Policy Paper concerning the Definition of a "voluntary patient" under s.2 of the Mental Health Act 2001

February 2010

IHRC

AN COIMISIÚN UM CHEARTA DUINE

IRISH HUMAN RIGHTS COMMISSION

1 INTRODUCTION

The Irish Human Rights Commission ("IHRC") has a statutory remit to endeavour to ensure that the human rights of all persons in the State are fully realised and protected, in law, in policy, and in practice. The IHRC seeks to ensure that Irish law and policy meet the standards of best international practice relating to human rights. Its functions include keeping under review the adequacy and efficacy of law and practice in the State relating to the protection of human rights, and making recommendations to Government as it deems appropriate in relation to measures which the IHRC considers should be taken to strengthen, protect and uphold human rights in the State.

In the present instance, the IHRC is making recommendations to the Government under Section 8(d) of the Human Rights Commission Act 2000 on the measures the Commission considers should be taken to strengthen, protect and uphold human rights in the State and in particular, to ensure that adequate protection is put in place under Irish law for certain categories of mental health patients in line with the State's obligations under the European Convention on Human Rights ("ECHR"). The categories of patient are those who may be deemed compliant incapacitated patients, and Wards of Court. The relevant legal provisions which govern these categories of patient are the Mental Health Act 2001 and the Lunacy Regulation (Ireland) Act 1871. In addition certain recommendations are made in relation to strengthening the protections in place in relation to the involuntary detention of children pursuant to a Court Order under section 25 of the Mental Health Act 2001, in so far as the issue of capacity to consent is relevant.

In relation to the categories of patient identified above, the recommendations being made to Government herein develop on the Observations on the Scheme of the Mental Capacity Bill 2008 issued in November 2008, which Scheme was referred to the IHRC pursuant to Section 8(b) of the Human Rights Commission Act 2000 by the Department of Justice, Equality and Law Reform in September 2008.[1]

The main purpose of the 2008 Scheme is to reform the existing Wards of Court system, in so far as it applies to adults, and effectively replace it with a modern statutory framework governing decision making on behalf of persons who lack capacity.[2] The scheme reflects the international move towards a functional approach to capacity, and the IHRC, in making observations on the scheme, welcomed this development overall. However the IHRC has identified certain categories of person whose right to liberty may be determined by the Mental Health Act 2001, and where very specific concerns about mental capacity arise, which require attention.

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[1] See www.ihrc.ie

[2] Press Release of the Department of Justice, Equality and Law Reform, "Minister Ahern Announces Proposals for a Mental Capacity Bill", (15 September 2008), available at www.justice.ie.

2 MENTAL HEALTH ACT 2001

The Mental Health Act 2001 was enacted further to the "friendly settlement" agreement reached between the State and the applicant in the proceedings *Croke v Ireland*[3] which challenged the provisions of the Mental Treatment Act 1945. The Long Title to the Act thus refers to the introduction of a range of new protective mechanisms which it was felt would bring the State into substantial conformity with its obligations under the ECHR. In relation to the Act the Mental Health Commission states;

> "In fulfilment of civil liberty requirements the Mental Health Act 2001 provides for the establishment of Mental Health Tribunals....The important safeguards recognised and enshrined in international protocols are now provided for in Irish law."[4]

In general terms, the 2001 Act provides for a periodic independent review of all involuntary admissions to psychiatric units (approved centres) by Mental Health Tribunals.[5] In addition the Act provides for the development of quality standards for psychiatric care, and the monitoring of compliance with those standards by an Inspector of Mental Health Services. Both the Inspector and the Tribunals are established under the auspices of the Mental Health Commission, which is an independent statutory body.

Under the 2001 Act, voluntary patients do not have their admission to an approved centre independently reviewed. This approach complies with the common sense understanding that a voluntary patient is not being detained against their will, and have given consent to their treatment and so do not require an independent mechanism to protect their right to liberty. The Royal College of Psychiatrists in the UK have issued good practice guidance in relation to the care of patients. One of the issues addressed is that of consent. The guidelines emphasise that where patients have capacity to make a decision, a psychiatrist must ensure that the patient's valid consent to any proposed treatment is sought and their decision recorded.[6] However the Commission is concerned that the definition of a voluntary patient under the 2001 Act is not sufficiently precisely drawn to protect the right to liberty of all those who may be admitted to an approved centre.

