse the application.

(4) The persons referred to in subsection (2) above are–
(a) the patient;
(b) the patient's named person;
(c) if the patient is a child, any person who has parental responsibilities in relation to the patient;
(d) a mental health officer;
(e) the Commission;[6]
(f) any guardian of the patient;
(g) any welfare attorney of the patient; and
(h) any other person having an interest in the welfare of the patient.

(5) Subsection (2) above is without prejudice to any right that a person has by virtue of any enactment or rule of law.[7]
…

Had a person in the situation of HL been informally detained in hospital in Scotland for the purposes of medical treatment after the commencement of this provision, an order for release could therefore have been sought from the Mental Health Tribunal. In that no new mechanism was provided whereby a deprivation of liberty in the context of adult incapacity could be prospectively and specifically authorised, as appears to be required by Article 5, this was only a partial solution to the issue raised by Bournewood. Although the case had not considered the situation in Scotland, the practical position was the same. Individuals who were compliant with, but unable to consent to, their living conditions were resident in secure psychiatric hospitals as informal patients, and people with dementia and other analogous conditions were living in nursing homes under private arrangements. Whether the gap in legislation generated litigation in Scotland in the aftermath of Bournewood is therefore examined.

III. LITIGATION IN SCOTLAND

The first reported case in which the issue arose was *Muldoon, Applicant*.[8] The applicant sought appointment as guardian to his mother, aged 77, who suffered from severe vascular dementia and was no longer capable of independent living or of managing her own affairs. She was living in a nursing home where she appeared to be content. The mental health officer opposed the appointment as not being the least

[6] The Commission here referred to is the Mental Welfare Commission, first established for Scotland by section 2 of the Mental Health (Scotland) Act 1960 and given functions in relation to adults with incapacity by section 9 of the Adults with Incapacity (Scotland) Act 2000.
[7] Only limited use has been made of this provision since its enactment; see Scottish Law Commission, *Adults with Incapacity* (Scot Law Com No 240, 2014) at para 3.64.
[8] 2005 SLT (Sh Ct) 52. Other sheriffs followed the approach taken by Sheriff Baird in *Muldoon*: see, for example, *M, Applicant* 2009 SLT (Sh Ct) 185 (Sheriff I McDonald); *CJR Applicant*, Kirkcaldy, 27 February 2013 (Sheriff Thornton).

restrictive option, therefore not in conformity with the 2000 Act.[9] The Sheriff appointed a safeguarder, in terms of section 3 of the Act, to report on the interests of the adult. The safeguarder instructed a report to be obtained by an independent social worker, who concluded that the least restrictive option would be an informal framework of care, which the adult was already enjoying. The Sheriff described the conclusion of the independent social worker as 'significant' and referred to it at length:

> While noting her severely impaired capacity to make decisions, [the adult] was, [the safeguarder] said, "compliant" with the care provided and to remaining where she was. Although recognising the noble motivation of the applicant, he noted recent guidance from the Mental Welfare Commission for Scotland (Authorising Significant Interventions for Adults Who Lack Capacity August 2004), which suggests a selective approach towards incapable adults. He said he agreed with that in the case of the adult who was incapable and "compliant" (that word again — I will return to it) and believed that welfare guardianship was not necessary to ensure her health, care and welfare.[10]

The Sheriff was not persuaded however, that this was the correct approach. Standing the decision of the European Court of Human Rights in Bournewood, he considered that he had no alternative but to grant the guardianship application. He observed:

> In other words, where the adult is compliant with the regime, but is legally incapable of consenting to or disagreeing with it, then that person is deprived of his or her liberty in breach of art 5 of the Convention, and that step should not be taken without express statutory [authority] governing it. ...
>
> In the present case, the appropriate statutory intervention is a guardianship order under Pt 6 of the Act. I believe it will benefit the adult and that such benefit cannot reasonably be achieved without the intervention.
>
> I believe that the effect of my ruling in this case will be that in every case where a court is dealing with an adult who is incapable but compliant, the least restrictive option will be the granting of a guardianship order under the Act (assuming of course that all the other statutory requirements are satisfied), for that way only will the necessary safeguards and statutory and regulatory framework to protect the adult (and the guardian), come into play.[11]

The sheriff did not make any assessment of whether, in terms of case-law from the European Court of Human Rights, the circumstances in the nursing home amounted to a deprivation of liberty, but advocated the appointment of guardians to all adults who were incapable of consenting to their care regimes.

In the wake of this decision, the Scottish Government issued guidance concerning the scope of the Act.[12] This guidance informed local authorities that the Scottish Government did not take the view that a guardian should be appointed in all cases where a move to residential accommodation was contemplated and the adult lacked capacity but was compliant. This divergence between the 'universal' and 'selective' approaches was the background against which the SLC's law reform project began.

---

[9] One of the principles set out in s 1 of the Adults with Incapacity (Scotland) Act is that, once it has been determined that an intervention is to be made in the life of an adult, that intervention 'shall be the least restrictive option in relation to the freedom of the adult consistent with the purpose of the intervention': s 1(3).

[10] 2005 SLT (Sh Ct) 52 at 54J.

[11] ibid at 58K - 59B.

[12] The guidance now appears as Annex 1 to the Adults with Incapacity (Scotland) Act 2000: Code of Practice for Local Authorities Exercising Functions under the 2000 Act, published on 1 April 2008.

IV. LAW REFORM PROJECT BEGINS

In addressing the Bournewood issue in Scotland, the SLC followed its normal course for a law reform project: (internal) scoping paper in 2010; consultation through issue of a Discussion Paper, published in 2012;[13] analysis of responses and preparation of (internal) policy paper in 2013 and publication of a report in 2014.[14] At the outset, in 2010, an Advisory Group was formed, consisting of lawyers and other professionals working in the area. This group met regularly throughout the duration of the project and its members contributed to the analysis of the issue and the development of proposals for reform of Scots law.

It is relatively common for law reform in Scotland to take place in the aftermath of legislative change in England and Wales. The statute books yield examples of an Act for England and Wales followed a year or two later by another with (Scotland) in its title, sometimes containing provisions not so very different from what was in the English legislation.[15] Since the reestablishment of the Scottish Parliament in 1999, that trend is probably less marked, but the phenomenon does still occur.[16] There is even a term for such adaptation of legislation from Westminster – 'putting a kilt on it'. With deprivation of liberty, however, the situation was different. By the time of the drafting of the Discussion Paper in 2012, it was apparent that there were significant difficulties with the operation of the Deprivation of Liberty Safeguards in England and Wales. It did not seem likely that they could be adopted, even with 'kiltification', in Scotland. The SLC therefore anticipated that a different approach would be needed. But the project team within the SLC realised early in its work that it was easier to criticise the safeguards than to fashion an alternative scheme.[17]

It was apparent from the outset that any scheme devised would have a potential reach that was extremely wide, both in terms of the number of individuals to whom it might apply and the range of settings in which it might operate. Insofar as definition was concerned, the Mental Capacity Act 2005 had simply provided that, for the purposes of the Act, 'references to deprivation of a person's liberty have the same meaning as in Article 5(1) of the Human Rights Convention'.[18] In individual situations, it had thus been necessary to try to distil from the Strasbourg jurisprudence the essence of the concept of deprivation of liberty in European Human Rights law. Case-law in England and Wales had canvassed in detail features which were argued to be material in deciding whether or not deprivation of liberty was taking place.[19] In particular, the relevance of reason, purpose and motive underlying the adoption of a particular regime had been debated. Comparison of the person's situation with the

[13] Scottish Law Commission, *Adults with Incapacity* (Scot Law Com DP No 156, 2012).
[14] Scottish Law Commission, *Adults with Incapacity* (Scot Law Com No 240, 2014).
[15] Such as the Mental Health Acts of 1959 and 1983, and the Mental Health (Scotland) Acts of 1960 and 1984.
[16] For a rather arcane example, compare the Fur Farming Prohibition Act 2000 and the Fur Farming Prohibition (Scotland) Act 2002.
[17] At para 4.30, the Discussion Paper observed 'It is certainly evident on an examination of the Deprivation of Liberty Safeguards that they are complex and that the statutory material and supplementary code are voluminous. It is less evident how a simple scheme which meets the needs of those it is designed to safeguard and is easy to administer could be devised'.
[18] Section 64(5).
[19] At the outset of the SLC project, it was evident that the cases of *Surrey County Council v P* and *Cheshire West and Chester Council v P* would be significant, owing to the particular issues raised by the circumstances of the individuals who were the subjects of each litigation.

