

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

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ABSTRACT

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

I. INTRODUCTION

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

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

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

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spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants.”¹

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

The European Court has justified the deprivation of liberty of persons of unsound mind on the basis that they may be a danger to public safety² but also that should be detained in their own ‘best interests’ to provide them with medical treatment³ (usually non-consensual treatment). In *Winterwerp v The Netherlands*, the court clarified that ‘unsound mind’ means that on the basis of ‘objective medical evidence’ the person must be found to have ‘a true mental disorder ... of a kind or degree warranting compulsory confinement.’⁴ States are given a wide margin of appreciation by the court to determine who is a person of unsound mind,⁵ and the majority of the case law on this provision focuses on people labelled with intellectual and psychosocial disabilities. The court’s jurisprudence is heavily reliant on medical evidence of impairment and as a justification for the necessity of detention, and in general, placement in a medical setting or an institution with medical supervision is required by the court where Article 5(1)(e) is engaged.⁶ While the court emphasises that such evidence must be ‘objective’ it has not, to date, significantly challenged the perceived objectivity of such evidence, considering this to form part of the margin of appreciation accorded to states in implementing the Convention.⁷

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

¹ Article 5(1)(e), European Convention on Human Rights.

² *Hutchison Reid v the United Kingdom* (2003) 37 EHRR 211, para. 52.

³ *Guzzardi v Italy* (1980) 3 EHRR 333.

⁴ *Winterwerp v the Netherlands* (1979) 2 EHRR 387, para. 39.

⁵ *Plesó v Hungary* App no. 41242/08 (ECHR, 17 January 2012), para. 61; *H.L. v the United Kingdom* (2004) 40 EHRR 761, para. 98.

⁶ *L.B. v Belgium* App no 22831/08, (30 July 2013), para. 93; *Ashingdane v the United Kingdom* (1985) 7 EHRR 528, para. 44; *O.H. v Germany* App no 4646/08, (ECHR 24 November 2011), para. 79.

⁷ *Rakevich v Russia* App no. 44914/09 (28 October 2003), para. 26.

⁸ *Guzzardi v Italy* (1980) 3 EHRR 333, para. 95; *H.M. v Switzerland* (2002) 38 EHRR 314, para. 45; *H.L. v the United Kingdom* (2004) 40 EHRR 761, para. 91; *Storck v Germany* (2005) 43 EHRR 96, paras. 73 and 74; *Stanev v Bulgaria* (2012) 55 EHRR 22, para. 117.

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

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

However, the Court has not yet considered whether the designation of an individual as a person of ‘unsound mind’ is itself an arbitrary construct. First, the term ‘unsound mind’ is relatively imprecise which could lead to arbitrariness. Second, even if ‘unsound mind’ is interpreted more strictly and linked to a diagnosis of disability or mental illness, the attribution of these labels to individuals have also been shown to be subject to wide socio-cultural variation.¹³ For example, Kirk and Kutchins’ seminal study¹⁴ on the reliability of psychiatric diagnoses showed that “the ranges of reliability for major diagnostic categories were found to be very broad, and in some cases ranged the entire spectrum from chance to perfect agreement, with the case summary studies (in which clinicians are given detailed written case histories and asked to make diagnoses – an approach that most closely approximates what happens in clinical practice) producing the lowest reliability levels.”¹⁵ This research demonstrates the

⁹ *H.L. v the United Kingdom* (2004) 40 EHRR 761, para. 91.

¹⁰ *Plesó v Hungary* App no. 41242/08 (ECHR, 17 January 2012), para. 59

¹¹ *Stanev v Bulgaria* (2012) 55 EHRR 22, para. 145; *Shtukaturov v Russia* (2008) 54 EHRR 27, para. 114.

¹² Peter Bartlett, ‘A mental disorder of a kind or degree warranting compulsory confinement: examining justifications for psychiatric detention’ (2012) 16(6) *International Journal of Human Rights* 831 at 832.