Section 2 of the Mental Health Act 2001 ("section 2") defines a voluntary patient as follows:

> "a person receiving care and treatment in an approved centre who is not the subject of an admission order or a renewal order".

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[3] Croke v Ireland (Application No. 33267/96) 21 December 1996.

[4] *Reference Guide Mental Health Act 2001*, Mental Health Commission at p.3.

[5] Children are dealt with separately under section 25 of the Act.

[6] The Royal College of Psychiatrists have also issued guidance in relation to seeking valid consent. See *Good Psychiatric Practice*, 3rd Ed, Royal College of Surgeons, College Report CR 154, at pp 23-24.

The Act therefore defines a voluntary patient by way of default; by what he or she is not, rather than assessing the capacity of the patient to consent to the admission.

Examining the definition of a voluntary patient more closely under section 2, it is noted that the patient is firstly defined as one who is not admitted under an "admission order". An admission order under section 14 of the Act is made when a consultant psychiatrist from an approved centre,[7] on foot of a recommendation to the clinical director of the centre, examines a person, is satisfied that the person is suffering from a mental disorder,[8] and makes an order known as an admission order for the reception, detention and treatment of the patient. A renewal order follows an initial admission order and is governed by Section 15 of the Act which states that the admission order will expire after 21 days and the consultant psychiatrist treating the patient may renew it for up to 3 months, then up to 6 months and thereafter up to 12 months; such renewals being subject to independent review by a Mental Health Tribunal. A voluntary patient is therefore also not one who is detained under a "renewal order".

2.1 Compliant Incapacitated Patients

However, a voluntary patient under section 2 is not necessarily one who is admitted voluntarily in the ordinary sense of the word as the statutory definition encompasses a wider category of persons. The Collins dictionary defines "voluntary" as: "done or undertaken by free choice". Where a person is considered to suffer from a sufficiently serious mental health condition, they may be admitted as an in-patient to an approved centre for treatment. Certain persons may not have the capacity either to consent to their admission to an approved centre, or their ongoing treatment in the centre, or to object to such an admission and treatment, but may nonetheless still be regarded as a voluntary patient for the purpose of the 2001 Act, simply because they are not the subject of an admission or renewal order. This is the category of patient defined as "compliant incapacitated patients" by the European Court of Human Rights ("ECtHR"). There is no provision or mechanism under the 2001 Act or other legislation to assess the ability of a voluntary patient to "choose" or "volunteer" to be admitted to an approved centre. These patients fall outside the procedural protections for involuntary patients set up under the Act in the form of periodic independent reviews of their admission to the approved centre. The Irish College of Psychiatrists has raised concerns that in contrast to those who are detained formally under mental health legislation, patients who are detained informally under the doctrine of necessity are not adequately safeguarded and their right to liberty may be violated. The Law Society of Ireland has also recommended that

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[7] Section 63 of the Mental Health act 2001provides that no one shall carry on a centre unless it is an approved centre. Section 64 of the Act empowers the Mental Health Commission to maintain a register of approved centres. A person suffering from a mental disorder may only be detained under the 2001 Act in an approved centre.

[8] See Appendix 1.

specific provision be made for persons who lack capacity and who may come within the provisions of the Mental Health Act 2001.[9]

Under the Act, if a voluntary patient, so defined, indicates that they wish to leave an approved centre and a consultant psychiatrist, registered medical practitioner or nurse of the approved centre is of the opinion that they are suffering from a mental disorder, he or she may detain the person under section 23 of the 2001 Act for a period not exceeding 24 hours.

Under section 24, during that 24 hour period, the consultant psychiatrist responsible for that person's care shall either discharge the person or arrange for their examination by another consultant psychiatrist. If both consultant psychiatrists determine that the person suffers from a mental disorder, the responsible consultant shall make an admission order and the status of the person will no longer be that of a voluntary patient and they then become entitled to all the procedural protections that accompany the status of involuntary patient.

Any automatic assumption that persons in psychiatric institutions lack mental capacity is not correct. Both voluntary and involuntary patients may possess legal capacity to make decisions. Human rights law starts from the presumption that persons possess capacity unless this is otherwise demonstrated. Similarly, in mental health care, capacity is now emphasised.[10] It should be recognised that identifying whether a person possesses or lacks capacity is not a simple matter: persons may possess legal capacity and then suffer a mental health reverse where for a short or long period of time they may lack capacity. Or they may possess capacity to make certain decisions – visiting shops, choosing clothes, attending a cinema, and yet at the same time lack the capacity to make informed decisions about financial matters. From both a legal and practical point of view, it is thus important to identify which patients possess, and which patients lack, capacity in the context of medical treatment.

