Annex B: Treatment of involuntary placement/treatment and mental capacity by international and regional human rights bodies

Introduction

1. The following provides some (non-exhaustive) examples of the different approaches currently taken by different international human rights bodies/actors to involuntary placement and treatment as well as the concept of mental capacity[254]. All of these areas are subject to sustained discussion at the international level and interpretation by different courts, such that this annex represents a snapshot of the position as at November 2018. As set out in the body of the report, the different legal approaches to the steps that should be taken in hard cases can also mask substantial areas of common ground, above all as to what should be done to ensure that those steps are not, in fact, required. Nonetheless, there remain substantially different interpretations (at international and regional level) of human rights obligations in this context.

Involuntary placement

2. Article 14(1)(b) CRPD makes clear that "the existence of a disability shall in no case justify a deprivation of liberty." However, the UN Human Rights Committee (the treaty body for the International Covenant on Civil and Political Rights, which includes its own right to liberty) and the Committee on the Rights of Persons with Disabilities have given differing interpretations of Article 14(1)(b).

[254] The differing views of relevant UN bodies as to involuntary detention and treatment are usefully summarised in a detailed document prepared by Dr Sándor Gurbai and Prof Wayne Martin of the Essex Autonomy Project from which this, in part, draws: http://autonomy.essex.ac.uk/resources/eapunsurvey/. See also by way of overview articles Fennell, P.W.H. and Khaliq, U., 'Conflicting or complementary obligations? The UN Disability Rights Convention, the European Convention on Human Rights and English law,' European Human Rights Law Review, 2011:6:662-674 and Bartlett, P.,'The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law,' Modern Law Review, 2012:75:752–778.

3. Both Committees agree that deprivation of liberty on the basis of disability alone is unlawful[255]. However, the two Committees differ as to whether it is ever permissible to deprive a person of their liberty to secure against risks to them or other people said to arise from their mental health condition (i.e. their disability). The Committee on the Rights of Persons with Disabilities takes the view 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."[256] This view is shared by others within the UN system, for instance the Office of the High Commissioner for Human Rights[257], and the Special Rapporteur on the Rights of Persons with Disabilities[258].

4. The UN Human Rights Committee, conversely, takes the view – which it sees as supported by Article 14(1)(b) CRPD – that "[t]he 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," and further that "[f]orced measures 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."[259] A similar view has recently been taken by the UN Human Rights Council Working Group on Arbitrary Detention ('WGAD')[260].

5. The lack of consensus at the UN level in relation to involuntary care and treatment was described in 2017 as an "impasse" by the UN Special Rapporteur in 2017 on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health[261]. It is echoed at Council of Europe level, which is particularly relevant for the Review given the fact that Council bodies (including the

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[255] UN Human Rights Committee: General Comment No. 35 (2014), on Article 9 - Liberty and security of person, para 19; UN Committee on the Rights of Persons with Disabilities, 2015: "Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities." para 6.
[256] UN Committee on the Rights of Persons with Disabilities, 2015: "Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities." para 13.
[257] Office of the United Nations High Commissioner for Human Rights, 2009: Thematic Study by the Office of the United Nations High Commissioner for Human Rights on enhancing awareness and understanding of the Convention on the Rights of Persons with Disabilities. A/HRC/10/48, para 48.
[258] See her report of 12 December 2017 (A/HRC/37/56) at para 52.
[259] UN Human Rights Committee: General Comment No. 35 (2014), on Article 9 - Liberty and security of person, para 19.
[260] In the context of a complaint against Japan (Opinion No. 8/2018): http://www.ohchr.org/Documents/Issues/Detention/Opinions/Session81/A_HRC_WGAD_2018_8.pdf,
[261] Dainius Pūras, "Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (2017) A/HRC/35/21, para 33

European Court of Human Rights ('ECtHR') are the treaty bodies for the ECHR, which is binding on public bodies – including the courts – in England & Wales:

- The Council of Europe's former Commissioner for Human Rights, Nils Muižnieks, has expressly endorsed the position of the Committee on the Rights of Persons with Disabilities[262];

- Conversely, the ECtHR has continued to hold that deprivation of liberty is lawful where it is a necessary and proportionate response to secure a person of unsound mind against risk to self of others. It has, significantly, done so having expressly considered the position of the Committee on the Rights of Persons with Disabilities set out above[263]. Further, case-law of the ECtHR could also be read not merely as permitting deprivation of liberty on this basis, but also requiring it where it is necessary to secure the right to life of a vulnerable individual[264]. The logic of the decision of the United Kingdom Supreme Court in Rabone v Pennine Care NHS Trust [2012] UKSC 2 was also to the effect that Article 2 of the ECHR imposed an obligation upon the relevant authorities to deprive Melanie Rabone of her liberty (in the psychiatric hospital where she was an informal patient) rather than allowing to return home, where she took her own life.

