MODULE 6

CAPACITY, COMPETENCE & SUPPORTED DECISION-MAKING AND GUARDIANSHIP
&
ADMISSION, TREATMENT AND DISCHARGE

Overall Learning Objective

To develop an understanding of how legislation can promote voluntary admission and treatment and protect the right of people with mental disabilities to exercise their right to legal capacity.

Rationale: People with mental disabilities should receive treatment on a voluntary basis and in the community. The extent to which this principle is applied varies a lot among countries. In many of them there is a lack of community based treatment options and most people are treated in psychiatric institutions, but also in the most developed community-based systems involuntary admissions and treatments remain a reality. The UN Convention on the Rights of Persons with Disabilities marks the beginning of a significant paradigm shift which is likely to have a significant impact on how issues of capacity, competence, involuntary admission and treatment are addressed in future mental health laws.

Module Content:

General overview

a. Capacity, Competency, Guardianship and supported decision making

- Legal capacity, supported decision-making and the CRPD
- Capacity/competence and guardianship – provisions and protections prior to the CRPD

b. Voluntary admission and treatment

c. Involuntary admission and treatment

- The right to live in the community, to liberty, to free and informed consent and the CRPD
- Involuntary admission and treatment – provisions and protections prior to the CRPD

d. Involuntary admission and treatment – special aspects

e. Conclusion

GENERAL OVERVIEW

It is commonly held that psychiatry took its first steps with Pinel freeing the mentally ill from their chains in prisons and caring for them in the newly established asylums. This ethical stance of support to vulnerable persons, however, has always been intertwined with the stance aiming at social control of people with disturbing or disruptive behaviour because of mental illness. Foucault considers that the scene actually describing the real birth of psychiatry as an institution is the involuntary treatment of King George III in 1800, when even the highest authority had to give way to the power of medicine and let his body be at disposal of doctors.

Legislation has traditionally played a role in trying to establish a **balance between individual freedom and the needs of protection of the society**. More often than not, however, the emphasis has been on protection of society rather than on protecting the rights of people with mental disabilities, despite the fact that people with mental disabilities are more likely to be victims of violence. Provisions regarding involuntary admission and treatment have always constituted the core of psychiatric legislation since the beginning of the 19th century. French Law 7443 of 1838 (*Loi sur les aliénés n° 7443 du 30 juin 1838*) promoted and written by Ferrus, but inspired by the teaching of his master Esquirol, became the paradigm for the drafting and implementation of psychiatric legislation and still today its structure is replicated with little variation in most countries. It is noticeable that only in 1990 this law has been replaced by *"Loi n. 90-527 du 27 juin 1990 relative aux droits et à la protection des personnes hospitalisées en raison de troubles mentaux et à leur conditions d'hospitalisation"* (Provost & Bauer, 2001)

Today, in light of the International Convention on the Rights of Persons with Disabilities (CRPD), we may see a new paradigm in terms of how future mental health laws are formulated. Indeed the CRPD has created a new paradigm shift not only in how people with mental disabilities, including mental disabilities, are viewed, but also how their rights should be promoted and protected.

Historically, people with mental disabilities have been viewed as "objects" of welfare or charity or medical treatment rather than holders of rights. Increasingly however countries are moving away from the notion that people with disabilities are objects of charity and pity by acknowledging that society itself is disabling. The Convention embodies this attitudinal change and is a major step forward towards altering the perception of disability and ensuring that societies recognize that all people with disabilities are holders of rights must have the opportunity to reach their full potential.[1]

[1] From Exclusion to Equality: Realizing the Rights of Persons with Disabilities. Handbook for Parliamentarians on the Convention on the Rights of Persons with Disabilities and its Optional Protocol, United Nations 2007. http://www.un.org/disabilities/default.asp?id=212

As outlined in Module 10 of this Diploma, 'From Exclusion to Inclusion: the right to be included in the community', the **CRPD has also led to a paradigm shift from "making systems better", towards "making better systems".** Currently mental health laws that incorporate international human rights standards essentially aim to minimize potential abuses that can occur in existing practices and procedures. So for example, in dealing with the issue of guardianship, mental health laws may include provisions specifying the procedure for appointment of a guardian, the duration of the appointment, the extent and scope of the decision-making powers of the guardian, and the need for a mechanism to appeal against the appointment of a guardian etc.

The drafters of the CRPD however, in an acknowledgment to the persistent abuse and overuse of the guardianship system in many countries, saw the need to promote a 'new system' whereby people with mental disabilities retain their legal capacity but are provided with support in making decisions when necessary (this is discussed in more detail below). In this way, it is argued, guardianship becomes a measure of last resort.[2]

Hence the CRPD has brought about a shift away from the notion that there is a need to regulate procedures, practices and systems in order to protect human rights, towards one which acknowledges that systems such as that of guardianship are fundamentally flawed and need to be entirely changed and rethought.

The drafting and the coming into force of the CRPD has given rise to much debate and discussion within the international human rights arena around issues of capacity, guardianship, as well as involuntary admission and treatment. An increasing number of voices are calling for the re-examination, in light of the Convention, of current systems, laws, procedures and practices related to these issues in countries.

This module aims to highlight some of the key aspects of this debate. At the same time, the module also explores how laws have, up until now, sought to regulate practices around capacity, guardianship, involuntary admission and treatment, in order to minimize human rights violations, an approach which many people today fundamentally dispute and challenge.

It is important to emphasize that this module is not promoting this particular approach. The aim is to outline concepts, procedures and criteria which up until now have been commonly accepted as the most effective means of safeguarding rights. As the debate and discussion around these issues evolves we may find that the concepts outlined below are no longer valid. We may also see some drastic changes in how these matter are addressed (or indeed not addressed) in future mental health laws.

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[2] From Exclusion to Equality: Realizing the Rights of Persons with Disabilities. Handbook for Parliamentarians on the Convention on the Rights of Persons with Disabilities and its Optional Protocol, United Nations 2007. http://www.un.org/disabilities/default.asp?id=212

A) CAPACITY, COMPETENCY, SUPPORTED DECISION MAKING AND GUARDIANSHIP

LEGAL CAPACITY, SUPPORTED DECISION-MAKING AND THE CRPD

Most persons with mental disabilities retain the ability to make informed choices and decisions regarding important matters affecting their lives. This is reinforced in Article 12.2 of the CRPD which provides that "State Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life". This relates to the provision in Article 12.1 that "persons with disabilities have the right to recognition everywhere as persons before the law." As such, the CRPD has brought about a paradigm shift away from the assumption that people with mental disabilities are incapable of making decisions to a **presumption of capacity,** and consequently of competence.

It was noted during the drafting of the Convention that "legal capacity has been constructed in ignorance of the disability experience. It is a protection which has been mechanically extended to persons with disability without asking us as to what it does to our lives and the quality of our living. It is on the basis of our lived experience that we are demanding that this Convention should accord recognition to us as persons before the law with full legal capacity. Any principle whereby we are denied the capacity to act would be no more than a legitimization of subsisting discriminatory laws.[3]"

Article 12 of the CRPD also that "States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity. " Article 12.4 further specifies that:

States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests. ...States Parties shall take all appropriate and effective measures to ensure the equal right of persons with disabilities to own or inherit property, to control their own financial affairs and to have equal access to bank loans, mortgages and other forms of financial credit, and shall ensure that persons with disabilities are not arbitrarily deprived of their property.

[3] Address to the plenary session of the ad hoc committee by Amita Dhanda on legal capacity. Available at: http://www.un.org/esa/socdev/enable/rights/art9plenary.htm (last accessed 20 July 2008).

One of the key recommendations of the 2008 report of the UN Special Rapporteur on Torture is that "in keeping with the Convention, States must adopt legislation that recognizes the legal capacity of persons with disabilities and must ensure that, where required, they are provided with the support needed to make informed decisions.[4]"

While guardianship model (discussed below) accepts that people can lack capacity and that it may at times be necessary to appoint a substitute decision maker or guardian, the Convention states that people always retain their legal capacity though they may at times require a degree of support in making decisions and in exercising their legal capacity. In this way the person concerned remains central to that decision-making process. With supported decision-making, the presumption is always in favour of the person with a disability who will be affected by the decision. The individual is the decision maker; the support person(s) explain(s) the issues, when necessary, and interpret(s) the signs and preferences of the individual.[5]

The paradigm shift away from the guardianship model, towards a model of supported decision making encapsulated in article 12 aims to limit the human rights violations so often associated with guardianship laws. Indeed in many countries these laws have led to discrimination and the deprivation of numerous rights, such as the right to vote, to decide where to live, to work, to marry, and even the right to have a family. [6]

As highlighted by Professor Amita Dhanda in the 2007 issue of Lancet which focused on mental health, Article 12 of the Convention "does not negate the need for support—instead, in acceptance of human interdependence, the Convention recognises the right to seek support, and in acceptance of human frailty, it establishes the standards for providing support and safeguards against abuse. The mechanisms of support for people with mental illness need not be based on the all-or-nothing theory of guardianship. The personal ombudsperson system in Sweden and the restricted guardianship procedures of India are steps in that direction[7].