This issue recently arose before the Supreme Court in the proceedings *EH -v- St. Vincents Hospital and Ors* (28 May 2009). Those proceedings concerned the case of a woman who was an involuntary patient in a hospital under the Mental Health Act 2001 from June 2008 to 10 December 2008. There was no dispute in the case but that the woman suffered from a 'Mental Disorder' within the meaning of that term in Section 3 of the 2001 Act. On the 10 December 2008 the Order

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[9] *See Proposed model for the delivery of a mental health service to people with intellectual disability*, Occasional paper OP58 (July 2004), at pp. 20-21. *See also Submission by Law Society to the Department of Justice, Equality and Law Reform on Scheme of Mental Capacity Bill 2008*, [2008] at p. 6.

[10] The Mental Health Commission has produced a Quality Framework for Mental Health Services in Ireland, Standards 2.2, 3.1 and 3.2 stipulate that service user's rights should be respected and upheld and that they should be facilitated to be actively involved in their own care and treatment through the provision of information. The standards also stipulate that service users should be empowered regarding their own care and treatment by exercising choice, rights and informed consent. *See Quality Framework for Mental Health Services in Ireland*, Mental Health Commission, 2007, .See also *Good Psychiatric Practice*, 3rd Ed, Royal College of Surgeons, College Report CR 154, at pp 23-24.

of the consultant psychiatrist was not affirmed by the Mental Health Tribunal (which reviews detention) due to a technicality, thus the Order had no further effect and she was no longer an involuntary patient. The woman remained in the hospital until 22 December 2008 categorised as a voluntary patient. On that date she attempted to leave the hospital. Section 23 of the Mental Health Act 2001 was invoked and a new admission order was made on 23 December 2008. At the time of the hearing the woman had been an involuntary patient in the hospital since that date.

In habeas corpus proceedings brought in both the High Court and on appeal to the Supreme Court, the Applicant submitted that due to her lack of capacity she should in fact have been regarded as an involuntary patient between 10 December and the 22 December 2008, rather than a voluntary patient, and she argued that on this basis her detention and the subsequent order made on 23 December, and the various orders that followed were invalid and that she was being arbitrarily detained. In particular the Applicant sought a declaration that the definition of voluntary patient under the 2001 Act was incompatible with Article 5 of the ECHR.

The Supreme Court made a number of observations in relation to the scheme of the 2001 Act. In relation to the interpretation of the provisions of the Act it was noted by the Court that this would be informed by the "paternalistic intent of the legislation". The Court expressed the view that a different approach was not mandated by Article 5 of the ECHR.

The Court also accepted the argument of the Respondent that the appeal was in fact a moot in so far as habeas corpus proceedings were concerned. It was argued that after the 22 December the Applicant became an involuntary patient, and any possible irregularity before this point (which was not accepted), would not infect or have a domino effect on any orders made subsequent to that point, such as to invalidate same. The Court stated:

> "Mere technical defects, without more, in a patient's detention should not give rise to a rush to court, notably where any such defect can or has been cured – as in the present case. Only in cases where there has been a gross abuse of power or default of fundamental requirements would a defect in an earlier period of detention justify release from a later one."

In relation to the specific issue as to whether the Applicant was properly categorised as a voluntary patient between 10 December and 22 December, the Court accepted the evidence before the High Court that the Applicant did not sign the voluntary admission form, and the hospital had recorded in her records that she lacked capacity to sign the form because of her "dementia and mental illness". The records also noted that if she were to attempt to leave the ward she would require to be detained under s.23 of the Mental Health Act 2001. In this regard it is apparent that the Applicant was not in the hospital as someone who had given her fully informed consent in the ordinary sense.

The question then arose as to the meaning of voluntary patient under s.2 of the 2001 Act. In this regard the Court found as follows:

> "The terminology adopted in s.2 of the Act of 2001 ascribes a very particular meaning to the term *"voluntary patient"*. It does not describe such a person as one who freely and voluntarily gives consent to an admission order. Instead the express statutory language defines a *"voluntary patient"* as a person receiving care and treatment in an approved centre who is not the subject of an admission order or a renewal order. This definition can not be given an interpretation which is *contra legem*."