Involuntary treatment

6. At the UN level, the Committee on the Rights of Persons with Disabilities takes the view that administering medical treatment absent free and informed consent is always unlawful as contrary to Articles 12 and 25 CRPD[265]. This view is shared by other UN actors[266], but not all. For instance, UN Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment not only considers that involuntary treatment is lawful in circumstances where (essentially) the individual lacks capacity to make decisions as to treatment as "a last resort to avoid irreparable damage to the life, integrity or health of the person concerned," but

[262] https://www.coe.int/en/web/commissioner/-/respecting-the-human-rights-of-persons-with-psychosocial-and-intellectual-disabilities-an-obligation-not-yet-fully-understood?inheritRedirect=true&redirect=%2Fen%2Fweb%2Fcommissioner%2Fthematic-work%2Fpersons-with-disabilities (August 2017).
[263] N v Romania (Application No. 59152/08), decision of 28 November 2017, at para 159.
[264] See Stanev v Bulgaria (Application No. 36760/06), decision of 17 January 2012 at para 128.
[265] UN Committee on the Rights of Persons with Disabilities, 2014: "General Comment No. 1 on Article 12: Equal recognition before the law." CRPD/C/GC/1, para 41.
[266] See the views summarised in the July 2018 Report of the United Nations High Commissioner for Human Rights on Mental Health and Human Rights: A/HRC/39/36

indeed that the withholding of treatment in such circumstances could be a human rights violation, since failure to provide treatment could constitute inappropriate practice, amount to a form of cruel, inhuman or degrading treatment or punishment, and constitute a form of discrimination[267].

7. The Council of Europe's Commissioner for Human Rights appears to adopt a similar position to that of the CRPD Committee vis-à-vis involuntary treatment[268]. The ECtHR has not, however, outlawed forced treatment for mental disorder (including of those with decision-making capacity). Indeed, it has held that the positive duty on states to protect the right to life under Article 2 ECHR "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."[269] It has also found a violation of Article 2 ECHR where doctors took the refusal of an individual showing symptoms of a mental disorder to consent to potentially life-saving physical treatment at face value "without putting in question [the man's] capacity to take rational decisions concerning his treatment,"[270] and the man then subsequently died. The ECtHR has, though, increasingly recognised that providing non-consensual treatment constitutes a serious interference with the individual's right to autonomy, requiring suitably strict procedural safeguards: see, for instance, X v Finland [2012] ECHR 1371.

8. For completeness, it should be noted that the German Federal Constitutional Court of 26 July 2016 (1 BvL 8/15) has also held that, even taking into account the views of the CRPD Committee, there are no good reasons under the text and spirit of CRPD to conclude that the CRPD is opposed to compulsory medical treatment where this is constitutionally required under strictly regulated circumstances.[271]

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[267] UN Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 2016: "Approach of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment regarding the rights of persons institutionalized and treated medically without informed consent". CAT/OP/27/2, para 15.
[268] See the comment noted above.
[269] Haas v. Switzerland [2011] ECHR 2422, para 54. See also Arskaya v Ukraine [2013] ECHR 1235.
[270] Arskaya v Ukraine [2013] ECHR 1235 at para 87.
[271] This decision is discussed at http://www.39essex.com/content/wp-content/uploads/2016/11/MC-Newsletter-November-2016-Capacity-outside-the-Court-of-Protection.pdf

Mental capacity, best interests decision-making and advance decisions

9. The Committee on the Rights of Persons with Disabilities considers that regimes such as the MCA 2005 are incompatible with obligations imposed by Article 12 CRPD (the right to equal recognition before the law)[272].