circumstances of 'an adult of similar age affected by the same condition or suffering the same inherent mental and physical disabilities and limitations' had also been mooted as a relevant exercise.[20]

The SLC, however, was not persuaded that these features would offer a framework around which to devise a scheme for Scotland. The Discussion Paper suggested:

> Were Scots law to develop provisions concerning deprivation of liberty which relied directly on concepts such as the purpose of a measure and the effect of a comparison with another person with similar disabilities in distinguishing deprivation of liberty from the provision of care, there would be a risk that such measures might not accord with Strasbourg case-law on Article 5.[21]

At the same time, the SLC recognised that human rights case-law does not prescribe a particular definition which Member States can simply copy out into domestic law. The Discussion Paper expressed the following view:

> The task for member States may therefore be better seen as the development and maintenance of a system which meets the needs and respects the rights of those with incapacity in their own jurisdiction.[22]

Thus, a central goal of the project was seen as the achievement of a scheme which was suited to people in Scotland.

V. GENERAL ASPIRATIONS

In planning for a scheme which was more straightforward to operate than the Deprivation of Liberty Safeguards, the SLC hoped to be able to include some definition of situations in which the scheme would apply, in contrast to the Mental Capacity Act 2005. At the outset, one feature which did appear to the project team to delimit the potential ambit of any scheme was the distinction between restriction of liberty and deprivation thereof. That there is a continuum between the two has often been remarked upon. The following passage, from the decision of the Grand Chamber of the European Court of Human Rights in the case of *Stanev v Bulgaria*, is typical:

> 115. The Court reiterates that the difference between deprivation of liberty and restrictions on liberty of movement, the latter being governed by Article 2 of Protocol No. 4, is merely one of degree or intensity, and not one of nature or substance.[23]

In addition to definition, the other main area upon which much effort would clearly be required was the detail of any authorisation process. Whilst there was a desire to minimise what could be perceived as 'red tape' in an area that presented particular challenges of quality of care and allocation of resources, it was also recognised that

[20] Lord Justice Munby in *Cheshire West and Chester Council v P* [2011] EWCA Civ 1257, [2012] PTSR 1447 at para 86.
[21] Scot Law Com DP No 156, 2012, para 6.60.
[22] Scot Law Com DP No 156, 2012, para 2.86.
[23] *Stanev v Bulgaria* (2012) 55 EHRR 22 at para 115. See also *Guzzardi v Italy* (1980) 3 EHRR 333 at para 93; *HM v Switzerland* (2004) 38 EHRR 17 at para 42; *HL v United Kingdom* (2005) 40 EHRR 32 at para 89; *Storck v Germany* (2006) 43 EHRR 6 at para 71; *Austin v United Kingdom* (2012) 55 EHRR 14 at para 57.

there would be some irreducible minimum as far as the content of an authorisation process was concerned.[24]

By the time of beginning work on the policy paper and report in 2013, the appeals from the decisions of the Court of Appeal in the *Surrey* and *Cheshire West* cases had been set down for hearing in the Supreme Court. The project team attended the Supreme Court for the duration of the hearings, in October 2013. The scheme which was developed by the SLC, embodied in a draft Bill and explained in the Report, was informed by these cases and their adjudication, particularly where deprivation of liberty in community settings was concerned.

VI. COMMUNITY SETTINGS

As is well known, the decision of the Supreme Court in the appeals of *Surrey* and *Cheshire West* gave rise to 'the acid test' for deprivation of liberty in this context.[25] If a person was 'subject to continuous supervision and control and not free to leave', he or she would be regarded as deprived of their liberty.[26]

Given the twin elements of the acid test, there must in theory exist individuals who are subject to continuous supervision and control but are also free to leave the premises they are in. Conversely, there must be those who are not free to leave, but are also not subject to continuous supervision and control.[27] It is very difficult, however, to formulate specific practical examples of such individuals. If it is not possible coherently to describe people or settings which are not included, then it is likely that, in practice, in a given situation, the test will be deemed to be met. When the penalty of erroneously determining that the test is not met is a breach of Article 5, error on the side of caution is to be expected.

Notwithstanding these difficulties, the SLC proceeded on the basis that the Supreme Court did not intend the test to apply to all those who were unable to consent to their circumstances in all situations. For day to day use, some more concrete version of the test, which could be applied directly by those working in social care, seemed to be required. Particular practical situations where deprivation of liberty needed to be addressed were focused by examining, firstly, how decisions are made about where a person without capacity has their home and, secondly, the conditions which restrict people in their daily life; in other words, the central questions of where people live, and how people live.

A. Where people live

'In proclaiming the "right to liberty", paragraph 1 of Article 5 is contemplating individual liberty in its classic sense, that is to say the physical liberty of the person'. This

[24] Principally, the need for any deprivation of liberty to satisfy the criteria set out by the European Court of Human Rights in *Winterwerp v Netherlands* (1979-1980) 2 EHRR 387 at para 39.
[25] An acid test has been said to be 'a sure test, giving an incontestable result' - The Phrase Finder online dictionary: www.phrases.org.uk/meanings/acid-test.html accessed 1 August 2016.
[26] *P v Cheshire West and Chester Council*; *P and Q v Surrey County Council* [2014] UKSC 19, [2014] AC 896 [48], [54] (Lady Hale), [63] (Lord Neuberger), [87] (Lord Kerr).
[27] ibid, [49] (Lady Hale), rejecting the suggestion that supervision and control is subsumed by freedom to leave.

statement of the position, from *Engel v Netherlands*,[28] is the starting point for examinations of the right to liberty by the Strasbourg court. The Court also observed that '(i)n order to determine whether someone has been "deprived of his liberty" within the meaning of Article 5, the starting point must be his concrete situation'.[29]

At the time when the SLC was formulating its proposals, the European Court of Human Rights had not found deprivation of liberty to exist simply from the fact of incapacity to reach a particular decision and its consequence that the matter will necessarily be resolved by someone else. As was observed by Parker J at first instance in the Surrey case, 'I do not accept that mere placement in a residential or domestic setting can be construed as creating confinement of itself just because the person cannot legally decide whether to remain there or not'.[30] But the SLC considered that compelling a person to live somewhere they did not want to be would be likely to involve an element of coercion or even detention. With the stated aim of meeting the needs and respecting the rights of people who lacked capacity in Scotland, it appeared right to attend to the need for process in such a situation. Determining a person's home is so important that, at least where there is dispute, involving the person or their family or friends, the decision should be taken by a court or a court-appointed substitute decision-maker.[31]

The SLC examined existing processes, and proposed that, with some modification, the current mechanism of the Intervention Order be used for the determination of where a person is to live. Only in cases of particular difficulty, as at present, is guardianship likely to be required.[32]

B. How people live

In attempting to address deprivation of liberty arising from restriction in community settings, the SLC decided to cover all situations where a person is accommodated under arrangements made by the State, or in places subject to statutory inspection. This includes all care homes and adult placements. The draft Bill therefore provides that this part of the scheme applies where a person has been 'placed, by reason of … vulnerability or need, in accommodation provided by (or as the case may be arranged for by) a care home service or an adult placement service'.[33]

Given the emphasis by the European Court of Human Rights on deprivation of liberty being a matter of the concrete situation of the individual, it appeared to the SLC that there were people whose care arrangements in such locations involved such a high degree of restriction that they should be regarded as deprived of their liberty. The care arrangements of the individual at the centre of the *Cheshire West* case, which were highly intrusive, albeit necessarily so, had generated a unanimous finding in the Supreme Court that he was deprived of his liberty. It may be that, almost instinctively, the justices felt that the magnitude of intervention in P's life was so great that an

[28] (1979-80) 1 EHRR 647, at para 58.
[29] ibid, para 59.
[30] Discussed in Scot Law Com DP No 156, 2012, para 4.39.
[31] See discussion of how these decisions may be reached in Scot Law Com No 240, 2014, paras 4.21 - 4.24 and 4.51.
[32] ibid, paras 4.25 - 4.28.
[33] Scot Law Com No 240, 2014, draft Bill s 52A(3).

authorisation process was essential. Likewise, the SLC considered that care arrangements which involved a level of restriction above a particular threshold should be subject to an authorisation process. But capturing that threshold in legislation would not be easy.[34]

It was readily apparent that the tethering of the definition of deprivation of liberty in the English and Welsh scheme to whatever the concept encompassed in Strasbourg jurisprudence from time to time had caused serious practical difficulty. It also appeared to necessitate detailed assessment of the circumstances of every individual potentially covered, and to lead to inconsistent outcomes around the country.[35] On the other hand, the rationale for the approach was self-evident – identification of deprivation of liberty under Article 5 depended on what the European Court of Human Rights had said it comprised, and any attempt to fix the concept in Scots law would run the risk of a mismatch.