This understanding of s.2, where neither capacity nor consent are relevant factors to determining the status of a patient, with the result that patients without capacity to consent, such as in the case of incapacitated compliant patients or Wards of Court, are not subject to the safeguards of the 2001 Act (in the form of independent periodic reviews of admission orders), is of concern to the IHRC insofar as it has implications for the State's compliance with its international human rights obligations, which will be considered further below.[11]

Indeed, the presumption of one's capacity under international standards suggests that the majority of persons voluntarily consenting to their admission in approved centres would continue to be categorised as voluntary patients following any amendment to the definition of Section 2 of the Mental Health Act 2001.

2.2 Wards of Court

In relation to the second category of vulnerable person identified earlier in this paper, namely Wards of Court, similar issues in relation to capacity to consent arise. It would appear at the present time that Wards of Court admitted to an approved centre are neither categorised as voluntary nor involuntary for the purpose of the 2001 Act, but are administratively considered in a category of their own.[12]

While the law in relation to Wards of Court is extremely complex and arcane it is only necessary to set it out briefly in this paper insofar as it is relevant to determining for legal purposes the decision making capacity of the person, the subject of wardship proceedings.

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[11] It was noted with approval by the Supreme Court in its judgement that the High Court (O'Neill J) did not accept that the Applicant had at any time been removed from certain procedural protections under the 2001 Act, as the Respondent hospital had kept a very high level of supervision of her condition, and were at all time poised to reinstate her position as an involuntary patient when judged appropriate to do so. Arising from the Judgment it would appear that the Mental Health Act 2001 also requires clarification as to how and when technical defects can be remedied in admission and renewal orders. The effect and ramifications of the *EH* decision may be that virtually all technical defects in admission and renewal orders can be cured by reference to what was described as the "paternalistic intent" of the Act.

[12] According to the 2006 Annual Report of the Mental Health Commission (MHC), there were 82 in-patients in psychiatric facilities under the classification "Ward of Court", that is neither voluntary nor involuntary. The Mental Health Commission's 2007 Annual Report records that there were 70 Wards of Court in psychiatric facilities during 2007.

Jurisdiction over Wards of Court is exercised by the President of the High Court and by the Circuit Court. The powers of the High Court in relation to wards and their estates are set out in the Lunacy Regulation (Ireland) Act 1871 and the procedure in relation to applications is governed by Orders 65 and 67 of the Rules of the Superior Courts. The Wards of Court system originated in the crown prerogative for the purpose of acting as guardian of persons with disabilities – the *parens patriae* or guardian of the people.

The 1871 Act does not confer jurisdiction to take a person into wardship but rather regulates it. The 1871 Act, while it recognises that wardship may be necessary because the person is considered to be incapable of managing his person or property, deals mainly with the power of the court over property issues. For example, it does not deal with the issue of withholding of medical treatment. There is no legislation dealing with how the court is to determine issues related to the person, as opposed to the property, of the ward. However the effect of wardship is to deprive the person of their legal capacity to make decisions, whether in relation to property or their own private person. *In the Matter of a Ward of Court (Withholding Medical Treatment) (No. 2)*[13] Chief Justice Hamilton gave a summary of the effect of wardship on the person:

> "When a person is made a Ward of Court, the Court is vested with jurisdiction over all matters relating to the person and estate of the Ward and then the exercise of such jurisdiction is subject only to the provisions of the Constitution; there is no statute which in the slightest degree lessens the court's duty or frees it from the responsibility of exercising that parental care... In the exercise of this jurisdiction the court's prime and paramount consideration must be the best interest of the ward."[14]

As stated a Ward of Court is legally deprived of all decision making capacity by virtue of that status, and in relation to treatment in an approved centre, they are essentially in a similar position to an incapacitated compliant patient, in that they are excluded from the procedural protections in relation to involuntary detention under the 2001 Act.[15]

As mentioned above the IHRC issued Observations on the Scheme of the Mental Capacity Bill 2008 in November 2008. The main purpose of the 2008 Scheme is to reform the existing Wards of Court system, insofar as it applies to adults, and replace it with a modern statutory framework governing decision making on behalf of persons who lack capacity.[16] This would allow the State to move forward to ratification of the United Nations Convention on the Rights of Persons with Disabilities which it has signed. For present purposes the significant aspects of