In some cases people may need 100% support in decision-making, but whether, in **practice** this amounts to the same as substitute decision making, is not clear from the Convention. Some argue that this is not the case. Amita Dhanda's address to the plenary session of the ad hoc committee, during the drafting of the CRPD, states that "whilst support from a

[4] Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, July 2008 (A /63/175)

[5] From Exclusion to Equality: Realizing the Rights of Persons with Disabilities. Handbook for Parliamentarians on the Convention on the Rights of Persons with Disabilities and its Optional Protocol, United Nations 2007. http://www.un.org/disabilities/default.asp?id=212

[6] Mental Disability and Advocacy Center. Autonomy and Legal Capacity. http://www.mdac.info/en/autonomy

[7] A. Dhanda & T. Narayan (2007). Mental health and human rights. The Lancet, Vol 370, October 6 2007

scale to 0-100 is acceptable the legal device of substituted decision-making or guardianship is unacceptable[8]".

The United Nations Handbook for Parliamentarians on the Convention on the Rights of Persons with Disabilities and its Optional Protocol however states that " Even when an individual with a disability requires total support, the support person(s) should enable the individual to exercise his/her legal capacity to the greatest extent possible, according to the wishes of the individual. This distinguishes supported decision-making from substituted decision-making, such as advance directives and legal mentors/friends, where the guardian or tutor has court-authorized power to make decisions on behalf of the individual without necessarily having to demonstrate that those decisions are in the individual's best interests or according to his/her wishes. **These mechanisms come into effect only when a person is authoritatively determined to be legally incapable of exercising his/her legal capacity (emphasis added).** Paragraph 4 of article 12 calls for safeguards to be put in place to protect against abuse of these mechanisms." [9]

Australia in its reservation[10] on the CRPD, has indicated that it understands the Convention in this light. The reservation states that "Australia recognizes that persons with disability enjoy legal capacity on an equal basis with others in all aspects of life. Australia declares its understanding that the Convention allows for fully supported or substituted decision-making arrangements, which provide for decisions to be made on behalf of a person, only where such arrangements are necessary, as a last resort and subject to safeguards".

Further guidance will be needed from the Committee on the Rights of Persons with Disabilities (which oversees the implementation of the CRPD) in the future to fully understand the implications of this article on issues of capacity, competence and guardianship.

Nevertheless as pointed out by Tina Minkowitz in her presentation on *The Paradigm of Supported Decision Making,* the supported decision making model promoted in the CRPD reinforces an approach based on inclusion rather than exclusion of people with disabilities[11]. Since the Convention requires governments to take appropriate and effective

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[8] Address to the plenary session of the ad hoc committee by Amita Dhanda on legal capacity. Available at: http://www.un.org/esa/socdev/enable/rights/art9plenary.htm (last accessed 20 July 2008).

[9] From Exclusion to Equality: Realizing the Rights of Persons with Disabilities. Handbook for Parliamentarians on the Convention on the Rights of Persons with Disabilities and its Optional Protocol, United Nations 2007. http://www.un.org/disabilities/default.asp?id=212

[10] Reservations are essentially caveats to a country's acceptance of a legally binding instrument such as the CRPD. They are statements which aim to exclude or to modify the legal obligation and its effects on the ratifying country. For other reservations on the CRPD go to http://un.org/disabilities/default.asp?id=475

[11] T. Minkowitz The Paradigm of Supported Decision Making http://nagano.dee.cc/tinalegal.htm

measures to ensure that people are provided with the support they may need to exercise their legal capacity, it will be important in the immediate future to get a better understanding of how supported decision making can be implemented in practice, and to examine the different models of this approach (currently few and far between) from around the world.

Canada and Sweden offer two examples of support decision making models that are currently being implemented:

- Canadian Association for Community Living: http://www.cacl.ca/
- Nidus Personal Planning Resource Centre and Registry (British Columbia, Canada): http://www.rarc.ca/textual/home.htm
- Sweden Personal Ombudsman Model - PO-Skane: http://www.po-skane.org/

Supported decision-making can take many forms. Those assisting a person may communicate the individual's intentions to others or help him/her understand the choices at hand. They may help others to realize that a person with significant disabilities is also a person with a history, interests and aims in life, and is someone capable of exercising his/her legal capacity[12]. Types of support may include, for example, support networks, personal ombudsperson, community services, peer support, personal assistant, and advance planning[13].

Although some models of supported decision making exist, there are a number of inherent difficulties with setting up such mechanisms. It is sometimes difficult to designate support networks, particularly when an individual cannot identify a trusted person or people. In addition, people in institutional settings are often denied this kind of support, even when it is available. As outlined in the UN Handbook for Parliamentarians on the CRPD, "establishing comprehensive support networks requires effort and financial commitment, although existing models of guardianship can be equally costly. Supported decision-making should thus be seen as a redistribution of existing resources, not an additional expense.[14]

The International Disability Alliance further states that "Governments are responsible for developing, supporting, promoting and offering support services, and for establishing safeguards to ensure a high quality of support and its compliance with standards such as: respect for the rights, will and preferences of the person, freedom from conflict of interest

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[12] From Exclusion to Equality: Realizing the Rights of Persons with Disabilities. Handbook for Parliamentarians on the Convention on the Rights of Persons with Disabilities and its Optional Protocol, United Nations 2007. http://www.un.org/disabilities/default.asp?id=212

[13] *IDA CRPD Forum Principles for Implementation of CRPD Article 12 http://psychrights.org/Countries/UN/FinalArticle12principles.pdf*

[14] From Exclusion to Equality: Realizing the Rights of Persons with Disabilities. Handbook for Parliamentarians on the Convention on the Rights of Persons with Disabilities and its Optional Protocol, United Nations 2007. http://www.un.org/disabilities/default.asp?id=212

and undue influence, and being tailored to individual circumstances[15].

CAPACITY/COMPETENCE AND GUARDIANSHIP – PROVISIONS AND PROTECTIONS PRIOR TO THE CRPD

Prior to the CRPD, countries have commonly accepted that in certain circumstances a person's ability might be impaired and that in some cases a person may totally lack the capacity to make decisions. Laws have consequently included provisions relating to assessment and criteria for incapacity, substitute decision-making and to guardianship. These concepts are expanded below.

When there is more clarity on the interpretation of CRPD it is likely that some of the concepts elaborated in the section below will change.

Definitions

Two concepts that are central to decisions about whether or not a person may make choices concerning various issues are "competence" and "capacity". These concepts affect treatment decisions in civil and criminal cases, and the exercise of civil rights by persons with mental disabilities. Legislation may therefore need to define capacity and competence, state the criteria for determining them, lay down the procedure for assessing them, and identify the actions that need to be taken when there is a finding of lack of capacity and/or competence.

There is a tendency to use the terms "capacity" and "competence" interchangeably in relation to mental health; however, they are not the same. Generally, capacity refers specifically to the presence of mental abilities to make decisions or to engage in a course of action, while competence refers to the legal consequences of not having the mental capacity. In these definitions, "capacity" is a health concept, whereas "competence" is a legal concept.

Capacity refers to individual levels of functioning, and competence to their impact on legal and social standing. For example, a person may lack mental capacity due to a serious mental disorder, and this may result in being found not competent to make financial decisions.

This distinction between capacity and competence is not universally accepted. In some legal systems, incapacity is used to mean legal incapacity, such as when minors below a certain age are not allowed to exercise certain rights or privileges. Competence, on the other hand, is a legal term applied to individuals who cannot understand the nature and

[15] IDA CRPD Forum Principles for Implementation of CRPD Article 12 http://psychrights.org/Countries/UN/FinalArticle12principles.pdf

purpose of the decision to be taken. In these cases, both the terms can be viewed as legal concepts.

Hence there is a distinction between capacity as a health concept and competence as a legal concept when discussing issues relating to capacity and competence.

Assessment of incapacity

Laws aiming to regulate issues around capacity in order to minimize potential abuses would need to carefully define and narrow the scope of capacity. While the presence of a disorder may affect capacity, a person may still have the capacity to carry out some decision-making functions. Capacity and competence are thus function-specific. Therefore, because capacity may fluctuate from time to time, and is not an "all or nothing" concept, it has been considered in the context of the specific decision or function to be accomplished. Some examples of specific capacities (which differ from country to country) are the following:

Capacity to make a treatment decision
The person must have the ability to: (a) understand the nature of the condition for which the treatment is proposed; (b) understand the nature of the proposed treatment; and (c) appreciate the consequences of giving or withholding consent to treatment.

Capacity to select a substitute decision-maker
The person must have the ability to: (a) understand the nature of the appointment and the duties of the substitute decision-maker; (b) understand the relationship with the proposed and (c) appreciate the consequences of appointing the substitute decision -maker.

Capacity to make a financial decision
The person must have the ability to: (a) understand the nature of the financial decision and the choices available; (b) understand the relationship to the parties to, and/or potential beneficiaries of, the transaction; and (c) appreciate the consequences of making the financial decision.
A finding of lack of capacity should be time-limited (i.e. it will have to be reviewed from time to time), because a person may regain some or complete functionality over time, either with or without treatment of the mental disorder.

Determining incapacity and incompetence
Determination of incapacity may be made by a health professional, but a judicial body would determine incompetence. Capacity is the test for competence, and people should be judged as lacking competence only if they are actually incapable of making specific kinds of decisions at a specific time.