¹³ See for example, Sami Timimi, ‘No More Psychiatric Labels: Campaign to Abolish Psychiatric Diagnostic Systems such as ICD and DSM (CAPSID)’ (2013) 40(4) *Self & Society* 6; Peter Kinderman, John Read, Joanna Moncrieff and Richard P. Bentall, ‘Expert Review: Drop the Language of Disorder’ (2013) 16 *Evidence Based Mental Health* 2; Peter Kinderman, ‘Mental health law and incapacity: The role of the Clinical Psychologist’ (2002) *Journal of Mental Health Law* 179; Henrick Anckarsäter, ‘Beyond categorical diagnostics in psychiatry: scientific and medicolegal implications’ (2010) 33 *International Journal of Law and Psychiatry* 59; Mark Rapley, Joanna Moncrieff and Jacqui Dillon, *De-medicalizing misery* (Great Britain: Palgrave Macmillan, 2011); Joanna Moncrieff and Sami Timimi, ‘The social and cultural construction of psychiatric knowledge: an analysis of NICE guidelines on depression and ADHD’ (2013) 20(1) *Anthropology & Medicine* 59; Tanya Marie Luhrmann, ‘Social defeat and the culture of chronicity: or, why schizophrenia does so well over there and so badly here’ (2007) 31(2) *Culture, Medicine and Psychiatry* 135.

¹⁴ Stuart A. Kirk and Herb Kutchins, ‘The myth of the reliability of DSM’ (1994) 15(1) *Journal of Mind and Behavior* 71.

¹⁵ Sami Timimi, ‘No More Psychiatric Labels: Campaign to Abolish Psychiatric Diagnostic Systems such as ICD and DSM (CAPSID)’ (2013) 40(4) *Self & Society* 6 at 8.

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

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

While there have been advances in the Court’s case law on liberty in broadening the scope of locations in which it recognises a deprivation of liberty can occur,¹⁸ and the recognition that a person’s acquiescence to a deprivation of liberty does not necessarily constitute valid consent¹⁹ a number of significant challenges remain. First, the Court’s case law has not yet addressed whether people with disabilities can be deprived of liberty in their own homes or private residences, although domestic case law in England²⁰ has determined that such forms of deprivation of liberty do breach Article 5 rights. Second, the Court’s jurisprudence on Article 5 generally focuses on whether the correct procedures prescribed in national law have been followed, rather than examining the substantive issue of whether the deprivation of liberty is justified on its merits. The main findings of violations of Article 5 for persons with disabilities to date, including *Stanev*, have therefore been based on procedural irregularities at the national level. As a result, the Court has found relatively few violations of Article 5 in cases of involuntary detention and treatment of persons with psychosocial disabilities.

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

¹⁶ Joanna Moncrieff, “‘Freedom is more important than health’: Thomas Szasz and the problem of paternalism” (2014) 11(2) *International Psychiatry* 46 at 47.

¹⁷ Robert I. Simon, ‘The Myth of Imminent Violence in Psychiatry and the Law’ (2006) 75 *University of Cincinnati Law Review* 631. See also See Alex D. Pokorny, ‘Predictions of Suicide in Psychiatric Patients’ (1983) 40 *Archives General Psychiatry* 249; Douglas Mossman ‘Assessing Prediction of Violence’ (1994) 62 *Journal of Consulting and Clinical Psychology* 783.

¹⁸ *Stanev v Bulgaria* (2012) 55 EHRR 22.

¹⁹ *H.L. v the United Kingdom* (2004) 40 EHRR 761.

²⁰ *P (by his litigation friend the Official Solicitor) v Cheshire West and Chester Council and another, P and Q (by their litigation friend, the Official Solicitor) v Surrey County Council* [2014] UKSC 19.

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

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

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

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

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

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

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

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

A similar issue was raised in the series of cases starting with *Re X* – in which the Court of Protection²⁸ and the Court of Appeal²⁹ grappled with the question of whether an individual, who is the subject of an application for the deprivation of his/her liberty, should be made a party to the relevant Court of Protection proceedings. Ultimately, in a subsequent decision, Mr Justice Charles interpreted the procedural requirements of Articles 13 and 14 of the CRPD as to require independent representation – which he felt could, in the majority of cases, be provided by members of the person's family.³⁰ Therefore, he found that the CRPD would require the relevant person to be joined as a party to the proceedings only when there was no other way to guarantee their independent representation in court. While these cases only dealt with procedural