The SLC concluded that the solution to this was to avoid using the term 'deprivation of liberty' in Scottish legislation and, instead, build on the idea of restriction to deprivation being a continuum, by trying to identify the threshold at which the transition occurs. So the concept of 'significant restriction of liberty' was fashioned, and defined. It was not intended to be broader than what the European Court of Human Rights would regard as deprivation of liberty, although it was considered that it would do no harm if protection were to be offered more widely than strictly required by Article 5. It was also fundamental to the SLC's ethos throughout the project that there should be a scheme tailored to circumstances in Scotland. In this regard, an observation made by a respondent to consultation concerning the need to attend to risks of inappropriate and excessive restraint, seclusion and sedation, was influential.[36] Finally, to assist those working in social care, the SLC aimed to create something measurable.

In preparing draft amendments to the Adults with Incapacity (Scotland) Act 2000, the SLC endeavoured to utilise the acid test set out in the *Cheshire West* decision. The composite element represented by the twin notions of lack of freedom to leave and subjection to supervision and control was reflected by providing for the regular use of any two of a list of three types of restrictive measure. The expectation was that, in practice, restriction of freedom to leave would be present in all situations where a person was significantly restricted; the triggering of the need for authorisation would therefore derive from the adoption of one of the other types of restriction on top of control of egress.

Elaborating the notion of freedom to leave was challenging. There is a difference between freedom to leave as a matter of law and such freedom as a matter of fact. 'Leaving' could be in the sense of going out to buy something from a nearby shop, or 'in the sense of removing himself permanently in order to live where and with whom

[34] Consultation had generated responses suggesting, variously, that any definition be contained in guidance, legislation or both. The SLC concluded that legislation was the appropriate vehicle: Scot Law Com No 240, 2014, paras 3.37 - 3.38 and 4.55.

[35] Research by the South London and Maudsley NHS Foundation Trust using real-life examples revealed little agreement in the application of the test amongst lawyers, psychiatrists, Independent Mental Capacity Advocates and Best-Interests Assessors: Cairns et al, 'Judgements about deprivation of liberty made by various professionals: comparison study' (2011) 35 *The Psychiatrist* 344.

[36] Scot Law Com No 240, 2014, para 3.28.

he chooses'.[37] One could further probe the extent to which these different senses are mutually exclusive or overlapping. Such analysis would not necessarily advance the search for a workable solution. The SLC decided to take as simple an approach as possible, partly because it seemed that when the European Court of Human Rights referred to 'freedom to leave' it meant something quite basic: can the person go out at will?[38] This probably reflects freedom as a matter of fact, and leaving in the sense of going out of the main door. Accordingly, the first element included in the SLC definition of significant restriction of liberty was that the person:

> (a) (i) is not allowed, unaccompanied, to leave the premises in which placed.[39]

Some individuals who live a restricted life are not prevented from leaving a building by a locked door, because physical disability prevents them from being able to make the attempt. The SLC did not wish that to operate as a practical restriction which would escape regulation, so added as an alternative that the person

> (ii) is unable, by reason of physical impairment, to leave those premises unassisted.[40]

Next, the SLC endeavoured to capture the idea of 'subject to continuous supervision and control'. This appeared to relate to how the person's actions are regulated. It could encompass physical measures within premises, or control directly imposed on the person, including by medication. The second and third elements of the definition were, therefore, that

> (b) barriers are used to limit the adult to particular areas of those premises,
> (c) the adult's actions are controlled, whether or not within those premises, by the application of physical force, the use of restraints or (for the purpose of such control) the administering of medication.[41]

C. Factors omitted

In relation to the presence of barriers in particular, the SLC recognised that there could be an overlap between these provisions and rules designed to exclude residents from areas of the premises for safety reasons. The draft Bill therefore included an exemption for what might fairly be described as 'house rules'.[42]

Another aspect of a person's life which may be relevant in an assessment of deprivation of liberty is the matter of social contact.[43] It is possible for those

---

[37] *Cheshire* (n 25) at [40], under reference to Lord Justice Munby in *JE v DE and Surrey County Council* [2006] EWHC 3459 (Fam), [2007] 2 FLR 1150. Practical application of this formula is not straightforward. Residential care may be the only option for an individual when a spouse can no longer care for them; in such a situation, the choice to live with a particular person may not be reciprocal. Whether a person in that situation has 'freedom to leave' in the *JE* sense is difficult to answer.

[38] See, for example, *Stanev* (n 22) at para 128: 'free to leave the home without permission whenever he wished'.

[39] Scot Law Com No 240, 2014, draft Bill section 52A(1)(a)(i).

[40] ibid, draft Bill section 52A(1)(a)(ii).

[41] ibid, draft Bill section 52A(1)(b) and (c). Restraint specifically includes special clothing, but not devices solely to protect against falling, like lapbelts and bedrails (section 52A(4)(b)).

[42] ibid, draft Bill section 52A(2), explained at para 6.27 of the Report.

[43] *Chosta v Ukraine* App no 35807/05 (ECtHR, 14 January 2014), where the court observed that in identifying deprivation of liberty, 'relevant objective factors to be considered include the possibility to leave the restricted area, the degree of supervision and control over the person's movements and the **extent of isolation**' (emphasis added).

responsible for the management of premises to take the view that a person who lives there should not have contact with another individual, perhaps a member of their family or a previous associate. The subjective motivation behind the imposition of such restrictions will be positive – the third party is perceived to have a detrimental effect or even to pose a risk of harm to the person living in the premises. But integral to all the Care Standards applying to the sorts of regime addressed is the principle that contact with friends and family is encouraged. The SLC did not want, even by implication, to compromise the primacy of the aim of maintaining social contact. It was also obvious that the rights of the other party to the prospective communication were involved.[44]

This omission from the SLC scheme did not reflect a view that such matters as restriction of contact or communication would be irrelevant to the assessment of whether deprivation of liberty had occurred. From the decisions of the European Court of Human Rights, it was plain that such restrictions would be relevant matters in any such assessment. Rather, the position was premised on the SLC's view that such matters should not be covered in this authorisation scheme, for the reasons explained above. Scotland already has legislation which can be used to restrict contact perceived to be detrimental to a vulnerable adult.[45]

Lastly, it was also decided not to include a 'catch-all provision', of the nature of 'any other restriction applied to the person concerned', on the basis that clarity and certainty were important goals of the scheme. These would be diminished were such generalised wording to be included.[46]

D. Process

Insofar as the process which would operate was concerned, the SLC derived assistance from the work of the Victorian Law Reform Commission in Australia.[47] The Commission had addressed deprivation of liberty in the context of adult incapacity, and had devised a process of 'collaborative authorisation' involving the manager of the premises where the person lives, a medical professional and the person's healthcare decision maker according to domestic law.[48] Adapting this to Scotland, the SLC devised a process requiring preparation by the manager of premises, or the person's social worker, of a statement of measures sought to be implemented. The Statement of Significant Restriction is at the heart of the proposed scheme. It is intended as a document which is served on those with an interest in the person's welfare, scrutinised during the authorisation process and available when premises are inspected or the person is visited by those with a monitoring role, such as the Mental Welfare Commission.