Mental health legislation (or other relevant legislation) aiming to regulate guardianship can thus lay down the procedure for determining a person's competence. For example:

a) As competence is a legal concept, a judicial body would determine this.
b) Ideally, a legal counsel should routinely be made available to a person whose competence is in question. Where a person is unable to afford a counsel, legislation may require that counsel be provided to the beneficiary free of charge.
c) Legislation should ensure there is no conflict of interest for the counsel. That is, the counsel representing the concerned person should not also be representing other interested parties, such as the clinical services involved in the care of the concerned person and/or the family members of the concerned person.
d) Legislation should have provisions to appeal to a higher court against the decision by the concerned person, the counsel, family members or clinical team.
e) Legislation should contain a provision for automatic review, at specified periodic intervals, of the finding of lack of competence.

Guardianship

As mentioned above, to date many countries accept that there are certain circumstances where, due to a mental disorder, a person may lack capacity to make decisions him/herself and that it may be necessary to appoint another person who is able to act in the best interest of that person. In the New South Wales Guardianship Act (No 257 of 1987) a "person in need of guardianship means a person who has a disability and who, by virtue of that fact, is totally or partially incapable of managing his or her person". Although the person concerned can apply for guardianship, it is most often a family member, or others who care for the person with a mental disability, who identify the need for guardianship and who make the necessary application for an assessment to determine whether a guardian should be appointed.

Whether or not to appoint a guardian is a complex decision, and consideration must be made within the context of the rights of persons to have as much control of their own lives as possible. Appointing a guardian does not imply that the person loses all decision-making powers, their ability to act for themselves in all circumstances and their dignity. For example, in the New South Wales Guardianship Act (No 257 of 1987), everyone exercising functions under the Act are obliged, among other things, "to take cognisance of the welfare and interests of persons under guardianship; [and to ensure] that the freedom of decision and freedom of action should be restricted as little as possible; that persons should be encouraged, as far as possible, to live a normal life in the community; that the views of persons should be taken into consideration; that the person's family relationships and cultural and linguistic environments should be recognised; that such persons should, as far as possible, be self-reliant in matters relating to their personal, domestic and financial affairs and should be protected from neglect, abuse and exploitation." Other alternatives to guardianship that could be considered in certain situations include power of attorney and advanced directives."

Some countries today include guardianship provisions within their mental health law, while others have a separate guardianship laws. In Australia, for example, there is a

detailed separate Guardianship Act (Guardianship Act, No 257 of 1987, Australia), whereas in Kenya the Mental Health Act (The Mental Health Act, 248 of 1991, Kenya) includes a section on guardianship.

If individuals are considered legally not competent and/or unable to manage their own affairs, legislation needs to make provisions for the appointment of a person or persons (guardian/trustee) to look after their interests. Since the finding of lack of competence is a legal issue, appointment of a guardian should be made by a judicial body.

Legislation may state the procedure to be followed for appointment of a guardian, the duration of such appointment and a process for review of the decision, as well as delineating the duties and responsibilities of the guardian. Legislation may, in addition, determine the extent and scope of the decision-making powers of the guardian. In many countries, the power of guardians is limited to only those subjects or areas in which a person is shown to truly lack legal competence.

Specifying the penalties if guardians fail to perform their duties is also a key feature in laws that aim to limit abuses in this area. Legislation should also give the affected person the right to a judicial review of the decision to appoint a guardian. Lastly, legislation should contain provisions and procedures for discharge from guardianship when the affected person regains competence in the future.

B) VOLUNTARY ADMISSION AND TREATMENT.

Mental health legislation should aim to promote and facilitate voluntary admission to mental health facilities. This means that treatment should only be provided if the person concerned gives his or her informed consent. Article 25 (d) of the CRPD specifically states that countries must "require health professionals to provide care of the same quality to persons with disabilities as to others, **including on the basis of free and informed consent** (emphasis added)" This implies that a person's refusal to receive treatment must also be respected.

Validity of the consent given depends on the consent being obtained freely without threats or inducements, appropriate disclosure of information has taken place, the risks and side effects of the treatment explained, alternative choices for treatment are offered, and the consequences of not taking treatment should be explained to the person.

Voluntary admission also brings with it the right to voluntary discharge from mental health facilities. However, legislation relating to discharge is complicated by the fact that most jurisdictions give powers to authorities to override this right to leave under certain circumstances, for example when a person meets the criteria for involuntary admission and treatment (discussed in further detail below).

C) INVOLUNTARY ADMISSION AND TREATMENT

THE RIGHT TO LIVE IN THE COMMUNITY, TO LIBERTY, TO FREE AND INFORMED CONSENT AND THE CRPD

Mental health law should promote the provision of mental health care services in the communities in which people live (see Module 5 for further discussion on this). Article 25 of the CRPD on health, requires countries to provide health services as close as possible to people's own communities, including in rural areas. Article 19 of the CRPD establishes the right for people with mental disabilities to live independently and be included in the community. It states that *'States Parties to this Convention recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community, including by ensuring that:*

> *(a) Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement;*
>
> *(b) Persons with disabilities have access to a range of in-, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community;*
>
> *(c) Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs.*

The provision of care in psychiatric institutions, which are often isolated from the community, far away from people's homes, and associated with human rights violations, can be seen as going against the spirit of the CRPD.

Another related issue which has received extensive attention in the international debate around the CRPD is whether or not, according to the Convention, people with mental disabilities can be involuntarily admitted to psychiatric institutions and treated against their will. Historically, it has generally been accepted that under certain specific and exceptional circumstances people with mental disabilities may be subject to compulsory admission and treatment. However this has led to unjustifiable and unlawful detention and treatment of people in psychiatric facilities in countries throughout the world.

In acknowledgment of this situation, Article 14 of the CRPD on liberty and security of person states that:

1. States Parties shall ensure that persons with disabilities, on an equal basis with others:

(a) Enjoy the right to liberty and security of person;

(b) Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.

2. States Parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of this Convention, including by provision of reasonable accommodation.

The International Disability Alliance (IDA)[16] argues that "liberty is a fundamental right that must be recognized and enforced without discrimination. When separate standards or procedures are used to deprive people with disabilities of their liberty (such as compulsory institutionalization or hospitalization) this violates the equal enjoyment of human rights. CRPD Articles 3, 14, 19 and 25 are relevant."[17]

The statement contained within Article 14 "that the existence of a disability shall in no case justify a deprivation of liberty" can be read to imply that disability can **never** be used as a basis for depriving someone of their liberty. Laws in many countries allow involuntarily detained in psychiatric institutions on the basis of specific criteria - namely the presence of a mental disorder and the risk of danger to self or other. One interpretation of the Article is that disability ***alone*** cannot be a reason for deprivation of liberty and that it may in some instances be permitted as long as it is not undertaken **unlawfully** or **arbitrarily**, and that any deprivation of liberty is **in conformity with the law** (Article 14b). Another interpretation is that the Article should be taken at its 'face value' – that a disability shall **in no case justify** a deprivation of liberty and that articles 12 (legal capacity), 25 (free and informed consent) reinforce the fact that involuntary admission and treatment is not permissible according to the Convention. This tension in interpretation is reflected in the debate and discussions on this matter during the drafting of the CRPD[18].

[16]The IDA is an international network representing a number of different disability organizations, which was actively involved in the negotiations related to the drafting the CRPD)

[17] International Disability Alliance (IDA) Position Paper on the Convention on the Rights of Persons with Disabilities (CRPD) and Other Instruments, April 25, 2008

[18] As outlined in the Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, July 2008 (A /63/175), During the convention-making process, some States (Canada, Uganda, Australia, China, New Zealand, South Africa and the European Union) supported deprivation of liberty based on disability being permitted when coupled with other grounds. Finally, at the seventh session of the Ad Hoc Committee on a Comprehensive and Integral International Convention on Protection and Promotion of the Rights and Dignity of Persons with Disabilities, Japan, with the support of China, sought to amend the text of article 14 to read "in no case shall the existence of a disability 'solely or exclusively' justify a deprivation of liberty". However, the proposal was rejected. See daily summary of discussion at the seventh session, on 18 and 19 January 2006, available at www.un.org/esa/socdev/enable/rights/ahc7summary.htm

Amita Dhanda points out that although the Convention neither expressly bans nor explicitly permits forced intervention, nevertheless this stalemate affords an opportunity to revisit forced interventions from the standpoint of people with mental illness[19].

The report of the UN Special Rapporteur on Torture states that the deprivation of liberty (ie. Article 14 of the CRPD), can in some instances amount to torture, inhuman and degrading treatment and punishment, and hence runs counter to the UN Convention Against Torture (and also counter to Article 15, Freedom from torture, of the CRPD). The report states that *"Many States, with or without a legal basis, allow for the detention of persons with mental disabilities in institutions without their free and informed consent, on the basis of the existence of a diagnosed mental disability often together with additional criteria such as being a "danger to oneself and others" or in "need of treatment". The Special Rapporteur recalls that article 14 of CRPD prohibits unlawful or arbitrary deprivation of liberty and the existence of a disability as a justification for deprivation of liberty. In certain cases, arbitrary or unlawful deprivation of liberty based on the existence of a disability might also inflict severe pain or suffering on the individual, thus falling under the scope of the Convention against Torture. When assessing the pain inflicted by deprivation of liberty, the length of institutionalization, the conditions of detention and the treatment inflicted must be taken into account."* In relation to treatment specifically, he further states that forced and non-consensual administration of psychiatric drugs, in particular of neuroleptics, for the treatment of a mental condition needs to be closely scrutinized and depending on the circumstances of the case, the suffering inflicted and the effects upon the individual's health may constitute a form of torture or ill-treatment[20].