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

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

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

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

²⁷ *Ibid.*

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

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

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

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

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

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

Article 14(1)(b) CRPD requires States Parties to ensure “that the existence of a disability shall in no case justify a deprivation of liberty.” This wording was initially put forward by the Working Group which developed the first draft of the Convention text. During the negotiation of the CRPD, States and civil society debated whether this provision should be framed to ensure that disability could not be the sole or exclusive basis for a deprivation of liberty. Canada, Australia, Uganda, China and New Zealand suggested adding the term ‘solely based on disability’ and the EU favoured the term ‘exclusively based on disability’ to this provision. Such an approach would have meant that the existence of a disability combined with the risk of harm to self or others could justify a deprivation of liberty. Many states, including Mexico and South Africa³³ and civil society organisations, including the International Disability Caucus and the World Network of Users and Survivors of Psychiatry³⁴ strongly opposed the proposal to include the term ‘solely’ or ‘exclusively’ in Article 14, and as a result, the final wording is as above.

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

³¹ Tina Minkowitz, ‘Comments on CRPD and Hague Convention on the International Protection of Adults’, available at <www.chrusp.org> (last accessed 12 January 2016).

³² Rosemary Kayess and Phillip French, ‘Out of Darkness into Light? Introducing the Convention on the Rights of Persons with Disabilities’ (2008) 8 *Human Rights Law Review* 1.

³³ Ad Hoc Committee, Third Session, Daily summary of discussions, May 26, 2004; Fifth Session, Daily summary of discussions, January 26, 2005.

³⁴ Ad Hoc Committee, Fifth Session, Daily summary of discussions, January 26, 2005.

³⁵ See for example Melvyn Colin Freeman et al, ‘Reversing hard-won victories in the name of human rights: a critique of the General Comment on Article 12 of the UN Convention on the Rights of Persons with Disabilities’ (2015) 2(9) *Lancet Psychiatry* 844; John Dawson, ‘A realistic approach to assessing

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

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

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

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

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

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

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

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

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

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

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

⁴² CRPD/C/GC/1, para 36.

⁴³ Ibid, paras 12 and 13.

⁴⁴ See for example Melvyn Colin Freeman et al, ‘Reversing hard-won victories in the name of human rights: a critique of the General Comment on Article 12 of the UN Convention on the Rights of Persons with Disabilities’ (2015) 2(9) *Lancet Psychiatry* 844; John Dawson, ‘A realistic approach to assessing mental health laws’ compliance with the UNCRPD’ (2015) 40 *International Journal of Law and Psychiatry* 70.

⁴⁵ See for example World Network of Users and Survivors of Psychiatry and Center for Human Rights of Users and Survivors of Psychiatry, *Response to Draft General Comment on Article 12* (New York, 2014) available at: <<http://www.ohchr.org/EN/HRBodies/CRPD/Pages/DGCArticles12And9.aspx>> (last accessed 30 June 2016); People with Disabilities Australia, the Australian Centre for Disability Law and the Australian Human Rights Centre, *Submission to the Australian Law Reform Commission: Equality, Capacity and Disability in Commonwealth Laws* (Sydney, July 2014), available at: <https://www.alrc.gov.au/sites/default/files/subs/136._org_people_with_disability_australia_pwda_the_australian_centre_for_disability_law_acdl_and_australian_human_rights_centre.pdf> (last accessed 1 July 2016); Sociedad y Discapacidad, *Submission to the CRPD Committee on the Draft General Comment on Article 12* (Lima, 2014), available at: <<http://www.ohchr.org/EN/HRBodies/CRPD/Pages/DGCArticles12And9.aspx>> (last accessed 1 July 2016).

⁴⁶ Tina Minkowitz, ‘The United Nations Convention on the Rights of Persons with Disabilities and the right to be free from nonconsensual psychiatric interventions’ (2007) 34(2) *Syracuse Journal of International Law and Commerce* 405; Tina Minkowitz, ‘Why Mental Health Laws Contravene the CRPD—An Application of Article 14 with Implications for the Obligations of States Parties’ (2011) *SSRN Working Paper Series*, available at <http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1928600> (last accessed 25 June 2016); Arlene S. Kanter, *The Development of Disability Rights under International Law: From Charity to Human Rights* (Routledge, 2014).

⁴⁷ UN General Assembly, Report of the Working Group on Arbitrary Detention: United Nations Basic Principles and Guidelines on the right of anyone deprived of their liberty to bring proceedings before a court (New York, 4 May 2015) WGAD/CRP.1/2015.