Reports addressing the proposed measures must be obtained from a medical practitioner and a mental health officer.[49] Built in to the scheme are provisions designed to achieve consensus among this group if at all possible. If, and only if, there is unanimity about the need to impose the restrictions in the statement, authorisation

[44] Scot Law Com No 240, 2014, paras 6.17 - 6.25.
[45] Adult Support and Protection (Scotland) Act 2007.
[46] Scot Law Com No 240, 2014, para 6.26.
[47] Victorian Law Reform Commission, Report on Guardianship (2012).
[48] ibid, paras 15.133 - 15.156.
[49] Scot Law Com No 240, 2014, paras 6.32 - 6.37; draft Bill section 52D.

could be by a person holding a welfare power of attorney or by a guardian with welfare powers.[50] If there is no such person, or if they decline to grant authorisation, and in situations where there is dissent among the authors of the reports, then the matter will have to be referred to the sheriff.[51]

Procedure in an application to the sheriff will be by summary application, all as governed by the rules specific to adults with incapacity. Service upon a wide range of individuals and bodies would be required, and a hearing would need to be fixed.

In recognition of the requirements of Article 5(4) of the Convention, the SLC also proposed that there should be rights of challenge and of appeal. The use of two distinct terms reflects the potential for authorisation by a substitute decision-maker (either a person holding a welfare power of attorney or a guardian with welfare powers), challenge of whose decision might not, strictly, be described as an appeal. The potentially problematic characterisation of such an authorisation is discussed below. Under the SLC scheme, challenge of such an authorisation would be by application to the sheriff, and could be made either by the adult or by any person having an interest in the personal welfare of the adult.[52] Where authorisation to implement restrictions has been granted by the sheriff, appeal would be to the sheriff principal in accordance with section 2 of the Adults with Incapacity (Scotland) Act 2000.

Were the scheme to be implemented, then for all such appellate steps but particularly in relation to challenge or appeal by the person themselves, specific practical arrangements would need to be made for the provision of advocacy services and legal advice and assistance, including legal aid, to render the rights conferred both practical and effective, as required under ECHR.[53]

Insofar as authorisation by a substitute decision-maker is concerned, questions necessarily arise about the required content of a guardianship order or power of attorney document.[54] More specifically, should an express power to authorise restriction, even of such intensity as to be tantamount to deprivation, be indispensable? The SLC devoted much consideration to this point. Ultimately, the view was taken that this was a matter of interpretation: the nature of what was proposed for the person, rather than any particular label for such measures, would need to be examined and the appointing order or document interpreted to assess whether sanctioning of the proposals was within the powers granted to the decision-maker. It was, however, anticipated by the SLC that this aspect would generate debate in the course of consideration of the scheme and any further consultation thereon.

Once authorisation has been granted to implement significant restriction of liberty, whether by a person holding a welfare power of attorney or by the sheriff, the proposed

[50] Scot Law Com No 240, 2014, para 6.38; draft Bill section 52E(2).
[51] Scot Law Com No 240, 2014, para 6.40; draft Bill section 52E(1)(b).
[52] Scot Law Com No 240, 2014, para 6.41 to 6.43; draft Bill section 52E(9).
[53] See, for example, dicta regarding the need for a remedy to be available not only in legislation but also in practice: *MH v UK* (2014) 58 EHRR 35.
[54] Scot Law Com No 240, 2014, para 4.61.

scheme provides that the authorisation, together with a copy of the Statement of Significant Restriction, must be intimated to the Mental Welfare Commission.[55]

E. 'Valid replacement'

Inclusion, in a limited category of cases, of the possibility of authorisation by a person acting under a welfare power of attorney was considered by the SLC to reflect the autonomy the person had exercised when choosing a substitute decision-maker.[56] As already noted, the scheme also provides that, in some situations, a guardian with welfare powers may authorise significant restriction of liberty. How authorisation by a substitute decision-maker should be analysed in terms of Strasbourg jurisprudence may be debatable: the second or subjective element in the concept of deprivation of liberty is that the person has not validly consented to the measures imposed. In the *Stanev* case, it was suggested that the wishes of a person with incapacity may 'validly be replaced' by those of another person.[57] As a matter of logic, that suggests that, where measures are authorised by a person acting under a welfare power of attorney or a guardian with welfare powers, the subjective element in deprivation of liberty does not exist – in other words, there is consent to the measures, therefore no deprivation of liberty.

The SLC did not consider that this isolated statement by the European Court of Human Rights provided sufficient authority for the proposition that, in such circumstances, no deprivation of liberty under Article 5 existed. The proposals were therefore drafted on the basis that if such authorisation by a welfare power of attorney or guardian with welfare powers is to be an element of the scheme, it should be viewed as equivalent to an administrative process and, therefore, one requiring access to a court under Article 5(4) to be provided.[58]

F. Duration of authorisation

The scheme provides that any authorisation will last for a period of one year after the date on which the authorisation is obtained.[59] This is the case whether the authorisation is granted by the sheriff, or by a substitute decision-maker. A renewal process is set out in the draft Bill. Preparation of the same range of reports and adjustment of the terms of the Statement of Significant Restriction amongst participants is provided for in like manner to the original authorisation process.[60]

VII. HOSPITALS: PHYSICAL HEALTHCARE

The SLC also made recommendations in relation to treatment as a hospital in-patient. Part 5 of the Adults with Incapacity (Scotland) Act 2000 sets out the mechanism by which the requisite authority for medical treatment is obtained where an adult patient is unable to consent themselves to such an intervention. There are however no provisions enabling the adoption of measures to prevent an adult who lacks capacity

[55] Draft Bill, section 52I.
[56] Scot Law Com No 240, 2014, para 4.59.
[57] *Stanev* (n 22) para 130.
[58] ibid, para 3.59.
[59] Scot Law Com No 240, 2014, para 6.44; draft Bill section 52E(13).
[60] Scot Law Com No 240, 2014, para 6.44; draft Bill section 52G.

from leaving the hospital premises. Such measures are already being adopted in the course of physical healthcare and the SLC recommended that provisions sanctioning that course of action and affording rights of challenge should be introduced. This is all set out in Chapter 5 of the SLC report, and only a brief overview is provided here.

The SLC considered that a process which was simpler than that proposed for community settings was required for physical healthcare situations. By their nature, admissions to hospital are likely to be short-term; it is contrary to Scottish Government policy for any person to have a hospital as their home.[61] There is likely also to be a degree of urgency in most cases, even if the situation does not constitute a medical emergency.

The first step in the SLC's suggested process requires an assessment of the person's capacity to decide whether or not to leave the hospital. If the person is found to lack such capacity, reasonable steps may be taken to prevent them from leaving. Rights of appeal are conferred on the patient, and on anyone claiming an interest in their personal welfare.[62]

The question of duration of such authority generated difficulty, with a number of different practical problems envisaged. The person's condition may fluctuate. Or there may be difficulty in finding a place to which they can be discharged and, although their medical treatment has concluded, they need to remain in hospital and to be kept safe within the hospital premises. It did not appear likely that selection of a fixed number of days would cover all eventualities. For this reason, the proposed statutory scheme allows restrictions to be imposed for so long as the need for them is 'manifest'; application of this criterion will be for the courts on a case by case basis. The scheme also confers a right to apply to the sheriff court for the sheriff to set a date beyond which there is to be no authority to continue to impose such restrictions.[63]

VIII. RELEASE PROVISION FOR OTHER PREMISES

Finally, the SLC recommended the introduction of a provision mirrored on section 291 of the Mental Health (Care and Treatment) (Scotland) Act 2003 but applicable in premises other than a hospital, to permit an adult who is in informal detention to obtain an order for release. At common law, such release may currently be available through Judicial Review, but that procedure is confined to the Court of Session; the proposed new provision should offer a remedy that is more straightforward to obtain.[64]

Under the proposed procedure, an order may be made for the release of any adult accommodated under arrangements made by the State, or in premises subject to inspection.[65] Proof of incapacity is not required: the provision applies where an adult is, or may be, incapable.[66] Application to the sheriff may be made by the adult, or by