Further guidance from the Committee on the Rights of Persons with Disabilities is needed on the full significance of the CRPD in relation to issues of involuntary admission and treatment. However, it is likely that countries will be required to carefully review their laws and practices involving the deprivation of liberty and treatment without free and informed consent. The UN Handbook for Parliamentarians on the CRPD states that countries "should note the Convention's emphasis on independent living within the community instead of forced institutionalization. States should also review these guarantees in relation to compulsory or forced medical interventions, and should ensure that there are laws and procedures to monitor the operation of this legislation, investigate cases of abuse and impose punitive measures, as necessary (article 16 (4)).[21]

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[19] A. Dhanda & T. Narayan (2007). Mental health and human rights. The Lancet, Vol 370, October 6 2007

[20] Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, July 2008 (A /63/175)

[21] From Exclusion to Equality: Realizing the Rights of Persons with Disabilities. Handbook for Parliamentarians on the Convention on the Rights of Persons with Disabilities and its Optional Protocol, United Nations 2007. http://www.un.org/disabilities/default.asp?id=212

INVOLUNTARY ADMISSION AND TREATMENT – PROVISIONS AND PROTECTIONS PRIOR TO THE CRPD

Mental health laws in most countries accept that under certain circumstances people with mental disabilities can be subject to involuntarily admission and treatment. To date laws that have aimed to curb potential violations associated with coercion have set out criteria and procedures to be followed in order to minimize the use and abuse of this practice. These procedures are expanded below.

Such laws have been guided by international human rights instruments that existed prior to the CRPD, such as the ICCPR, the ICESCR and the Principles for the Protection of Persons With Mental Illness and the Improvement of Mental Health Care (MI Principles). It is important to note however that it is increasingly being recognized that the MI Principles do not afford adequate protections for people with mental disabilities and that they are superseded by the CRPD insofar as they contradict the provisions of the Convention[22].

When there is more clarity on the interpretation of CRPD in relation to issues of involuntary admission and treatment it is possible that some of the concepts elaborated in the section below will change.

Before entering into the details concerning criteria and procedures for involuntary admission and treatment it is important to stress that vast majority of people with mental disabilities will never need involuntary admission to hospital. Laws in many countries have focused almost exclusively on issues of involuntary admission and treatment to the detriment of other important human rights considerations, despite the fact that this matter does not concern the majority of people with mental disabilities. This 'imbalance' is certainly something that modern mental health laws should aim to redress.

a) involuntary admission and treatment: combined or separate?

Mental health legislation in some countries combine involuntary admission and involuntary medical treatment into one procedure, while in others these procedures are separate.

Under the **"combined" approach,** once patients are admitted involuntarily, they may be treated involuntarily without having to undertake a separate procedure for sanctioning treatment. Some family groups, professionals and others have argued that the purpose of involuntary admission in most instances is to reverse a deteriorating clinical condition. It is asserted that there is no purpose in admission to hospital if no treatment is provided. In

[22] Most recently the Special Rapporteur on Torture noted in his 2008 report that the acceptance of involuntary treatment and involuntary confinement runs counter to the provisions of the Convention on the Rights of Persons with Disabilities. Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, July 2008 (A /63/175)

fact, in Portugal, the law states that "compulsory detention may *only* be determined in cases where it is deemed to be the only way of guaranteeing that the detained patient is submitted to treatment…" (Mental Health Law No 36, 1998, Portugal) and in Pakistan, the law refers only to "admission for treatment" (Mental Health Ordinance for Pakistan, 2001). It is possible, of course, that a patient may not require medication, but may benefit from less intrusive therapies (such as psychotherapy, support groups or occupational therapy). Nonetheless, within the single approach, whether actually provided for or not, medical treatment *can* be given if admission is approved. This does not imply that in the combined approach the person cannot play any part in the treatment plan. Indeed it is good practice for the practitioner to always try and get cooperation and approval for treatment from the patient.

Under a fully **"separate" approach**, the admission and treatment procedures are independent of each other. First, the person is assessed for involuntary admission, then, if an involuntarily admitted he or she requires involuntary treatment, the treatment need has to be assessed and a separate procedure for sanctioning such treatment is necessary. Many individuals and organizations, especially user groups, object to combining involuntary admission and involuntary treatment and argue that a person's consent or refusal to admission and to treatment, are separate issues. Persons may require involuntary admission but not involuntary treatment, or, indeed, involuntary treatment without having to be placed outside their homes or communities. Moreover, it is argued that capacity is issue-specific, in that a person who is judged to be lacking capacity to make decisions regarding admission to a mental health facility may still retain the ability (capacity) to make decisions regarding treatment. It is agued that involuntary treatment violates fundamental human rights principles and that the provision of two independent procedures for invoking involuntary admission and involuntary treatment ensures an extra layer of rights protection for persons with mental disabilities.

On the other hand, advocates of the combined approach contend that with the separate approach there is a risk that if too much time elapses between the two processes, treatment can be seriously delayed, with detrimental effects for the individual concerned, as well as, possibly, to health care workers and other patients if the person is highly aggressive.

Another possible variation of the combined and separate approaches, that could incorporate the advantages of both, is to consider the need for admission and treatment separately, but to combine the processes for determining and sanctioning them. In other words, the same practitioner(s), and possibly the same review body (or independent authority), that assesses the need for admission may also (in the same session) assess whether the person has the capacity to consent to treatment, and whether involuntary treatment is indeed required. This could lead to a range of different outcomes.

A review of fifteen European legislations (Salize & Dressing, 2002) found that seven Member states (Austria, Denmark, Germany, Luxembourg, Netherlands, Sweden and the United Kingdom) define involuntary placement and involuntary treatment as distinct

modalities in their legal frameworks, thus acknowledging that admitting a person compulsorily may not necessarily include compulsory treatment. However, regardless of distinguishing these modalities on a legal level, there are Member States where patients must accept treatment whenever being detained involuntarily, as it is the case in Sweden, Denmark or Luxembourg. In this review eight countries (Belgium, Finland, France, Greece, Ireland, Italy, Portugal, Spain) use a combined approach.

The following paragraphs discuss the criteria and procedure for involuntary admission and treatment. Where a "combined" procedure is utilized, i.e. treatment is provided (as required) as an integral part of involuntary admission and treatment, it should be "read into" admission. In other words, if admission is permitted, then treatment is automatically permitted, though it should never be given unless clinically required. Where treatment is to be provided as a "separate" process from admission, the criteria and process for *admission* are largely the same as under the "combined" procedure, but involuntary *treatment* is considered separately.

b) Criteria for involuntary admission

i. Presence of a mental disorder

First and foremost, laws that have sought to regulate involuntary admission and treatment in order to minimise overuse of these procedures have set very specific criteria that need to be met before compulsion can be undertaken. The first criteria is that the presence of a mental disorder as defined by internationally accepted standards be demonstrated (as discussed above this issue has been at the root of some controversy in light of Article 14 of the CRPD). However, the type, severity and degree of a mental disorder qualifying for involuntary admission varies in different jurisdictions. Some countries allow involuntary admission only for specific mental disorders such as psychotic illness, while others mention "severe mental disorder (illness)", while still others use the broader definition of mental disorder as the qualifying criteria for involuntary admission. A crucial issue for mental health legislation has been to determine whether specific conditions should be included or excluded from involuntary admission. The more contentious diagnoses include mental retardation, substance abuse and personality disorder. Choices in this regard will reflect the values of a particular country or community. The following table taken from a review of European legislations (Salize & Dressing, 2002) classifies which states do provide special regulations for placing and treating subgroups of patients.

1.9 Special regulations apart from the general laws, acts or legal instruments directing involuntary placement for certain groups of patients

	number	*countries*
for people in guardianship	8	Aus, Den, Ger, Gree, Ire, Lux, Port, Spa
for mentally ill offenders	13	Aus, Bel, Den, Fin, Fra, Ger, Gree, Ital, Lux, Neth, Port, Spa, Swe
for persons with addictive behaviour	4	Aus*, Fin, Fra, Swe
for mentally handicapped persons	2	Den, Fin

* Austria: only for addicted offenders

ii. Serious likelihood of immediate or imminent danger and/or serious deterioration if failure to treat:

The presence of a mental disorder alone is not sufficient to justify involuntary admission and additional criteria are also required. The two most often utilized grounds for authorizing involuntary admission of persons with mental disabilities are "serious likelihood of immediate or imminent danger " and "the need for treatment".

- ***Serious likelihood of immediate or imminent danger*** – This criterion can be applied in the best interests of the patients themselves to prevent harm to themselves, or for the safety of others. Preventing harm to self, to carers, families and society in general is an important obligation of the State, and thus it is often a key element of legislation.
- *Likelihood of serious immediate or imminent deterioration if failure to treat:* This criterion, like the dangerousness/safety criteria, solicits a great deal of controversy. There are a number of organizations and individuals, including users of mental health services and user groups, who object to this criterion. The MI Principles (Principle 16) state that involuntarily admission may be considered if, "in the case of a person whose mental illness is severe and whose judgement is impaired, failure to admit or retain that person is likely to lead to a serious deterioration in his or her condition or will prevent the giving of appropriate treatment that can only be given by admission to a mental health facility…." This principle usually includes the concurrent presence of a number of factors. First, the illness must be "severe" (issue of definition); secondly, it must be proved that there is "impaired judgement" (issue of capacity); and thirdly, there must be reasonable grounds to suspect that failure to admit the person will lead to serious deterioration in his/her condition or prevent administering appropriate treatment (prediction of treatment issue).