⁴⁸ A General Comment is an authoritative interpretation of the text of a treaty provision by its monitoring body, but is not legally binding on states who ratify the treaty in the same way that the treaty text is binding. For more detail on the legal status of General Comments, see Helen Keller and Leena Grover (2012): ‘General Comments of the Human Rights Committee and their Legitimacy,’ in Helen Keller, Geir Ulfstein and Leena Grover (eds), *UN Human Rights Treaty Bodies: Law and Legitimacy*, (Cambridge University Press, 2012), 116-198; Phillip Alston, ‘The historical origins of the concept of “General Comments” in human rights law’, in Laurence Boisson de Chazournes and Vera Gowland-Debbas (eds), *The International Legal System in Quest of Equity and Universality: Liber Amicorum Georges Abi-Saab* (Martinus Nijhoff, 2001), 775.

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

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

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

⁴⁹ UN High Commissioner for Human Rights, Annual Report, A/HRC/10/48 (26 January 2009) at 48.

⁵⁰ Peter Bartlett, ‘The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law’ (2012) 75(5) *Modern Law Review* 752.

⁵¹ UN Committee on the Rights of Persons with Disabilities, *Guidelines on Article 14* (adopted September 2015), available at: <<http://www.ohchr.org/Documents/HRBodies/CRPD/GC/GuidelinesArticle14.doc>> (last accessed 20 January 2016) at para 14.

⁵² CCPR/C/GC/35, para. 19.

⁵³ WGAD/CRP.1/2015, para. 56.

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

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

In cases of harm to others, along with Minkowitz,⁵⁶ Kanter,⁵⁷ O’Mahony and Gooding⁵⁸ I support the proposition that these should be addressed through the criminal justice system, with the appropriate reasonable accommodations and support to enable the person to effectively participate in the process. Where the person is exposed to, or at risk of harm from others who seek to abuse or exploit her, I contend that it is a disproportionate response to deprive the victim of abuse of her liberty, and that instead, responses should focus on the perpetrator of abuse.⁵⁹ Given these findings, the purported justification of deprivation of liberty that appears to hold the most legitimacy to me concerns the right to life. Some scholars have argued that at a

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

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

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

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

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

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

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

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

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

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

⁶⁰ See for example Sascha Mira Callaghan and Christopher Ryan, 'Is there a future for involuntary treatment in rights-based mental health law?' (2014) 21(5) *Psychiatry, Psychology and Law* 747.

⁶¹ *Osman v UK* (1998) 29 EHRR 245 at para. 115. See also *L.C.B. v United Kingdom* (1998) 27 EHRR 212, para. 36.

⁶² *Ibid*, para. 116.

⁶³ *Kayak v Turkey* App no 60444/08, (ECHR 12 July 2012).

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

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

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

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

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

⁶⁴ *Reynolds v the United Kingdom* App no 2694/08, (ECHR 13 March 2012).

⁶⁵ App no. 45076/05 (ECHR 5 December 2013), para. 69.

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

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

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

Finally, it must be noted that the European Court has clearly stated that the right to life in Article 2 does not imply a corresponding right to choose to end one's life, or to avail of assisted suicide. In *Pretty v UK*, the court held that no such right could be found in Article 2, 3 or 8 of the ECHR.⁶⁸ However, it also held that the legalisation of assisted suicide in a State Party to the Convention would not necessarily violate the operational duty to respect the right to life in Article 2.⁶⁹ It is significant that the Court has found

⁶⁶ *Keenan v the United Kingdom* (2001) 33 EHRR 38 para. 99.

⁶⁷ *Ibid*, para. 90.

⁶⁸ *Pretty v the United Kingdom* (2002) 35 EHRR 1 paras 39-40.

⁶⁹ *Ibid*, para. 41.

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

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

The UK's approach to protecting the rights to life and liberty of persons with disabilities is more heavily reliant on the ECHR than on the CRPD, as disability-specific deprivations of liberty are still permitted through various legislative frameworks, primarily – in England and Wales – the Mental Health Act 1983 and the Mental Capacity Act 2005.⁷⁰ Before exploring the implications of these Acts in terms of human rights compliance and their interpretation in case law, it is worth briefly setting out the UK's position on domestic incorporation of human rights norms. As noted above, the ECHR has a particularly high status in the hierarchy of laws, being incorporated into domestic law through the Human Rights Act 1998. This legislation places an obligation on all public bodies (including providers of health and social care services) to comply with the ECHR in carrying out their functions. The 1998 Act also ensures that individual litigants can allege a violation of human rights protected in the ECHR in domestic courts, and that courts are empowered to make findings about the compatibility of domestic legislation with the ECHR.