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[13] In the Matter of a Ward of Court (Withholding Medical Treatment) (No. 2) 1996 SC 2 IR 100.
[14] At page 106.
[15] For a further discussion of capacity and the law see; Law Reform Commission, *Report on Vulnerable Adults and the Law*, (LRC 83 – 2006), 2006. This Report provided detailed recommendations for the enactment of new capacity legislation.
[16] Press Release of the Department of Justice, Equality and Law Reform, "Minister Ahern Announces Proposals for a Mental Capacity Bill", (15 September 2008), available at www.justice.ie.

the Bill are heads 5 and 6. Head 5 of the 2008 Scheme provides that the court may make declarations as to whether a person has or lacks capacity to make a decision or decisions on such matters as are described in the declaration.[17]

Head 6 of the 2008 Scheme provides that if the court has declared that a person lacks capacity to make a decision or decisions concerning his or her personal welfare or his or her property, the court may, by making an order, make the decision or decisions on the person's behalf or appoint a personal guardian to make the decision or decisions on the person's behalf.[18]

It was noted by the IHRC in its Observations that even if the proposed legislation abolished the wards of court system, existing wards of court could still remain under the old system unless they successfully apply for a review of their wardship.[19] In addition, it was also noted that it was unclear what safeguards apply under the proposed 2008 Scheme to the reception and detention of a person in an approved centre, where that person is the subject of a declaration in relation to his or her capacity to make decisions in relation to health care. In other words it is not clear whether they will be considered voluntary or involuntary, and therefore whether they will have their admission reviewed on a periodic basis by a Mental Health Tribunal, or similar body established for that purpose.[20]

As matters currently stand, wards of court still remain outside the protections of the Mental Health Act 2001, and the proposed capacity legislation, although signifying a considerable improvement in human rights terms on the wards of court system, may still not fully address the concerns outlined by the IHRC in the present paper. In this regard the recommendations in this paper should be read in conjunction with the recommendations in the IHRC's Observations on the Scheme of the Mental Capacity Bill 2008. This paper will primarily focus on the effect of section 2 of the Mental Health Act 2001 in relation to the right to liberty under international standards. It will also briefly address the need to introduce criteria by which one's capacity can be determined.[21]

2.3 Children

Under section 2 of the Mental Health Act 2001, "child" is defined as a person under 18 years of age. Section 25 of the Act sets out the procedure for the involuntary admission of children and it is clear from the scheme of the Act that children are deemed to lack capacity until they reach eighteen years of age.

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[17] Head 5 (i) and (ii) of the 2008 Scheme.

[18] Head 6(1) and (2) of the 2008 Scheme.

[19] Head 41 of the 2008 Scheme. Such a review is carried out in the same manner as a review of a declaration of incapacity under Head 14 of the 2008 Scheme.

[20] In the UK, detention of people who lack capacity is conditional on meeting six requirements in relation to age, mental health, mental capacity, best interests, eligibility and no refusals (no valid advance decision). *See* Sections 4A and 4B and Sections 12(1) and 17-20 of Schedule A1 and Schedule 1A of the Mental Capacity Act 2005 as amended.

[21] It is noted that both Scotland (The Incapacity Act 2000) and England and Wales (The Mental Capacity Act 2005) have relatively recently introduced capacity legislation which takes a "functional approach" to determining capacity.

Under section 25 it is the HSE that has competence to make an application to the District Court for an Order authorising the detention of a child in an approved centre for treatment for a period up to 21 days. Such an application is made on the basis of a psychiatric assessment that the child is suffering from a mental disorder. In the event that the child's parent or other person acting *in loco parentis* refuses or is not available to consent to such an examination of the child, an application may be made for an Order under the section and the Court may make directions as to the examination of the child and the furnishing of a report on foot of the examination to the Court. There is provision for the Order to be extended by the Court for a further period of three months after the initial 21 days, and thereafter for a period up to six months. In addition an Order can be made in urgent circumstances on an *ex parte* basis, and it is unclear whether such an Order can be revoked within the initial 21 days period.