The following table describes the combinations deriving from these two criteria in fifteen European legislations (from Salize & Dressing, 2002)

1.10 Criteria or conditions of person specified by statutes, laws or acts

criteria	*countries*
Mental disorder + danger	Aus, Bel, Fra*, Ger, Lux, Neth
mental disorder + danger *or* mental disorder + need for treatment	Den, Fin, Gree, Ire, Port, UK
mental disorder + need for treatment	Ita, Spa, Swe

* France: danger criterion (to the person him-/herself) and need for treatment criteria in the HDT-procedure; threat to others or to public safety in the HO-procedure, need for treatment is not mentioned as a criterion in this case.

iii. Admission should include a therapeutic purpose

Another requirement in some laws is that persons should be admitted involuntarily only if there is a therapeutic purpose to the admission. This does not necessarily mean that medication must be provided, as a wide range of rehabilitative and psychotherapeutic approaches may be implemented. In such laws a lack of therapeutic success does not imply a lack of therapeutic purpose, and involuntary admission can be justified if the person is receiving therapeutic care, even if the available treatments are not able to completely cure the person's condition. The argument is that a person requiring purely custodial care should not be kept in a psychiatric facility as an involuntary patient.

When applying the above criteria, it is also important to consider the principle of ***"the least restrictive environment"***. In other words, a person may not be admitted if other, less restrictive alternatives, such as community care, can be utilized.

c) Procedures for involuntary admission and treatment

Mental health legislation usually outlines the procedure to be followed for involuntary admission. This procedure will vary from country to country.

i. Who should conduct the assessment?

As an additional safeguard to protect the rights of those being detained involuntarily, the MI Principles recommend that two independent *medical practitioners* who examine the patient separately and independently conduct the assessment. This is an important principle. However, in low-income countries with a scarcity of psychiatrists and general medical professionals, and even in some developed countries, this has been deemed impractical, and other viable alternatives have been legislated. For example, other accredited mental health practitioners (such as psychiatric social workers, psychiatric nurses and psychologists) may need to be trained and accredited, as has been done in South Africa. In most Canadian provinces, there is only one physician in the community who authorizes a short-term (24–72 hours) admission. Thereafter, an independent

physician examines the person in hospital, and if the physician does not consider a longer retention necessary the person is discharged.

The MI Principles require that at least two practitioners examine a person before he/she is admitted or treated. *Multiple examinations* by *more qualified* people may well provide the greatest protection to patients, but if legislating and enforcing this means that other patients who need care are not treated because the scarce resources are being used in assessing one person – or persons are not assessed at all because they come from a region where there are no or not enough qualified practitioners as legislated – then clearly this does *not* provide better protections.

Moreover, ostensibly, more qualified professionals may be less able to do mental health status examinations than those assumed to be less qualified. For example, in many developing countries medical doctors have had very little training and experience in mental health, whereas certain psychiatric nurses are highly skilled and experienced. On the other hand, many psychiatric symptoms are manifestations of an underlying physical illness, and examination by at least one medical doctor is important. Locally appropriate solutions are clearly more important than any rules described in any book.

A recent comparison of legislation commissioned by the European Commission (Salize & Dressing, 2003) has shown that 7/15 countries require the assessment be done by a trained psychiatrist (Austria, Greece, Ireland, Netherland, Portugal, Spain and the UK) while the other (Belgium, Denmark, Finland, France, Italy, Germany, Luxembourg and Sweden) require just a physician. However, in all Member States, thorough assessments are performed by psychiatrists as soon as a patient is admitted to a psychiatric facility. The same comparison has also shown that 4 countries (Belgium, Germany, Denmark and Netherlands) require just one expert certification to start the procedure, Finland requires three certificates, all the other two.

In general the standards of having two independent assessments, one of which is by a qualified practitioner, always apply. If a second assessment absolutely cannot be undertaken prior to an initial admission due to circumstances within a country, it should occur on admission and prior to treatment being administered. If there is a discrepancy between the first and the second assessment, a third independent practitioner should examine the person and make recommendations, following which a majority recommendation should be instituted.

ii. Who should make the application?

The issue of who should make the application for involuntary admission is a further difficult and much debated area. In some countries, based on the recommendations of a mental health practitioner, either a family member, close relative or guardian, or another State-appointed person (e.g. in the United Kingdom, a social worker), makes an application to the designated mental health facility (either a mental hospital or a psychiatric ward in a general hospital) to admit the patient to the facility. In other

countries, the application for admission is made even before the medical examination, and the examination takes place on the basis of the application.

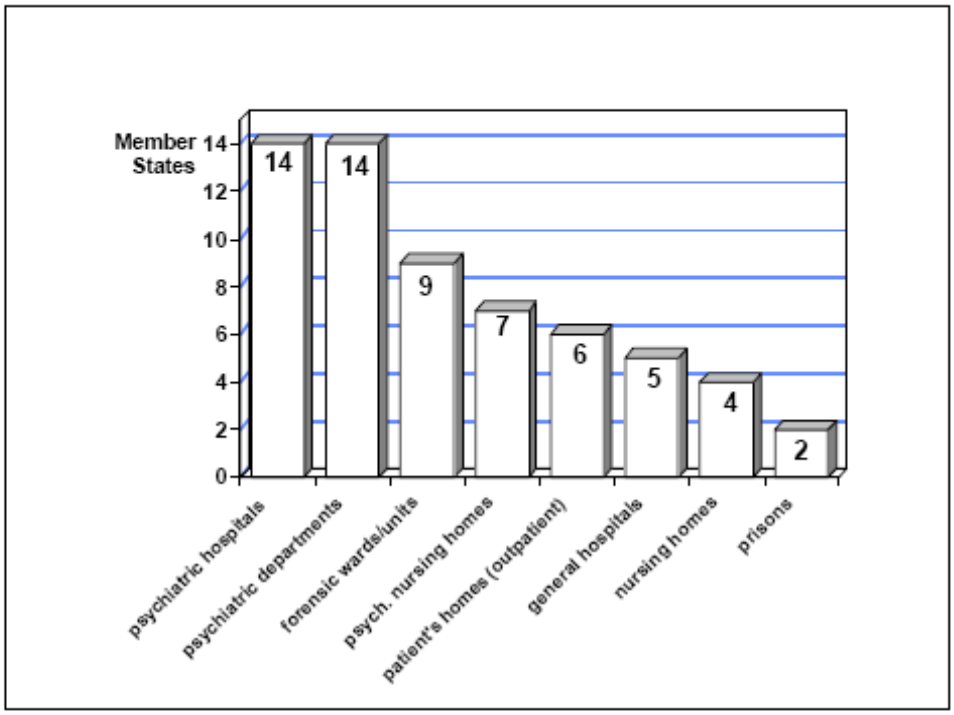
In some cases, certain families believe it is their prerogative to make the decision on whether and when a family member needs involuntary care and treatment, and that they should have a say on whether and when outside help is needed. In yet other countries, family members are not involved in the application at all because it is felt that most families do not wish to run the risk of later being blamed by the family member with a mental disability for committing them for admission and treatment. Such differences reflect different cultures and different processes adopted by countries, and none of the options can be considered the only "correct" one.

iii. Where should the patient be admitted?

Countries have to make decisions regarding where involuntary patients are to be admitted. Human rights oriented laws might include provisions specifying that, like other health admissions, this should be as near to the patients' homes as possible. Facilities in general hospitals may be developed to accommodate most involuntary patients. The mental health facility should be accredited as providing adequate and appropriate care and treatment before being permitted to admit involuntary patients.

The types of facilities accommodating patients admitted involuntarily are now much more than twenty years ago. The following figure is taken from a comparison of European laws (Salize & Dressing, 2002) and shows the types of facilities accredited for compulsory admissions reported in EU laws.

2.4 Facilities for involuntary placement and/or treatment



* psychiatric hospitals:	all Member States except Italy
psychiatric departments at general hospitals:	all Member States except Luxembourg
forensic wards/units:	Austria, Belgium, Denmark, Finland, France, Germany, The Netherlands, Sweden, United Kingdom
psychiatric nursing homes:	Belgium (only for aftercare), Germany, The Netherlands, Portugal, Spain, Sweden, United Kingdom
person's home (involuntary outpatient treatment):	Belgium (only for aftercare), Germany (civil commitment), The Netherlands (only after initial inpatient episode), Portugal, Sweden
general hospitals:	Belgium, Denmark (for treating somatic co-morbidity), Italy, Spain, Sweden (for treating somatic co-morbidity)
non-psychiatric nursing homes:	Belgium, Germany (civil commitment), Spain, Sweden
prisons:	Belgium, Greece

iv. Who should review the proposal and continued admission

Countries utilize an independent authority such as a review body, tribunal or a court to determine whether involuntary admission can be authorised or not, based on medical/psychiatric/professional expertise, as outlined above. The independent authority's decision should not be influenced by instructions from any source whatsoever. As with the issues mentioned above, resources and local conditions should determine what kind of review body is needed and the procedures to be followed. Again, countries need to balance priorities and rights. For example, despite the fact that most involuntary admissions are not categorized as being "emergencies", given the criteria for involuntary admissions, any delays in having a patient admitted and treated may need to be avoided. An appropriate balance is needed between preventing potential harm to self or others, on the one hand, and ensuring that the correct procedures are followed, that a proper

examination of the case is conducted so as to avoid the unjustifiable detention of the person concerned. In some countries it may not be possible to have the independent authority review each case prior to a person's admission. Rather than delay admission, the law may provide a specified time frame (which must be short) in which the case must be reviewed. The following table (from Salize & Dressing, 2003) shows how this time frame is regulated in some EU countries.