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

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

⁷⁰ Other regimes exist in Northern Ireland and Scotland, which are not discussed here.

⁷¹ Office for Disability Issues, *UK Initial Report on the UN Convention on the Rights of Persons with Disabilities* (London: 2011), at para 132 available at <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/345120/uk-initial-report.pdf> (last accessed 26 January 2016).

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

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

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

⁷² Section 1(2) Mental Health Act 1983 as amended by section 1, Mental Health Act 2007.

⁷³ Section 1(2A) Mental Health Act 1983 as amended by section 2, Mental Health Act 2007.

⁷⁴ Section 32, Mental Health Act 2007.

⁷⁵ See for example David Pilgrim, Bernice Pescosolido and Anne Rogers, *The Sage Handbook of mental health and illness* (Sage Publications, 2011); Simon Lawton-Smith, John Dawson and Tom Burns, 'Community treatment orders are not a good thing' (2008) 193(2) *The British Journal of Psychiatry* 96; Tom Burns and John Dawson, 'Community treatment orders: how ethical without experimental evidence?' (2009) 39(10) *Psychological medicine* 1583.

⁷⁶ *H.L. v the United Kingdom* (2004) 40 EHRR 761.

⁷⁷ Sections 4A and 4B, Mental Capacity Act 2005 as amended by sections 5(2) and 56, Mental Health Act 2007 and S.I. 2009/139, article 2(b) with article 3.

⁷⁸ *P (by his litigation friend the Official Solicitor) v Cheshire West and Chester Council and another*, *P*

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

In respect of *Cheshire West*, the most important aspect of the decision for the present argument was Baroness Hale’s ruling that the right to liberty must be a universal one⁸¹ – and its content and related obligations should not therefore be varied for different population groups, such as persons with disabilities. This case involved three adults with learning disabilities who experienced various restrictions in their movements and/or would have been prevented from leaving the places where they lived (one litigant lived in adult foster care and the other two in care homes). The leading judgment written by Baroness Hale acknowledged that none of the litigants had made any efforts to leave, and that these placements were in their ‘best interests’ but nevertheless recognised that they were de facto deprived of their liberty under Article 5 ECHR, although the deprivations were justified under Article 5(1)(e) and did not give rise to a violation of the individuals’ human rights.

Baroness Hale cited the CRPD in support of her argument about the universal nature of human rights for persons with disabilities, and acknowledged that the ECHR should be read ‘in light of’ the CRPD, and has indeed already begun to influence Strasbourg jurisprudence since the decision of *Glor v Switzerland*.⁸² The positive developments in the ECHR jurisprudence which serve to align the court’s position closer to the CRPD in cases involving deprivation of liberty and denial of legal capacity have been noted by Lewis⁸³ and Series,⁸⁴ among others. While the court can clearly continue to develop its jurisprudence in this direction, it will inevitably confront the stumbling block that Article 5(1)(e) justifies disability-specific forms of deprivation of liberty, whereas Article 14 CRPD does not, as discussed above. However, for states struggling to comply with both standards, as I argued above, moving away from the kind of detention permitted by the ECHR and towards the standard enshrined in the CRPD can certainly be undertaken, even where the CRPD is not directly applicable in domestic law. Justifications for moving away from the ECHR and towards the CRPD include the fact that the CRPD is the most recent expression of how international human rights norms

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

⁷⁹ House of Lords Select Committee on the Mental Capacity Act 2005, *Mental Capacity Act 2005: post-legislative scrutiny* (London: 2014), available at

<<http://www.publications.parliament.uk/pa/ld201314/ldselect/ldmentalcap/139/139.pdf>> (last accessed 1 February 2016).

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

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

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

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

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

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

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

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

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

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

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

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

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

⁹⁰ *Ibid.*

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

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

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

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

⁹² Ibid, at para. 1.45.

⁹³ Ibid.

⁹⁴ *Savage v South Essex Partnership NHS Foundation Trust and MIND (Intervener)* [2008] UKHL 74.