[61] Scot Law Com No 240, 2014, para 5.3.
[62] Scot Law Com No 240, 2014, draft Bill at section 50A.
[63] The provisions were informed by features of the existing Scottish schemes in relation to detention under the public health legislation and for seeking a declaration of excessive security under the Mental Health (Care and Treatment) (Scotland) Act 2003; see further discussion at paras 4.30 - 4.38 and 5.19 - 5.24 of the Report.
[64] Chapter 7 of the Report.
[65] Scot Law Com No 240, 2014, para 7.2; draft Bill at section 52J(1).
[66] Ibid.

any person claiming an interest in the personal welfare of the adult.[67] If the sheriff is satisfied that the person is being detained unlawfully, they must grant an order requiring the cessation of detention.[68] The mandatory nature of the provision could create practical difficulties in the event that the adult has immediate care needs. The SLC anticipated that, in such a situation, consideration would be given to the use by the sheriff of the powers under section 3 of the 2000 Act, to make an appropriate consequential or ancillary order, provision or direction.[69]

IX. CONCLUSION

This project was directed towards remedying a gap in Scots law. As it progressed, profound questions about the nature of the law reform task emerged. Was the project about more than simply addressing that deficiency, more than achieving formal compliance with Article 5? Could any changes that might be proposed deliver a tangible benefit to people with cognitive disability? What were we trying to fix?

It cannot be claimed that these questions were conclusively answered during the five years of work by the SLC. Perhaps this is not surprising - problems of characterisation in this area are longstanding. As long ago as 1681, the Scottish Institutional writer, Viscount Stair, asserted that restraint of a 'furious person' or a person risking harm to himself was not an interference with the right to liberty, but an action in pursuance of a duty of love and mercy.[70]

At the centre of the project were two essential principles, the right to autonomy and the need for protection. The balancing of these two goals may depend on a third concept, that of benefit, which is at the heart of the Adults with Incapacity (Scotland) Act 2000. Whether benefit to an individual requires greater priority to be given to protection or to autonomy is likely to depend on the context of a proposed intervention, and will vary throughout the span of every human life.

In trying to meet the challenge posed by Article 5 in relation to adults who lack some decision-making capacity, it is likely that several strands will be relevant. Individual rights of challenge of proposed significant restriction of liberty may be part of the response in Scotland, as may the pursuit of government policy and professional commitment directed to reducing levels of security that are excessive.[71] Regular and sometimes unannounced inspection of care facilities is also likely to contribute.[72] In this regard, a member of the Advisory Group was able to share with the project team her experience of restrictions imposed at an institutional level:

> The story is sometimes that when you ask why the door is locked, it turns out that one of the 20 residents used to try to get out a lot, and they just settled for always having it locked in case even though she's now in a wheelchair and the other nineteen haven't ever been consulted.

[67] Scot Law Com No 240, 2014, para 7.3; draft Bill at section 52J(2).
[68] Scot Law Com No 240, 2014, para 7.4; draft Bill at section 52J(3).
[69] Scot Law Com No 240, 2014, page 98, explanatory note to section 52J.
[70] Stair, *Inst* I, 2, 5.
[71] Lady Hale has referred to the contribution made by government policy and professional commitment in reducing excessive security for patients detained under mental health legislation: *G v Mental Health Tribunal for Scotland* [2013] UKSC 79, 2014 SC (UKSC) 84, [70].
[72] The regulator in Scotland is the Care Inspectorate: www.careinspectorate.com

> Another is that you see the lovely dementia friendly garden or roof terrace and when you ask to step out to look at it, no one on duty knows where the key is, or whether it is "allowed" to open the door, because they've never seen it open.
>
> Another is when all the doors to the bedrooms are locked all day because one resident might go into someone else's room and steal their chocolate.
>
> Only the minimum restraint, for the minimum time, affecting the minimum number of people reviewed as often as humanly possible is the main idea.[73]

Compliance with Article 5 of the European Convention on Human Rights requires that there should not be arbitrary interference with the right to liberty of any adult in a member State. The need to secure such compliance for Scotland was the genesis of the project conducted by the SLC but, for the project team, it became equally important to contribute to minimising the degree of restriction to which many adults with incapacity are subject in their daily lives. If securing ECHR compliance leads to levels of restriction in residential care and on individuals being as much as necessary, but as little as possible, delivery of a significant tangible benefit will have been achieved.

Acknowledgment.

The author is grateful to Professor Hector MacQueen, Scottish Law Commission, for his comments on an earlier draft of this article. Any remaining errors or infelicities of language are hers alone.

[73] Professor June Andrews OBE, Dementia Services Development Centre, University of Stirling.

XU VS. THE HOSPITAL AND HIS GUARDIAN – INVOLUNTARY INPATIENT TREATMENT

Bo Chen*

I. INTRODUCTION

China's first Mental Health Law (hereinafter, MHL) came into force on 1 May, 2013. It was praised as a landmark for rights protection of persons with mental disabilities in China[1]. The MHL reflects typical "rights-based" mental health legislation, in which involuntary inpatient treatment[2] is only permitted when a person with severe mental disorder is seen to pose a risk of harm to self or others.[3] Compared with the municipal mental health regulations before the MHL, it is believed to introduce a higher threshold for involuntary inpatient treatment.[4] For example, under the Shanghai Municipal Mental Health Regulation (before being amended according to the MHL), a person with mental disorder can be involuntarily committed and treated if he or she were regarded as lacking insight and in need of treatment.[5] Because of the gap between the threshold of involuntary inpatient treatment before and after the MHL, it was commonly believed that many people involuntarily hospitalised would be discharged after MHL's entry into force. For example, Yongqiang Lin predicted that in Guangdong Province, 90% of patients currently hospitalised would leave hospital because they would not meet the new criteria.[6] It is now two years since the coming into force of the MHL, and no evidence is observed that those patients in Lin's prediction can be successfully discharged. An explanation as to why this is the case may be offered by the case of Mr. Xu,[7] a man who unsuccessfully sued both his appointed guardian and the hospital that sought his involuntary hospitalisation, claiming that his right to liberty had been denied.[8]

---

* Ph.D. student and School of Law Fellow at the Centre for Disability Law and Policy, School of Law, National University of Ireland, Galway.

[1] X. Zhao and J. Dawson, 'The New Chinese Mental Health Law' (2014) 21 Psychiatry, Psychology and Law 669.

[2] The MHL does not make a distinction between involuntary commitment and involuntary treatment, but adopts the term 'inpatient treatment' that combines detention and treatment in Article 30. For English version, see 'Translated and Annotated Version of China's New Mental Health Law' (2012) 24 Shanghai Archives of Psychiatry 305.

[3] Sascha Mira Callaghan and Christopher Ryan, 'Is There a Future for Involuntary Treatment in Rights-Based Mental Health Law?' (2014) 21 Psychiatry, Psychology and Law 747.

[4] Yang Shao and others, 'Current Legislation on Admission of Mentally Ill Patients in China' (2010) 33 International Journal of Law and Psychiatry 52.

[5] Article 30 of the Shanghai Municipal Mental Health Regulation, entry into force on 7 April 2002. For a more detailed comparative research, see Yang Shao and Bin Xie, 'Approaches to Involuntary Admission of the Mentally Ill in the People's Republic of China: Changes in Legislation From 2002 to 2012' (2015) 43 Journal of the American Academy of Psychiatry and the Law Online 35.

[6] Yang Chen, 'Involuntary Commitment Is Only For People Who Are Both Severely Ill and Dangerous', *XKB* Newspaper (Guangzhou, 18 December 2012) A09. The report is available at http://epaper.xkb.com.cn/view/834408 , accessed on 1 December 2015.

[7] （2015）沪一中民一（民）终字第2018号 [*Xu vs. the Hospital and his Guardian – Involuntary Inpatient Treatment*, First Civil Court of Shanghai No.1 Intermediate People's Court, Final No. 2018, 15 September 2015] (translated by Author).