1.19 Maximum period of time between psychiatric assessment and compulsory admission (begin of placement) – regular procedure

country	*period*
Austria	4 days
Belgium	15 days
Denmark	for danger criterion: 24 hours; for treatment-criteria: 7 days
Finland	3 days
France	HDT-procedure: 15 days; HO-procedure: 24 hours
Germany	different for each Federal State: ranging from 24 hours to 14 days
Greece	10 days
Ireland	24 hours
Italy	2 days
Luxembourg	3 days
The Netherlands	5 days
Portugal	12 days
Sweden	4 days
Spain	not defined
United Kingdom	14 days

Comment: Across the Member States the legally stipulated period of time that may elapse between the psychiatric assessment and the actual start of detention is heterogeneous. No common patterns can be identified, suggesting that the defined periods depend very much on the organisational requirements of the respective co-operation between the assessment-making and the decision-making authorities. In Denmark and France, periods vary in each case according to the admission criteria applied (threatening harm or need for treatment).

As soon as the review body makes its decision, the relevant action should be implemented. There should then be ongoing, automatic, mandatory and regular reviews of status. In practice, most involuntary admissions are brief, lasting days or a couple of weeks, with most patients showing good recovery and/or no longer meeting the requirements for involuntary admission. There is little reason, in most instances, to continue the involuntary admission beyond this period. Patients may either recover sufficiently to be discharged, or be well enough to be able to make their own decisions to voluntarily continue the placement.

The independent authority should give patients an opportunity to state their views and opinions regarding involuntary admission (including whether they believe they are being incorrectly admitted or where they would choose to be admitted), and these should be taken into account when making decisions.. The following table (from Salize & Dressing, 2003) shows the duration of the initial admission and the periodicity of subsequent reviews in 15 EU states.

1.21 Statutory maximum duration of involuntary placement / statutory re-approval of decision

	maximum length of initial placement	*re-approval by*
Austria	3 months	3 months
Belgium	40 days for observation, 2 years for regular placement	after 25 days of initial observation, 15 days before end of individually ordered length
Denmark	not defined	3, 10, 20, 30 days, then monthly
Finland	9 months	3 months
France	not defined	HDT-procedure: 15 days, then monthly HO-procedure: 1 month, 3 month, 6 month
Germany	preliminary detention: 6 weeks regular placement 1 year, in obvious cases 2 years	preliminary detention: 6 weeks regular placement: 6 months (defined by Federal State of Saarland only)
Greece	6 months	3 months
Ireland	21 days	21 days, 3 months, 6 months, 12 months
Italy	7 days	7 days
Luxembourg	preliminary detention: 14 days	14 days
The Netherlands	preliminary detention: 3 weeks regular placement: 6 or 12 months	preliminary detention: 3 weeks regular placement: 6 or 12 months
Portugal	not defined	2 months
Spain	not defined	6 months
Sweden	4 weeks	4 weeks, 4 months, 6 months
United Kingdom	assessment order: 28 days treatment order: 6 months	28 days 6 months

Comment: Only Denmark, France, Portugal and Spain do not define a maximum duration of initial involuntary placements. In the remaining Member States, the maximum length of initial placements can vary from seven days to two years, depending mostly on regulations regarding re-approval or re-assessment procedures, which are established in all Member States. Those countries defining a maximum length of initial placements also allow premature termination of placements under certain conditions. For treatment and rehabilitation purposes, some Member States (Bel, Den, Fin, Fra, Ger, Ire, Neth, Spa), allow the interruption of involuntary placements for short periods (from several days up to several weeks).

The law should ensure that patients are informed immediately of the grounds for involuntary admission, and that this is also conveyed promptly to the patients' legal representatives and family members if appropriate. Moreover, an important element to be incorporated into legislative provisions on involuntary admission is the right to appeal to quasi-judicial and judicial bodies. Legislative sections dealing with involuntary admission should include this right and set out the process to be followed – for patients, their

families and/or legal representatives – for appeal to a mental health review body and/or a court against the initial detention.

d) Procedures for discharge

The procedures for discharging a person from involuntary admission and treatment should be as flexible as possible to ensure that a person is not retained for any period longer than is necessary. Continued admission is only justified upon the persistence of the mental disorder of a severity and form that prompted the involuntary admission. If involuntary admission is no longer warranted, the patient may be discharged without further care, either by a doctor or a professional as determined by law, or by the review board if it has considered the case. If patients so choose, they may be transferred to voluntary status to continue care and treatment as an inpatient or outpatient. Such patients have the right to be discharged when they so wish. . There is a need for a statutory process for reviewing cases at regular intervals and as well as a process for appealing involuntary detention decisions. To facilitate this procedure, it is useful for countries to have standardized forms which must be filled in at various stages.

e) Criteria for involuntary treatment (where procedures for admission and treatment are separate)

There is considerable overlap between the criteria for involuntary admission and involuntary treatment. The main difference, however, is that, regarding *treatment*, the person has to be found to lack the capacity to make informed decisions. Provisions aiming to restrict the use of involuntary treatment tend to specify that treatment without consent can be considered only when all of the following conditions are met:

1.A determination that a patient has a mental disorder has been made in accordance with international medical standards.

2. The patient lacks the capacity to give or withhold informed consent to the treatment proposed (see also section below on incapacity and incompetence).

3. Treatment is necessary to:

(i) bring about an improvement in the patient's mental disorder

(iii) protect the patient from self harm or protect others from significant harm

(ii) prevent deterioration of the patient's mental state

Treatment without consent and without the authorization of a legally constituted body should be instituted only, and strictly, in emergencies, and only for the duration of the emergency

It is important to recall that the deprivation of liberty on the basis of a disability and the determination of incapacity are currently being disputed by many as being contrary to the spirit of the CRPD.

f) Procedures for involuntary treatment (where procedures for admission and treatment are separate)

There are a number of different ways in which a treatment process – as distinct from the admission process – is applied. The treatment decision may be independent in terms of:

a) *time* – involuntary treatment is assessed only after the patient has been admitted;
b) *criteria* – mental health status that requires involuntary admission is different from the capacity to decide treatment; and
c) *professional and authorizing power* – different people, with different skills, are involved in deciding who needs to be involuntarily admitted and who requires involuntary treatment.

Whether part of a combined or separate process, involuntary treatment should always be proposed by a suitably qualified and accredited mental health practitioner. Which professional category this is will depend on country resources and situations. As with admission, a second independent, accredited mental health practitioner, who has independently examined the patient and reviewed the entire medical and treatment records of the patient, may be utilized to confirm the treatment plan. Practitioners making treatment decisions may only do this within their professional scope of practice. It is important to emphasize once again that the designated professionals need to have the requisite training, competence and expertise to perform this role – and legislation should stipulate these criteria.

Based on the above recommendations, the treatment plan – as with admission recommendations – may be sanctioned by an independent authority (this may be the review body). The independent authority may be required to verify that the patient does indeed lack the capacity to give consent to treatment, and (under some legislations) that the proposed treatment is in the best interests of the patient. As with admissions, this independent authority may be quasi-judicial or judicial. The key point is that the independent authority is different from the individual(s) proposing the treatment, and is made up of people with the requisite skills and knowledge to judge the competence of the patient. Although in some situations this body will be different from the body that authorizes the admission, this may not be possible in all situations. Where only a single body is available, its members would need to bear in mind the differing admission and treatment criteria. The authority could then decide on a range of options, for example, that a person must be involuntarily admitted but cannot be medically treated without his/her consent, that the patient be both admitted and treated, or that neither involuntary admission nor treatment is permissible.

When involuntary treatment is recommended, whether as part of a "combined" or "separate" approach, it is essential that the patient be protected from any undue harm and that the proposed treatment should aim to benefit the patient. In general, treatment should always be applied in response to a recognized clinical symptom, have a therapeutic aim, and be likely to entail a real clinical benefit – and not only have an effect on the

administrative, criminal, family or other situation of the patient. Involuntary treatment must meet national and/or international treatment guidelines for the particular mental health condition – whichever offers the most protection and safeguards against abuse. Involuntary treatment must not be given for longer than is necessary, and should be systematically reviewed by the treating health practitioner and periodically by an independent review body. In some statutes, a maximum time limit for treatment may be stipulated. Where a time limit is stipulated, involuntary treatment must not extend beyond the sanctioned limit or beyond the restoration of the patient's capacity – *whichever happens earlier.*

Patients and those caring for them must be informed immediately of their rights when patients are being involuntarily treated. Patients and their families and/or personal representatives must have a right to appeal to a review body, tribunal and/or court against the imposition of involuntary treatment. Once again, it is useful to have standardized forms for the process of appeal to a review body.