10. First, the Committee challenges the validity of linking mental capacity to legal capacity, the capacity, in particular, to make decisions regarded as having legal effect. The Committee assert, in particular, that mental capacity is not "as commonly presented, an objective, scientific and naturally occurring phenomenon. Mental capacity is contingent on social and political contexts, as are the disciplines, professions and practices which play a dominant role in assessing mental capacity."[273]

11. Second, the Committee considers that substituted decision-making[274], such as provided for in the MCA 2005, is impermissible. Rather, as set out in General Comment 1 (in particular), the Committee considers that only supported decision-making is acceptable. It is important to understand that the Committee's interpretation of this concept includes, but goes further than, the principle in s.1(3) MCA that a person is not to be considered to lack capacity to take a decision unless all practicable steps to support them to do have been taken without success. The Committee does not accept, in essence, that it is ever permissible to conclude that a person lacks capacity to take a decision such that another person may take it on their behalf; rather the person must always be given the support necessary to express their will and preferences, which should dictate the outcome of the decision made. In extremis, the Committee consider, it is acceptable to proceed on the best interpretation of the person's will and preferences; the Committee reject, however, any approach which enables the decision-maker to proceed on what is believed to

[272] Hence its recommendations in the Concluding Observations on the UK set out in the main body of this report.
[273] UN Committee on the Rights of Persons with Disabilities, 2014: "General Comment No. 1 on Article 12: Equal recognition before the law." CRPD/C/GC/1, para 14.
[274] Defined as a situation where (i) legal capacity is removed from a person, even if this is in respect of a single decision; (ii) a substitute decision-maker can be appointed by someone other than the person concerned, and this can be done against his or her will; or (iii) any decision made by a substitute decision-maker is based on what is believed to be in the objective "best interests" of the person concerned, as opposed to being based on the person's own will and preferences UN Committee on the Rights of Persons with Disabilities, 2014: "General Comment No. 1 on Article 12: Equal recognition before the law." CRPD/C/GC/1, para 27.

be in the best interests of the person concerned, as opposed to the person's will and preferences.

12. It should be noted that on this interpretation of Article 12 CRPD, legislation which 'fused' mental health and mental capacity law (such as the Mental Capacity Act (Northern Ireland) 2016) would be incompatible with the CRPD[275], as it would still proceed on the basis of a differential approach in law based upon whether the person had or lacked decision-making capacity.

13. The CRPD Committee encourages advance decision-making as an important form of support, "whereby [the person] can state their will and preferences which should be followed at a time when they may not be in a position to communicate their wishes to others." However, "[t]point at which an advance directive enters into force (and ceases to have effect) should be decided by the person and included in the text of the directive; it should not be based on an assessment that the person lacks mental capacity."[276] On its face, the CRPD Committee's approach would therefore also rule out advance decision-making (including appointment of an attorney) in the form provided for in the MCA and (to a more limited extent at present) in the MHA[277].

14. Outside the context of placement and treatment, the other UN bodies have not engaged with the concept of mental capacity in detail, although, as noted above, the UN Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment appears to accept the legitimacy of the concept of mental capacity.

[275] The Committee on the Rights of Persons with Disabilities did not expressly comment upon this legislation in their Concluding Observations on the United Kingdom in 2017, but it had been drawn to their attention, and it is reasonable to assume that they intended to encompass it within their definition of (for them) illegitimate substituted decision-making.
[276] UN Committee on the Rights of Persons with Disabilities, 2014: "General Comment No. 1 on Article 12: Equal recognition before the law." CRPD/C/GC/1, para 17.
[277] See also the view of Zeid Ra'ad Al Hussein, UN High Commissioner for Human Rights that, even where advance directives of powers of attorney or in force, "Even when such instruments are in force, persons with psychosocial disabilities must always retain their right to modify their will and service providers should continue to seek their informed consent" (United Nations High Commissioner for Human Rights, 2017: Mental health and human rights. A/HRC/34/32), para 28.

15. There remains considerable debate as to the extent to which the CRPD Committee's interpretation of Article 12 goes beyond the obligations imposed by the Convention[278]. Most immediately, and importantly, for our purposes, the ECtHR has considered both Article 12 and the General Comment 1, in the context of interpreting Article 8 ECHR. The ECtHR sees Article 12 CRPD as imposing an obligation to require respect for the rights, will and preferences of the individual concerned, but does not see them automatically as determinative: see AM-V v Finland [2017] ECHR 273 (endorsing both a functional model of mental capacity analogous to that set down in the MCA 2005 and an approach similar to the best interests approach in the MCA 2005)[279].

[278] These issues are discussed in detail in the work of the Essex Autonomy Project on compliance of the mental capacity regimes in the United Kingdom with the CRPD: https://autonomy.essex.ac.uk/subject/crpd/.

[279] Other courts, outside the Council of Europe, have interpreted the CRPD in this fashion, most recently the Supreme Court of Victoria in PBU v Mental Health Tribunal and Melbourne Health; NJE v Mental Health and Bendigo Health [2018] VSC 564.