In relation to the definition of voluntary and involuntary patient in the Mental Health Act 2001, it appears that children, irrespective of their stage of maturity or capacity also fall outside these strict definitions. As section 25 only refers to the HSE making an application, it is otherwise within the discretion of the child's parent or guardian whether they will be admitted as a voluntary patient, and whether or not the child objects to such an admission is not a consideration. In addition, where it is the HSE that makes the application for an involuntary admission Order, although the possibility of hearing the child is not excluded by the terms of the legislation, it is unclear what safeguards are in place to ensure that the views of the child are taken into account by the Court. There were eight involuntary admissions of children to approved centres in 2008, which was an increase of four from the previous year. Of the eight admissions, six were to adult units. In 2007 all involuntary admissions of children were to adult units. Two hundred and forty seven (247) of 392 overall admissions of children in 2008 were to adult units and 278 of those admissions concerned children of 16 and 17 years of age. Within that category, 223 were admitted to adult units.[22]

3 EUROPEAN CONVENTION ON HUMAN RIGHTS

The ECHR contains a prohibition on arbitrary or unlawful deprivation of liberty under Article 5.

Article 5, in so far as relevant, provides:

> "1. 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: ... (e) the lawful detention of persons ... of unsound mind...

[22] Mental Health Commission *Annual Report 2008*, at pp. 29-31.The Mental Health Commission believes that the provision of age appropriate approved centres for children and adolescents must be addressed as a matter of urgency.

4. Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful."

There are two main questions which the ECtHR will pursue relevant to the definition of "voluntary patient" under the Mental Health Act:

1. Whether there was a "deprivation of liberty" for the purposes of Article 5;

2. If so, was the detention lawful and in accordance with a procedure prescribed by law?

3.1. Whether there was a "deprivation of liberty" for the purposes of Article 5

The ECtHR will first examine whether there has been a deprivation of liberty which will trigger the protections of Article 5 of the ECHR. The ECtHR has stated that the notion of deprivation of liberty within the meaning of Article 5 comprises both objective and subjective elements. The objective element has been described as a person's confinement in a particular restricted space for a not negligible length of time and the requisite additional subjective element is that s/he has not validly consented to the confinement in question.[23]

(i) Objective Test: Degree and Intensity (type, duration, effect, manner of implementation)

In order to decide if a restriction on one's freedom falls within the scope of Article 5, the ECtHR will consider the type, duration, effects, and manner of implementation of the measure in question.[24] According to the ECtHR the distinction between a 'deprivation of' and 'restriction upon' liberty is merely one of degree or intensity, and not one of nature or substance.[25] The jurisprudence of the ECtHR is instructive in this regard.

The ECtHR recently determined the case of *Gulub Atanasov v Bulgaria*[26] wherein the applicant was defined as a "voluntary patient" under Bulgaria's domestic law and found as follows:

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[23] This test was recently applied in the case of *Shtukaturov v Russia* (Application No. 44009/05) 27 March 2008.

[24] *Engel and Others v The Netherlands* judgment of 8 June 1976, Series A no. 22, p. 25, paras 58-59, *Guzzardi v. Italy*, judgment of 6 November 1980, Series A no. 39, p. 33, para 92; *Nielsen v. Denmark*, judgment of 28 November 1988, Series A no. 144, p. 24, para 67; and *H.M. v. Switzerland*, no. 39187/98, ECHR 2002-II.

[25] *Guzzardi v Italy* judgment of 6 November 1980, Series A no. 39, p. 33, para. 93. In this case a suspected Mafia member was the subject of a residence order requiring him to live on an island for 16 months where he was required to comply with a curfew, report to police twice a day, get permission of police to make a call or have an outside visitor. By 11 votes to 7 the Court held that there had been a deprivation of liberty within the meaning of Article 5.

[26] *Gulub Atanasov v Bulgaria* (Application no. 73281/01) 6 November 2008.

> "the hospital staff treated the applicant as a person deprived of his liberty and the applicant was not free to go home when he so wished...The Court considers, therefore, that the applicant was deprived of his liberty."[27]

In the recent case of *Shtukaturov v Russia*[28] the Applicant was also categorised as a "voluntary patient" under national law. He was placed in a locked facility and was not permitted to communicate with the outside world. Following an escape attempt, he was tied to his bed and had his sedative increased. The ECtHR held that the objective test for deprivation of liberty under Article 5 was satisfied.