When periodically reviewing involuntary treatment, the independent authority must ensure that grounds for continuing involuntary treatment persist. Where a time for allowing involuntary treatment has been stipulated and treatment beyond this time is required, the process of sanctioning treatment must be repeated. The mere refusal of treatment by a patient should not be considered as adequate grounds for resanctioning involuntary treatment.

g) Substitute Decision Maker/Proxy Consent

As outline the whole concept of substitute decision-making and guardianship are currently being disputed in light of the CRPD, with some arguing that these procedures are not permissible under the Convention and others stating that they are only permissible as a measure of last resort. What remains undisputed is that the CRPD promotes a model of supported decision making which enables people to remain steadfastly in the centre of decisions related to their lives and their care.

Nevertheless to date many jurisdictions provide for the appointment of a personal representative, usually a family member who has the right to give consent to treatment on the patient's behalf. Substitute decision making or "proxy" consent in many circumstances is a form of involuntary treatment.

Any proxy or surrogate is be bound by a "substituted judgement" standard in making decisions for a person without capacity. That is, surrogates are required to make the decision they believe the person would have made if that person had the capacity to make the decision. Where the person never had capacity – such as certain people with intellectual disability – the standard merges with a "best interest" standard. Even then, however, surrogates are required to strive to learn about the person's particular situation so that they can make the decision that is closest to their perception of the known wants

and needs of the person concerned. There are advantages to proxy decisions by family members; they are the most likely to have the patients' best interests at heart and to be familiar with the patient's own values. Simultaneously, it should be acknowledged that "proxy" decisions – particularly when they happen to be made by family members – might not be truly independent. Conflicts of interest can occur in families, and family members may equate their best interests with the patient's best interests. Safeguards incorporated in rules governing involuntary treatment should therefore also apply to proxy consent; e.g. patients should have the right to appeal even in circumstances of proxy consent.

In some countries' legislation, provision is made for an **"advance directive",** whereby persons with mental disabilities may, during periods when they are "well", determine what they find acceptable or unacceptable for periods when they are unable to make informed decisions. They may also determine who should make decisions on their behalf at times when they cannot make informed decisions A recent study has shown that the negotiation of a joint crisis plan among patients and mental health teams, including the preparation of advance directives specifying treatment preferences, can result in reduced involuntary admissions in patients with severe mental disorders (Henderson, 2004).

More problematic is when a person with a mental disabilities specifies advance refusal of treatment. Some mental health professionals are reluctant to accept that such an advance refusal should apply in a later situation when a patient meets the criteria for involuntary treatment, and where honouring the advance refusal of treatment would deprive a seriously ill patient of needed treatment, or where patients could do harm to themselves or others.

D) INVOLUNTARY ADMISSION AND TREATMENT – SPECIAL ASPECTS

a. Non protesting patient

A particular category is constituted by non-protesting patients: those who are incapable, due to their mental condition, to give consent to admission and/or treatment, but who do not refuse mental health interventions. Patients may not refuse for many reasons, such as a neurological condition (delirium, dementia, learning difficulty), which precludes their understanding of the need, purpose and the fact of admission to a mental health facility. Quite often patients with mental disabilities succumb to a show of authority because they do not realize they are free to resist. This explains the high rate of perceived coercion which the literature has started to outline (Bindman et al., 2005). Such patients who feel intimidated into consent should not be considered to be, or admitted as, non- protesting patients. Every effort needs to be made in the law to safeguard against this type of situation and the person should have their rights explained very carefully. The rights of non-protesting patients are protected in a manner identical to those of involuntary patients. Non-protesting patients should qualify for automatic review procedures. They

and their families and carers should have the right to appeal their position. They should also enjoy all other rights afforded to other patients, such as notification of their rights, to confidentiality, adequate standards of care and other rights.

b. ***Involuntary admission of children and adolescents***

Legislation protecting the human rights of children and adolescents should take account of their particular vulnerabilities. It should specifically aim to respect, protect and fulfil their rights, as laid out in the UN Convention on the Rights of the Child (CRC) and in the Convention on the Rights of Persons with Disabilities. Indeed the right to live in the community and to have access to appropriate care close to home, as with all the rights outlined in the CRPD, are equally applicable and relevant to children with mental disabilities.

In many countries there are no specialized mental health services for minors, and legislation can therefore play an important role in promoting the establishment of and access to such services in the community. Legislation should specifically discourage the involuntary admission of minors in mental health facilities.

Minors should have access to a personal representative to adequately represent their interests, especially when admitted to mental health facilities and throughout the course of such admission. In most instances, their personal representative would be a family member. However, where there is potential or real conflict of interest, there should be legal provisions for the appointment of another independent personal representative.

Consent to treatment of minors also needs attention in legislation. Many jurisdictions use age (usually 18 years) as the sole criterion for determining a minor's right to consent or refuse consent. However, a significant number of minors, especially teenagers, have sufficient maturity and understanding to be able to consent or withhold consent. It is important that the evolving capacity of children is respected in accordance with the CRC and the CRPD. Furthermore all children should as far as possible be a part of discussions and decisions being made around their treatment.

c. ***Treatment in Emergency situations***

Laws in many countries include provisions for emergency situations when urgent action may be required.. In such situations it may not be feasible or reasonable to expect compliance with substantive procedures for involuntary admission and treatment which can take time.

In most countries, emergency is defined as one where there is immediate and imminent danger to the person concerned and/or danger to the health and safety of others and time required to follow substantive procedures would result in undue delay and increase the likelihood of harm to the concerned person or others. In such situations, legislation may

permit immediate involuntary admission to hospital and/or immediate involuntary treatment based on an assessment carried out by a qualified medical practitioner (not necessarily one who is accredited for this purpose). Usually, emergency admission or treatment is limited to a short time, for example not beyond 72 hours.

Laws that contain provisions for emergency situations may include the following specifications:

A qualified practitioner should examine the person and certify that the nature of the emergency requires immediate involuntary admission and treatment.

a) emergency treatment does not include irreversible treatments such as psychosurgery, participation in clinical trials and experimental treatment and also sterilisation procedures.

b) A treatment plan should be drawn up under the supervision of a medical or mental health professional.

c) Procedures for involuntary admission and/or involuntary treatment should be initiated immediately if it is assessed that the person is likely to require involuntary care beyond the stipulated time limit for emergency treatment.

d) It is inappropriate to reapply emergency powers when a patient has been released following completion of the procedure for involuntary admission, unless there is a substantial change in the nature of the emergency.

e) Patients' family members, personal representatives and/or a legal representative should be immediately informed of the use of emergency powers.

f) Patients, their families and/or personal representatives have the right to appeal to a mental health tribunal and courts against emergency admission and treatment.

The following table summarizes the provisions of emergency treatment in EU states (from Salize & Dressing, 2002)

1.20 Short-term detention (emergency cases)

	max. duration of short-term detention	*decision-making authorities for short-term detention*
Austria	48 hours	psychiatrist
Belgium	10 days	prosecutor
Denmark	Regular procedure applies to emergency cases also	psychiatrist
Finland	Regular procedure applies to emergency cases also	psychiatrist
France	48 hours	mayor (Paris: police)
Germany	24 hours (15 Federal States) 3 days (1 Federal State)	Municipal public affairs office or psychiatrist
Greece	48 hours	prosecutor
Ireland	Regular procedure applies to emergency cases also	psychiatrist
Italy	48 hours	public health department
Luxembourg	24 hours	police or physician or psychiatrist or guardian or social worker
The Netherlands	24 hours	mayor
Portugal	48 hours	psychiatrist
Spain	24 hours	psychiatrist
Sweden	24 hours	psychiatrist
United Kingdom	72 hours	police or physician plus social worker

Comment: Emergency procedures for short-term placement are usually applied at night, at week-ends or whenever immediate action is deemed necessary. Short-term detention is permitted from 24 up to 72 hours (except in Belgium, where it can take 10 days). In some Member States, the decision-making authorities for short-tem placements differ from those deciding upon the regular detention procedures.

d. Treatments requiring additional protection

Sterilisation is not a treatment for mental disorders and having a mental disorder should not be a reason for sterilisation without informed consent. Psychosurgery and other irreversible treatments should not be permitted as involuntary treatment and as additional protection, all such treatment should be reviewed and sanction by an independent review body. Using psychosurgery and lobotomy as examples, the 2008 Interim Report of the

Special Rapporteur on Torture states that the more intrusive and irreversible the treatment, the greater the obligation on States to ensure that health professionals provide care to persons with disabilities only on the basis of their free and informed consent[23].

The use of "unmodified" electroconvulsive therapy (ECT) without anesthesia or muscle relaxants creates a serious risk of harm to patients, including bone, ligament and spinal fractures, cognitive deficits and possible loss of memory. The Special Rapporteur in his report stresses that this cannot be considered as an acceptable medical practice, and may constitute torture or ill-treatment.

In relation to modified ECT the World Health Organization specifically states that ECT should be administered only after obtaining informed consent[24]. Furthermore people should be informed of the possible secondary effects and related risks such as heart complications, confusion, loss of memory and even death[25].