[8] Article 82 of MHL states "Persons with mental disorders and their guardians and close relatives who believe that administrative bodies, medical facilities, other relevant agencies, or individuals have violated the provisions of this law and infringed on the legal rights and interests of persons with mental disorders may legally initiate a lawsuit. But in Xu's case, Xu's capacity to litigate was challenged and

Based on the search on *China Judgments Online*[9], the official website for open judgments operated by the Supreme People's Court of the People's Republic of China, Xu's is the first case that a hospitalised person sued for his discharge under the MHL. As will be argued in this case note, Xu's failure suggests that the MHL needs stronger safeguarding measures, such as independent review body and periodic re-evaluation, to achieve its rights-protecting purpose. It can be also argued, through Xu's case, that the change in criteria for involuntary inpatient treatment would not result in the discharge of patients who no longer satisfy the criteria unless the court adopts an explicit approach in identifying whether a patient has the capacity to "complete hospital discharge procedures" in Article 45. In addition, the case of Xu raises concerns about whether the law and practice in China is compliant with the UN Convention on the Rights of Persons with Disabilities (hereinafter, CRPD), which China ratified on 26 June 2008. It is outside of the scope of this case note to provide a detailed analysis of the tensions between the MHL and China's obligations under the CRPD, nonetheless Xu's case offers some insights into the potential implications of the CRPD in the way the MHL is operating.

It is worth noting that, unlike most mental health laws or legislation in common law jurisdictions that focus on authorising and regulating involuntary commitment and treatment, the MHL covers broader issues including promotion of psychological well-being and prevention of mental disorder (Chapter II), diagnosis and treatment of mental disorders (Chapter III), rehabilitation of mental disorders (Chapter IV), and measures necessary to implement the law such as financial input (Chapter V). Among them, Article 21, which states "… if it appears that a family member may have a mental disorder, other family members shall help them obtain prompt medical care, provide for their daily needs, and assume responsibility for their supervision and management", reaffirms family responsibility for the care of people with mental disorders. The family's total responsibility and access to community-based support are important factors in this case, as well as in many other cases, but this case note only addresses the provisions on inpatient treatment and discharge that are applied in the court's decision.

This case note will present the case of Xu with a view to examining the operation of the MHL in Chinese courts. The following two sections will look at the facts and the decision in this case. The fourth section will then discuss the interpretation and application of the MHL in Xu's case and provide some insights from the perspective of the CRPD. The case note concludes with a brief summary of the main points of the article, and highlights the need for ongoing research into the operation of the MHL in China.

---

then settled through an assessment of Xu's capacity to litigate. An analysis on this issue, see Bo Chen, 'Right to Litigate of Persons with Psychosocial Disabilities in China: From Mental Health Law to the UN Convention on the Rights of Persons with Disabilities', *Disability Rights Study in China 2015* (Social Science Academic Press, Beijing 2015).

[9] http://www.court.gov.cn/zgcpwsw/, accessed on 1 February 2016.

II. FACTS

Xu is a male Chinese citizen who was born in the 1960s. Xu was hospitalised by a mental hospital in Shanghai in the December of 2001 for the first time. His second involuntary inpatient treatment, which continues at the time of writing, commenced on 12 July 2003.[10]

Prior to his hospitalisation, Xu lived in Australia between 1989 and 2000. According to the medical record provided to the court, Xu had been diagnosed with mental disorder in 1997 and become unemployed, "ill-tempered for no reason"[11], depressed, and was gambling. Xu was repatriated by the Australian government in 2000. After repatriation to China, he insisted on returning to Australia and it was reported that he had behaved dangerously towards others. The report indicates that his first hospitalisation following repatriation was committed by the Mental Health Centre in Putuo District in December 2001, where he was diagnosed with schizophrenia. He was prescribed Chlorpromazine and the medical record described the administration of the drug as "very effective". But when he stopped the medication after leaving the hospital, his condition deteriorated. He started to refuse food and suspected that the food was poisoned by his family. Two weeks before his second hospitalisation, his condition became much worse. The report also recorded that he had broken his father's nose in a conflict. This was also the trigger for this hospitalisation to the Shanghai Qingchun Mental Health Rehabilitation Hospital (hereinafter, the hospital).[12]

The information above, which was recorded in Xu's medical report, was accepted by the court and quoted in the judgment.

In the second half of 2008, Xu's father passed away and his older brother was appointed as his guardian by the neighbourhood committee in the place of his residence (hereafter, neighbourhood committee).[13]

---

[10] His commitment was facilitated by his father who signed the consent form. *Xu vs. the Hospital and his Guardian – Involuntary Inpatient Treatment*, p. 1

[11] This term "ill-tempered for no reason" is translated by Author from "无故发脾气", a piece of description on the medical record and quoted by the judgment. See *Xu vs. the Hospital and his Guardian – Involuntary Inpatient Treatment*, p. 1.

[12] *Xu vs. the Hospital and his Guardian – Involuntary Inpatient Treatment*, p. 1.

[13] No information on how or why the older brother was appointed as Xu's guardian is given in the judgment. However, it is a tradition in China that the older brothers and sisters are expected to play the role of parent if the father or mother is unavailable. The appointment of guardian for adults with no/limited capacity for civil conduct is addressed in Article 17 of General Principles of the Civil Law of the People's Republic of China (hereinafter, GPCL): A person from the following categories shall act as guardian for a mentally ill person without or with limited capacity for civil conduct: (1) spouse; (2) parent; (3) adult child; (4) any other near relative; (5) any other closely connected relative or friend willing to bear the responsibility of guardianship and having approval from the unit to which the mentally ill person belongs or from the neighbourhood or village committee in the place of his residence. In case of a dispute over guardianship, the unit to which the mentally ill person belongs or the neighbourhood or village committee in the place of his residence shall appoint a guardian from among his near relatives. If disagreement over the appointment leads to a lawsuit, the people's court shall make a ruling. If none of the persons listed in the first paragraph of this article is available to be the guardian, the unit to which the mentally ill person belongs, the neighbourhood or village committee in the place of his residence or the civil affairs department shall act as his guardian.

Xu requested the hospital to permit him to leave a number of times. On 7 April 2011, the hospital approached Xu's older brother and informed him that the hospital wanted him to take Xu out, because Xu had already been detained in the hospital for eight years. The hospital also had concerns about the fact that Xu attempted to escape once.[14] The older brother, however, "begged" the hospital to keep Xu committed because he said he could not handle the caring of and monitoring of Xu. The older brother also declared that "if something bad happens during the hospitalisation, I will take the full responsibility and have no claim to the hospital."[15] Xu did not regain his liberty because his older brother refused to take him out. Later on, Xu made a complaint to the local committee of his neighbourhood about his hospitalisation. The local committee tried to negotiate with his older brother, but it failed again.[16]

In order to leave the hospital, Xu asked his mother to replace his older brother as his guardian. In 2012, his mother raised the motion on the ground that the older brother failed to fulfil the duty of a guardian. She claimed that the older brother worked in another province and paid no attention to Xu. Although Xu's mother expressed her willingness to act as the guardian and Xu favoured it too, the court held that, given her age, housing condition and low income, his mother lacked the ability to provide care. The court also held that the older brother fulfilled his duties as a guardian. In this case, the court instructed a research institution on forensic examination to carry out an examination in which Xu was found with residual schizophrenia and with limited capacity for civil conducts.[17]

Having failed in all the attempts to leave, Xu sued the hospital and his older brother for jointly violating his right to personal liberty on 6 May 2013, five days after the entry into force of MHL. Xu had three claims in this case: a. acknowledgment that his right to liberty was violated by the hospital and his older brother; b. an immediate end to the deprivation of his liberty; and c. compensation to be paid by the hospital and his older brother amounting to 10,000 RMB (approximately 1,500 euros).[18]

Because of the administrative rules of the hospital, Xu could not leave the hospital to personally lodge his claim. However, following lodgement by his representing lawyer, the court immediately refused to accept the case because the court thought Xu was incapable of litigating. After a number of rounds of negotiation and communication, and a specific assessment of Xu's capacity to litigate, the case was deemed admissible by the court.[19] The first hearing took place five months after the date the