In the case of *Storck v Germany*[29] the ECtHR noted that the applicant was placed in a locked ward of a private psychiatric institution, at her father's request. She was under the continuous supervision and control of the clinic personnel, was not free to leave during her entire stay and was unable to maintain regular social contact with the outside world. Objectively, the ECtHR therefore considered the applicant to have been deprived of her liberty.[30]

The applicant in *Ashingdane v UK*[31] was considered to have been "detained" for the purposes of Article 5.1(e) even during a period when he was in an open ward with regular unescorted access to the unsecured hospital grounds and the possibility of unescorted leave outside the hospital.[32]

(ii) Subjective Test: *De jure* legal capacity vs *de facto* understanding of applicant

The ECtHR has also had occasion to consider cases where the applicant may have possessed or lacked the capacity to consent to her/ his stay in a psychiatric institution. Thus in *Shtukaturov v Russia*[33] the ECtHR opined that the applicant's behaviour in requesting his release and attempting to escape demonstrated a *de facto* understanding of his situation despite a *de jure* lack of capacity. The ECtHR held:

> "even though the applicant was legally incapable of expressing his opinion, the Court in the circumstances is unable to accept the Government's view that the applicant agreed to his continued stay in the hospital."[34]

In that case, the Russian Government primarily relied on the legal construction of "voluntary confinement", whereas the applicant referred to his own perception of the situation. The ECtHR noted that he had subjectively perceived his

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[27] *Gulub Atanasov v Bulgaria* (Application no. 73281/01) 6 November 2008 para 65.
[28] *Shtukaturov v Russia* (Application No. 44009/05) 27 March 2008.
[29] *Storck v Germany* no. 61603/00, ECHR 2005-V, of 16 June 2005.
[30] *Storck v Germany* no. 61603/00, ECHR 2005-V, of 16 June 2005, at para 73.
[31] *Ashingdane v. the United Kingdom*, judgment of 28 May 1985, Series A no. 93.
[32] *Ashingdane v. the United Kingdom*, judgment of 28 May 1985, Series A no. 93 at paras 24 and 42.
[33] *Shtukaturov v Russia* (Application No. 44009/05) 27 March 2008.
[34] Shtukaturov v Russia (Application No. 44009/05) 27 March 2008 paragraph 109.

confinement in the hospital as a deprivation of liberty and the ECtHR ultimately found a violation of Article 5.1.

In the *Storck v Germany*[35] case the ECtHR found that a violation of Article 5.1 had occurred. It found that if the applicant had the capacity to consent to the treatment, this had not been borne out on the facts, while if she had lacked this capacity, she could not have validly agreed to the treatment:

> "the Court considers the key factor in the present case to be that...the applicant tried on several occasions to escape...Under these circumstances, the Court is unable to discern any factual basis for the assumption that the applicant – presuming that she had the capacity to consent – agreed to her continued stay in the clinic. In the alternative, assuming that the applicant was no longer capable of consenting...she cannot in any event be considered to have validly agreed."[36]

In the case of *H.L. v. United Kingdom,*[37] the ECtHR defined the category of compliant incapacitated patient. The case concerned the confinement of an adult with autism in a psychiatric institution. The applicant lacked the capacity to consent and had never attempted to leave. The ECtHR found that there had been a deprivation of liberty under Article 5. In *HL* the ECtHR considered the key factor in the case to be that the health care professionals treating and managing the applicant exercised complete and effective control over his care and movements. His responsible medical officer indicated clearly that, had the applicant resisted admission or subsequently tried to leave, she would have prevented him from doing so and would have considered his committal as involuntarily under the relevant Act. Accordingly, the concrete situation was that the applicant was under continuous supervision and control and was not free to leave. The ECtHR considered that any suggestion to the contrary had been fairly described by Lord Steyn in the domestic court as "stretching credulity to breaking point" and as a "fairy tale".[38]

The applicant's lack of consent was regarded as the decisive feature distinguishing the case from the previous case of *H.M. v. Switzerland*[39] where the applicant had been legally capable of expressing a view but had been undecided as to whether or not she wanted to stay in the nursing home (the clinic had been able in that instance to draw the conclusion that she did not object).[40]

To address this lacuna in domestic law in relation to incapacitated compliant patients, the UK amended its Mental Capacity Act 2005 by means of the Mental Health Act 2007.

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[35] *Storck v Germany* no. 61603/00, ECHR 2005-V, of 16 June 2005.
[36] *Storck v Germany* no. 61603/00, ECHR 2005-V, of 16 June 2005 at para 76.
[37] *H.L. v. the United Kingdom* no. 45508/99, ECHR 2004-IX.
[38] *H.L. v. the United Kingdom* no. 45508/99, ECHR 2004-IX at para 91.
[39] *HM v Switzerland* Application no. 39187/98 of 26 February 2002.
[40] *Storck v Germany* no. 61603/00, ECHR 2005-V, of 16 June 2005 at para 77.