WHO also states that ECT should never be performed on minors.

The following table summarizes the content of EU member states regulations with regard to special types of treatments (Salize & Dressing, 2002).

1.25 Special mental health care interventions

	number	*countries*
application regulated	7	Aus, Den, Ger, Ire, Neth, Port, UK
not regulated in law	8	Bel, Fin, Fra, Gree, Ita, Lux, Spa, Swe

interventions	explicitly permitted	Permitted on defined conditions	explicitly prohibited
pharmaceutical intervention	Den, Ire, Neth		Aus *
Electro-convulsive therapy (ECT)	Den	Ire, Port, UK	Aus
Psychotherapy	Ire	Ger	
Psychosurgery		Den, Ire, Port, UK	Den, Ger
Treatment of somatic comorbidity	Den	Ger	
Forced feeding	Den, Ger, Neth		

* Austria: depot neuroleptics

Comment: Numerous psychiatric treatments or interventions can potentially be applied compulsorily. Across the Member States, coercive application of interventions is regulated by a wide variety of stipulations or statutes. Common patterns could not be identified. If not regulated on a legal level, the application procedures and rules might be directed by codes of practice or court decisions etc. Please note: list of interventions might be incomplete for some Member States.

e. Major medical and surgical procedures

[23] Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, July 2008 (A /63/175)
[24] WHO Resource Book on Mental Health, Human Rights and Legislation (2005). World Health Organization, Geneva
[25] Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, July 2008 (A /63/175)

Major medical or surgical procedures on patients with mental disabilities should be performed only after obtaining proper informed consent. If the patient is considered not competent to give informed consent, legislation should only permit such procedures under exceptional circumstances and with adequate safeguards. Involuntary medical and surgical procedures may be permitted if they are deemed to be life-saving and delay caused by waiting for restoration of patients' capacity to consent would cause inordinate delay and put the patients' lives at risk.

f. Seclusion and restraint

Physical restraint or involuntary seclusion of a patient must always be considered as a traumatic event with a relevant potential for abuse.

The UN Special Rapporteur on Torture notes that "poor conditions in institutions are often coupled with severe forms of restraint and seclusion. Children and adults with disabilities may be tied to their beds, cribs or chairs for prolonged periods, including with chains and handcuffs; they may be locked in "cage" or "net beds" and may be overmedicated as a form of chemical restraint. It is important to note that "prolonged use of restraint can lead to muscle atrophy, life-threatening deformities and even organ failure", and exacerbates psychological damage. He concludes that the prolonged use of restraints and of solitary confinement and seclusion, may amount to torture or ill-treatment in violation of the UN Convention on Torture and of Article 15 of the CRPD[26].

The terms "seclusion" and "restraint" may need to be defined in legislation, as there can be various interpretations of what is meant by these terms. Moreover, there may be different types of seclusion and restraints that may apply in different circumstances.

In some instances it is the lack of resources that lead staff to resort to seclusion and restraint procedures. Lack of resources cannot be used as a means of justifying the overuse and abuse of this practice, and immediate action needs to be taken to prevent this. At the same time, countries need to develop their mental health infrastructure in order to minimize the potential for this form of abuse.

In order to protect against the abusive use of seclusion and restraints, laws in some countries outline the exceptional circumstances when these procedures are permitted. For example, restraints and seclusion may be allowed when they are the *only* means available to prevent immediate or imminent harm to self or others, and then used for the shortest period of time necessary. They may only be authorized by an accredited mental health practitioner. If used, there needs to be ongoing active and personal contact with the person subject to seclusion or restraint, which goes beyond passive monitoring. Legislation may ensure that restraints and seclusion are used as procedures of last resort when all other

[26] Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, July 2008 (A /63/175)

methods of preventing harm to self or others have failed. In particular, legislation must ban the use of restraints and seclusion as a form of punishment.

All episodes of physical restraint and seclusion should be recorded in a register that is made available to the review body for its perusal and for identification of facilities that may be abusing these interventions. Information should include details of the circumstances leading to restraint and seclusion, the duration, and the treatment given to bring about a speedy termination of the restraint or seclusion. Where possible, there should be a legislative requirement to immediately inform patients' families and/or personal representatives when patients are subjected to seclusion or restraint procedures.

g. Protection when participating in clinical and experimental research

Article 15 (Freedom from torture or cruel, inhuman or degrading treatment or punishment) of the CRPD states that "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment". In particular, no one shall be subjected without his or her free consent to medical or scientific experimentation". Furthermore States are required to take all effective legislative, administrative, judicial or other measures to prevent persons with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhuman or degrading treatment or punishment.

The fact that medical or scientific experimentation is contained within CRPD's article on torture indicates that coercion in these practices could amount to torture, cruel, inhuman or degrading treatment or punishment in violation of the Convention. Consequently mental health laws which have previously included provisions allowing medical or scientific experimentation and research without informed consent may need to be reviewed in light of the CRPD.

Involuntary treatment in community settings

Some countries have enacted legislation that permits involuntary treatment of patients residing in community settings. It is important to note that the current international debate and discussion concerning the permissibility of involuntary admission and treatment in light of CRPD also holds true for involuntary treatment in community settings. Nevertheless several countries have enacted involuntary treatment in the community as it is regarded by some as being less restrictive than a hospital (although it can be argued that the highly restrictive living conditions and intrusive medical interventions that can be part of community orders are sometimes more restrictive than, for example, a short stay in hospital). Examples of less restrictive settings would generally include outpatient treatment, day hospital treatment, partial hospitalization programmes and home-based treatment.

There are a number of reasons why some countries have seen the need to make provision for involuntary treatment in the community. First, professionals and others are concerned

about the occurrence of a "revolving door" situation, whereby persons with mental disabilities undergo involuntary admission and treatment, stop medication on discharge and relapse, leading to an ongoing cycle of involuntary admission and treatment. Secondly, there is a fairly common public – as well as professional – perception that deinstitutionalization has failed in many countries, and that the number of persons with mental disorders in the community poses a public risk (Harrison, 1995; Thomas, 1995).

Some countries have community supervision orders that require individuals to reside at a specified place and attend specified treatment programmes (such as counselling, education and training). They also grant the individuals access to mental health professionals at their homes, but do not include having to submit to medication without consent. Other countries have enacted community treatment orders that include a provision for involuntary medical treatment. Under New Zealand's Mental Health (Compulsory Assessment and Treatment) Act, Sec. 28(2), when a court has ruled that the certification criteria (for involuntary treatment) have been met "the court shall make a community treatment order unless the court considers that the patient cannot be treated adequately as an outpatient, in which case the court shall make an inpatient order."

Certain other countries have introduced the concept of conditional leave in order to aid community reintegration of patients who have received involuntary treatment in hospital settings. At this juncture, the evidence base for the effectiveness of compulsory community supervision and/or treatment orders is still rather new. Such orders appear to decrease rehospitalization and total hospital days when they are accompanied by intensive community-based treatment, which requires a substantial commitment of manpower and financial resources (Swartz et al., 1999). Certainly community supervision and treatment legislation could only feasibly be introduced only in the context of accessible, quality community-based mental health services that emphasize voluntary care and treatment as the preferred option. There is a significant risk that compulsory community supervision could cause mental health services to rely on compulsion for providing community based care, rather than focusing on making such services acceptable to users and investing efforts and resources in engaging users in such services voluntarily.

Critics – particularly those from groups representing users – have argued that compulsory supervision and treatment orders amount to "institutionalization" within the community, and they are strongly opposed to such measures being taken.

As in cases of involuntary admission and treatment, where community orders are implemented they must be regularly reviewed and the orders revoked when the criteria are no longer met. Furthermore, people subject to involuntary care in the community should also have the right to appeal their status. Involuntary care in the community should be considered as an alternative option to involuntary admission in a mental health facility, rather than as an alternative to voluntary community care. The criteria for involuntary treatment described above should therefore prevail in all instances of involuntary care and treatment.

The following table represents the situation in EU legislations as to community outpatient commitment (Salize & Dressing, 2002).

1.27 Compulsory outpatient treatment

	number	*countries*
mentioned as an option	4	Bel, Lux, Port, Swe
not considered by law	11	Aus, Den, Fin, Fra, Ger, Gree, Ire, Ita, Neth, Spa, UK

Comments: Involuntary outpatient treatment as a follow-up to an involuntary inpatient episode is considered to enhance the continuity of treatment as well as public safety. Additionally, it is discussed as an alternative to involuntary inpatient treatment. However, the efficacy of coercive outpatient treatment has not yet been confirmed by research, which might contribute to the fact that only four Member States mention the option of this modality in their laws.

CONCLUSION

The UN Convention on the Rights of Persons with Disabilities has brought about a new paradigm in how future mental health laws are formulated. Provisions around guardianship, involuntary admission and treatment are central features in many national laws of today. However, the current debate and discussion on the meaning and interpretation of CRPD provisions on the right to legal capacity, to supported decision-making, to liberty and security of person, to informed consent, the right to live and receive care in the community etc. are an indication that countries will need to review their current laws and practices in order to afford stronger protections against discrimination and abuses of persons with mental disabilities. The guidance of the Committee on the Rights of Persons with Disabilities will be key in understanding both the requirements of the Convention and how these are to be legislated and implemented in countries.

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