[14] The judgment provides no further reason for why the hospital wanted Xu's older brother to take Xu out. But it quoted from Xu's forensic examination report that Xu was assessed "with residual schizophrenia" and "in remission of symptom" in 2012.
[15] *Xu vs. the Hospital and his Guardian – Involuntary Inpatient Treatment*, p. 2.
[16] Ibid, p. 1-2.
[17] Capacity for Civil Conduct is a legal term in the GPCL. It has a similar meaning as legal capacity to exercise rights in civil affairs, or decision-making capacity in common law traditions. Article 13 of GPCL states: "[a] mentally ill person who is unable to account for his own conduct shall be a person having no capacity for civil conduct and shall be represented in civil activities by his agent ad litem. A mentally ill person who is unable to fully account for his own conduct shall be a person with limited capacity for civil conduct and may engage in civil activities appropriate to his mental health; in other civil activities, he shall be represented by his agent ad litem or participate with the consent of his agent ad litem." And Article 14 states: "[t]he guardian of a person without or with limited capacity for civil conduct shall be his agent ad litem."
[18] *Xu vs. the Hospital and his Guardian – Involuntary Inpatient Treatment*, p. 3.
[19] Ibid, p. 2-3.

claim was submitted. Xu claimed that he had recovered from his mental health problem but the hospital refused to release him because his guardian refused to take him out. Xu pointed out the fact, again, that his older brother was working in another province, did nothing for him and had no intention of fulfilling his duty of guardianship. Xu also noted in his claim that his older brother occupied an apartment under his name and took the rent.

Xu's older brother did not attend the hearings. The hospital submitted to the court that they made their best effort to allow Xu leave. They contacted his older brother many times, but his older brother repeatedly refused to consent to his release. They also argued that the "principle of voluntary inpatient treatment" did not apply to Xu, because he was involuntarily hospitalised in 2003.

Before giving the judgment, the court contacted Xu's mother, the older brother, Xu's other brother and the director of the neighbourhood committee[20] for their opinions. Although his mother wanted Xu to leave, she could not bear the actual responsibility for Xu's daily life. The other three agreed that keeping Xu in the hospital was the best option, while the older brother also expressed his willingness to take Xu out when he retires in several years.[21]

III. DECISION

The court of first instance recognised the result of the assessment in the previous guardian-replacement case that Xu was a person with limited capacity for civil conducts. Also, in the forensic examination to determine Xu's capacity to litigate, Xu was found not to have fully recovered from his mental health problem. Based on these assessments, the court of first instance held that Xu's status of limited capacity to civil conduct remained and the guardian should be in place for activities outside the scope of his ability.

The court held that Xu's older brother fulfilled his duty as a guardian[22] by putting Xu in the hospital. The court acknowledged that keeping Xu in the hospital was the best choice that the older brother could make. The court pointed out, in particular, that along with the guardian's duty, "a guardian also enjoys the right to choose reasonable method of fulfilling the guardianship."[23]

[20] The neighbourhood committee is not a branch of government but bears some local administrative duties, mediating conflicts between residents for example. In the matter of this case, the neighbourhood committee also holds the right to appoint guardians based on Article 17 of the GPCL.
[21] *Xu vs. the Hospital and his Guardian – Involuntary Inpatient Treatment*, p. 4.
[22] In this case, Xu's older brother's role of guardian was legally recognised by the court in the previous guardian-replacement case. Generally, the appointment of guardians is covered by the GPCL in conjunction with the Civil Procedure Law of People's Republic of China on identifying a person with no/limited capacity to civil conduct. However, the MHL sets that "guardians for mentally disordered patients are to be those eligible under the provisions of GPCL". For a discussion on this, see X. Zhao and J. Dawson, 'The New Chinese Mental Health Law' (2014) 21 Psychiatry, Psychology and Law 669, 680.
[23] *Xu vs. the Hospital and his Guardian – Involuntary Inpatient Treatment*, p. 1. It is also addressed by Article 18 of the GPCL that "A guardian's rights to fulfil his guardianship in accordance with the law shall be protected by law".

The court also held that the Article 44 of MHL, which states "[p]ersons with mental disorders who are voluntarily admitted to the hospital may request discharge at any time and medical facilities shall comply with such requests", did not apply because "Xu was involuntarily committed by his father with assistance of the neighbourhood committee on grounds of dangerous behaviour", as such "leave was subject to the approval of his guardian".[24] Since the guardian did not consent to Xu's discharge, the hospital's refusal to Xu's request of discharge then did not violate his right.[25] Therefore the court of first instance held that there was no violation of Xu's right to liberty. All of Xu's claims were rejected by the court. Xu appealed against this decision.

On 15 September 2015, the Shanghai No.1 Intermediate People's Court rejected Xu's appeal on the basis that the finding and application of law in the first instance was correct. This was the final decision of the case.[26]

IV. DISCUSSION

Based on the fact that the court attempted but failed to find a suitable person to take charge of Xu's life in the community[27], it can be assumed that the decision would be possibly different if Xu could access adequate community-based services. Having this in mind, the court's decision is still questionable for its interpretation of the rules of involuntary inpatient treatment. It can be argued that the MHL should be amended with periodic reviews and an independent review body on involuntary inpatient treatment. It also notes that the court did not fully address the question whether Xu had the capacity to leave by himself without his guardian's consent.

Then, a brief analysis based on the CRPD will follow. It can be argued that the decision in the case failed to protect Xu's right to legal capacity, liberty and community living under the CRPD that China ratified without reservation.

A. Voluntary Inpatient Treatment in MHL

The MHL introduced the principle of voluntary inpatient treatment in Article 30. Article 30 also states "[i]f the result of the psychiatric evaluation indicates that a person has a severe mental disorder, the medical facility may impose inpatient treatment if the individual meets one of the following conditions: (1) self-harm in the immediate past or current risk of self-harm; (2) behaviour that harmed others or endangered the safety of others in the immediate past or current risk to the safety of others." However, for patients harmful or dangerous to themselves, their guardians can refuse the inpatient treatment, while guardians of patients found harmful or dangerous to others can only demand a re-evaluation and a formal medical certification if they do not agree with the treatment. If the results of re-evaluation and medical certification favour the involuntary inpatient treatment, it will happen regardless of the guardian's opinion.[28] Under the

[24] Ibid.
[25] Ibid.
[26] In principle, the second instance of civil cases is the last instance. See Article 10 of the Civil Procedure Law of People's Republic of China.
[27] Ibid, p. 3-4.
[28] Article 31, 32, and 35 of the MHL.

rule of voluntary inpatient treatment, a voluntary patient can request to leave at any time and the hospital should allow the discharge.[29]

The court held that Xu was hospitalised involuntarily because he was diagnosed with mental disorder and once injured his father in their conflict, but it seems problematic that Xu has to continue being involuntarily hospitalised after twelve years, especially considering there is no other evidence suggesting Xu has been dangerous to others since then. The court's decision implies that if a person were involuntarily hospitalised once, he or she could be involuntarily hospitalised indefinitely.[30]

This can be a particularly dangerous interpretation as the MHL does not set any specific duration, interval for re-evaluation, or independent and impartial ongoing review of the detention. It has been argued by Chinese psychiatrists that a similar safeguarding effect can be achieved by Article 44 which states "[w]hen there are changes in the clinical status of a patient with a mental disorder receiving inpatient treatment because they met conditions specified in the second clause of Article 30, the medical facility shall promptly arrange for registered psychiatrists to conduct an evaluation. When the evaluation finds that the patient no longer requires inpatient treatment, the medical facility shall immediately inform the patient and the guardians."[31] Xu's case raises a doubt as to the effectiveness of this safeguarding measure.

There are a number of articles addressing the inadequate safeguards in the MHL, and most of them propose an independent review body.[32] These proposals echo some safeguarding standards in other jurisdictions. For example, the member states of the European Union were recommended to adopt safeguards on involuntary placement and treatment for persons with mental disorders that decisions to subject a person to involuntary placement or to involuntary treatment should be "taken by a court or another competent body" and "formally reviewed."[33] Zhao and Dawson pay particular emphasis on the proactive, regular and formal scrutiny and the involvement of experienced legal professionals and laypersons representing legal and community perspectives of the review body.[34] However, an in-depth analysis on this issue is beyond the scope of this case note. For Xu's case, it can be argued that the result would be different if periodic re-evaluations could be inserted into the internal procedure of the hospital. It is reasonable to assume that, after a period of inpatient treatment, Xu might be assessed as no longer with severe mental disorders or dangerous to himself or others and thus converted to a voluntary patient whose request for discharge should be complied with by the hospital. This relates to the "capacity to complete hospital discharge procedures" in the MHL.