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

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

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

⁹⁵ *Keenan v the United Kingdom* (2001) 33 EHRR 38. See also *Slimani v France* (2006) 43 EHRR 49 and *Kilinc v Turkey* App No 40145/98 (ECHR 7 June 2005)

⁹⁶ *Savage v South Essex Partnership NHS Foundation Trust* [2010] EWHC 865 (QB) at para. 89.

⁹⁷ *Savage v South Essex Partnership Foundation Trust and MIND (Intervener)* [2008] UKHL 74 at para. 13.

⁹⁸ *Rabone v Pennine Care NHS Foundation Trust* [2012] UKSC 2.

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

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

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

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

⁹⁹ Ibid at para. 34.

¹⁰⁰ Ibid at para. 43.

¹⁰¹ Sascha Callaghan, Christopher Ryan and Ian Kerridge, ‘Risk of suicide is insufficient warrant for coercive treatment for mental illness’ (2013) 36(5) *International Journal of Law and Psychiatry* 374.

¹⁰² App no. 45076/05 (ECHR 5 December 2013).

¹⁰³ Mental Capacity Act (Northern Ireland) 2016. For a critique of this Act’s compliance with the CRPD, see Eilionóir Flynn, ‘Mental (In)Capacity or Legal Capacity? A Human Rights Analysis of the Proposed Fusion of Mental Health and Mental Capacity Law in Northern Ireland’ (2013) 64(4) *Northern Ireland Legal Quarterly* 485.

¹⁰⁴ See for example, Derek Morgan and Kenneth Veitch, ‘Being Ms B: B, autonomy and the nature of legal regulation’ (2004) 26 *Sydney Law Review* 107; Peter Kinderman, ‘Mental health law and incapacity: The role of the Clinical Psychologist’ (2002) *Journal of Mental Health Law* 179; Joanna Moncrieff, “‘Freedom is more important than health’: Thomas Szasz and the problem of paternalism’ (2014) 11(2) *International Psychiatry* 46; Bruce J. Winick, ‘The Side Effects of Incompetency Labeling and the Implications for Mental Health’ (1995) 1 *Journal of Psychiatry, Public Policy and Law* 42; Sheila Wildeman, ‘Protecting rights and building capacities: Challenges to global mental health policy in light

that there is an increasing coherence in the methods and findings of functional assessments of mental capacity,¹⁰⁵ the critique of these approaches by critical psychiatrists,¹⁰⁶ users and survivors of psychiatry,¹⁰⁷ disabled people's organisations¹⁰⁸ and human rights scholars¹⁰⁹ serves as a basis for challenging this perspective.

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

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

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

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

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

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

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

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

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

lived experience of emotional distress within the user and survivor movement.¹¹² For example, Muskett's review of the global literature on trauma-informed care in mental health demonstrates that hospitals and services which used these approaches – including de-escalating crisis situations with peer support, counselling, and talking therapies which acknowledge the person's distress without medicalising the experience, reported a marked decrease in the use of coercive practices such as restraint, seclusion and involuntary admission.¹¹³ There is also significant evidence on the effectiveness of non-coercive practices for people experiencing extreme distress, self-harm, challenging behaviour and mental health crisis through methods such as family group conferencing,¹¹⁴ the use of personal ombuds,¹¹⁵ circles of support¹¹⁶ and open dialogue,¹¹⁷ which have been written about extensively in the literature on Article 12 CRPD.¹¹⁸

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

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

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

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

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

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

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

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

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

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

The European Court did not suggest that *Reynolds* should have been detained in these circumstances, although it did find that a violation of the operational duty to protect the right to life had occurred. However, the Court has in previous cases outlined what measures should be taken in respect of prisoners who are at risk of suicide as discussed above¹¹⁹ and so would have been at liberty to reiterate those here or develop new guidelines on necessary measures. Therefore the Court's decision to remain silent on this matter in *Reynolds* can be interpreted as a deliberate one. The reluctance of the Court to specify what might constitute reasonable steps in these situations may also be attributable in part to its remit as an international court, and the judges may well have felt that domestic authorities are better positioned to determine what reasonable measures would be.

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

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

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

VII. CONCLUSION

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

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

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

¹²⁰ (2012) 55 EHRR 22.

¹²¹ *Ibid*, at para. 153.

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

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

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

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

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

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

¹²⁵ [2015] UKSC 47.

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

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

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

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

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