---

[29] Article 44 of the MHL.

[30] It is shown in the judgment that Xu's older brother told the judge that Xu once attacked a female gate-keeper when he attempted to escape from the hospital during the commitment. See *Xu vs. the Hospital and his Guardian – Involuntary Inpatient Treatment*, p. 4. But no evidence shows that this statement was confirmed by the hospital or cross-examined in the court.

[31] Michael R Phillips and others, 'China's New Mental Health Law: Reframing Involuntary Treatment' (2013) 170 American Journal of Psychiatry, 588.

[32] Chunyan Ding, 'Involuntary Detention and Treatment of the Mentally Ill: China's 2012 Mental Health Law' (2014) 37 International Journal of Law and Psychiatry 581; Zhao and Dawson (n 1).

[33] Article 12 of the Recommendation Rec(2004)10 of the Committee of Ministers to member States concerning the protection of the human rights and dignity of persons with mental disorder.

[34] Zhao and Dawson (n 1) 677.

B. Capacity to Leave Hospital or to Lead a Good Life?

The hospital in Xu's case requested his older brother to take Xu out and expressed in the hearing that the only obstacle to release was the guardian's refusal. Article 45 of the MHL states that "[w]hen persons with mental disorders are unable to complete hospital discharge procedures themselves, these procedures shall be completed by their guardians." Xu used it as a basis to argue that his older brother failed to do his duty, but the court held that it was a legitimate choice as a right of being a guardian.

This relates to the ambiguous decision-making power between Xu and his guardian. The essence of this question lies on whether Xu had the capacity to leave the hospital independently.

Xu was found to have limited capacity to civil conduct, which means he can independently make civil conduct that falls within the scope of his capacity.[35] The court's decision mentioned this in principle but did not give any clear finding on what Xu was capable of doing independently. The decision does not reflect any effort made by the court to identify whether a guardian was needed in this specific task: Xu's discharge.

It could be possibly argued that the rationale of the court in making its decision was that Xu lacked the capacity to take care of himself out of hospital. It is not an unreasonable concern, given that no community-based service and support for independent living was available. Yet this is not what the MHL requires to be considered. Instead, the MHL requires consideration of whether or not Xu had the capacity to "complete hospital discharge procedure by himself".

In fact, based on empirical research on the cause of long-term hospitalisation after the implementation of MHL in a mental health institution, 64.6% of 370 respondents who have been hospitalised for more than one year could not be discharged because their family members refused, and only 20.5% believed that they could not leave because of doctors' disapproval.[36] Ji and Li argue that it has been a serious issue that many patients who should be discharged had to be kept in hospitals because of guardians' refusal.[37] They propose that hospitals should allow patients disqualified to involuntary inpatient treatment to complete the discharge procedure independently and they call for guidance to be provided by relevant authorities.[38] The decision in Xu's case failed to bring about such a change.

C. Compliance with the CRPD

The previous sections critically considered the safeguards provided in the MHL. This section will briefly outline some of the requirements of the CRPD in relation to these issues.

[35] Article 13 of the GPCL.
[36] Lixin Luo, Xiangjiao Liao, Zhimei Xie, et al., 'The Cause of Long-term Hospitalisation after the Implementation of Mental Health Law' (2014) Vol 22, No. 12, China Journal of Health Psychology 1769.
[37] Yongzhang Ji and Guohai Li, 'Confusions and Thoughts about the Rules of Discharge in the Mental Health Law' (2015) 1 Vol 26 Jiangsu Health Management 146.
[38] Ibid, 147.

Articles 12, 14 and 19 are relevant to the case of Xu, as the decision raises significant concerns about Xu's right to liberty, legal capacity and living independently and being included in the community. These articles, in particular, appear to have been compromised in the case of Xu with no remedy provided by the Chinese courts. It has been argued by the UN Committee on the Rights of Persons with Disabilities (hereinafter, Committee) in the Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities (hereinafter, Guideline on Article 14), that these rights are closely interrelated and interdependent.[39] The Committee's "Concluding Observations" on the Initial Report of China (hereinafter, Concluding Observations) two years before the decision of the Xu's case are of note. The Committee recommended law reforms, which included introducing positive obligations to promote these above-mentioned rights.[40]

Meanwhile, the emphasis here is given to the fact that the court relied on the guardianship system to override Xu's preference to leaving hospital. Article 12 of the CRPD requires member states to recognise that persons with disability enjoy their legal capacity on an equal basis with others in all aspects of life and provide access to support in exercising their legal capacity, as well as safeguards.[41] Respecting the will and preference is also the core of the General Comment No.1 on Equal Recognition before the Law (hereinafter, General Comment No.1) that interprets Article 12 as prohibiting substitute decision-making systems, which would include guardianship in Xu's case. General Comment No. 1 states:

> "[t]he denial of the legal capacity of persons with disabilities and their detention in institutions against their will, either without their consent or with the consent of a substitute decision-maker, is an ongoing problem. This practice constitutes arbitrary deprivation of liberty and violates articles 12 and 14 of the Convention. States parties must refrain from such practices and establish a mechanism to review cases whereby persons with disabilities have been placed in a residential setting without their specific consent. "[42]

It has been a highly controversial question as to whether mental health legislation authorizing involuntary treatment and commitment is permissible under the CRPD[43], and giving an answer to this question is far beyond the scope of this case note. However, unlike many debates on legal capacity and General Comment No.1, there was no such controversy on whether or not substitute decision-making should play the role as a last resort with support possibly given.[44] The uncertainty in current theoretical debates and law reform proposals surrounding "hard cases"[45] should not affect Xu who has no difficulty in understanding and expressing his decision and poses no more risk to himself or others than anyone else. The hospital also acknowledged that the

[39] Paragraph 8 and 9 of the Guideline on Article 14.
[40] UN Committee on the Rights of Persons with Disabilities, Concluding Observations on the Initial Report of China, adopted by the Committee at its eighth session (17–28 September 2012).
[41] Article 12 of the CRPD.
[42] Paragraph 40 of the General Comment No.1.
[43] See Callaghan and Ryan (n 3); Tina Minkowitz, 'Why Mental Health Laws Contravene the CRPD-An Application of Article 14 with Implications for the Obligations of States Parties' (2011) Available at, http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1928600 accessed 19 December 2015.
[44] John Dawson, 'A Realistic Approach to Assessing Mental Health Laws Compliance with the UNCRPD' (2015) International Journal of Law and Psychiatry.
[45] Piers Gooding, 'Navigating the "Flashing Amber Lights" of the Right to Legal Capacity in the United Nations Convention on the Rights of Persons with Disabilities: Responding to Major Concerns' (2015) 15 Human Rights Law Review 45.

only obstacle to his discharge was the guardian's refusal. The court's decision did not follow the CRPD even in a conservative sense, or try to respect Xu's will and preference as much as possible along with the existence of the guardianship system.

In addition, because China is not a member state of the Optional Protocol of CRPD, Xu cannot submit his complaint to the Committee.

IV. CONCLUSION

This case provides an insight into how the MHL is operating and how the courts have responded to cases such as this one. Although it is just one case, Xu's case is significant in being the first case where an involuntarily hospitalised person sought discharge based on the new MHL. This article discussed the court's decision with a critical view on its application of the principle of voluntary inpatient treatment and the guardian's role. The final section offered a brief account of how Xu's case relates to the CRPD, particularly noting that Xu was not among those "hard cases" in legal capacity-related debates.

Based on the reflection of Xu's case, the MHL could not fulfil its full potential of rights promotion unless a stronger safeguarding approach were adopted.[46] More research is required to explore the necessary development and reform of the MHL and mental health service in the new era of the CRPD.

[46] Shao and Xie (n 5).