3.2 Article 5(1) of the ECHR: "Lawful Detention" and "Procedure Prescribed ` by Law"

Once the ECtHR is satisfied that a deprivation of liberty has occurred, it will consider whether the detention was arbitrary or unlawful. The lawfulness of detention depends on conformity with the procedural and substantive aspects of domestic law while also overlapping to a certain extent with the general requirement in Article 5.1 to observe a "procedure prescribed by law".[41] Where any one of these conditions is breached, the ECtHR will find that a violation of Article 5 has occurred. In this regard the conditions do not make up a cumulative test, but may be considered separately by the ECtHR. These conditions are dealt with below.

"Lawfulness"[42] and conformity with a "procedure prescribed by law" relate to both the order and execution of the measure depriving the individual of his liberty. The term "lawful" has been given a broad meaning by the ECtHR:

> "The notion underlying the term ['procedure prescribed by law'] is one of fair and proper procedure, namely that any measure depriving a person of his liberty should issue from and be executed by an appropriate authority and should not be arbitrary".[43]

It may be gleaned from its jurisprudence of the ECtHR that there are three considerations for the ECtHR in this regard[44]:

(i) Compliance with domestic law

The ECtHR considers conformity of the measure with the substantive and procedural rules of national law essential.[45] This was repeated by the ECtHR in the recent case of *A and Others v UK*[46]. It may be said that lawfulness, within the meaning of Article 5.1, presupposes conformity with domestic law. Consequently, where a breach of domestic law occurs, there will be a breach of the Article 5.[47]

It follows, therefore, that the ECtHR can and should exercise a certain power to review whether domestic law has been complied with.[48] The ECtHR has been explicit in its use of this power:

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[41]Winterwerp v. the Netherlands, judgment of 24 October 1979, Series A no. 33 at para 39.

[42] Lawfulness under Article 5.1 carries the same meaning as in accordance with the law under Article 8-11.

43 Winterwerp v. the Netherlands, judgment of 24 October 1979, Series A no. 33 at para 45.

44Ashingdane v. the United Kingdom, judgment of 28 May 1985, Series A no. 93 at para 46.

45 Tokic and Others v Bosnia and Herzegovina (Applications nos. 12455/04, 14140/05, 12906/06 and 26028/06) 8 July 2008 at para 63

46 A. and Others v. the United Kingdom (Application no. 3455/05) Grand Chamber 19 February 2009 at para 164.

47 Storck v Germany no. 61603/00, ECHR 2005-V, of 16 June 2005 at para 38, Gulub Atanasov v Bulgaria (Application no. 73281/01) 6 November 2008, Winterwerp v. the Netherlands, judgment of 24 October 1979, Series A no. 33.

48 Storck v Germany no. 61603/00, ECHR 2005-V, of 16 June 2005 at para 34.

> "On the evidence adduced, the Court has no cause for finding that the applicant's deprivation of liberty during the [relevant] period...was "unlawful" in the sense of not being in accordance with the relevant domestic law."[49]

Similarly, while the ECtHR has regard to the domestic courts' findings of fact, it is not constrained by those legal conclusions as to whether or not the applicant was deprived of his/her liberty within the meaning of Article 5.1.[50] This is demonstrated in the case of *HL v UK*[51] where the domestic court examined the issue of deprivation of liberty on the tortious ground of false imprisonment and the ECtHR made clear that it did not consider the domestic legal criteria to be relevant to the Convention.[52]

(ii) Conformity of domestic law the spirit of the Convention

It is not enough that the measure complies with domestic law; the domestic law must also be in conformity with the Convention, including the general principles expressed or implied therein,[53] and must therefore be of a certain quality. The ECtHR has found detention measures to be legal under domestic law yet classified as "illegal detention" in contravention of Article 5 in a number of cases.[54] An example of some of the qualities the domestic law must exhibit (this list is not exhaustive) are foreseeability, protection from arbitrariness and substantive and procedural safeguards.

(a) Foreseeability

The ECtHR has stated that the domestic law in question must be sufficiently precise to allow the citizen to foresee, to a degree that is reasonable in the circumstances, the consequences which a given action might entail.[55] It must contain clear and accessible rules governing the circumstances in which it is permissible for the state to deprive an individual of his or her liberty and the procedure to be followed.[56]

(b) Protection from arbitrariness

In *H.L. v UK*[57] the ECtHR held that the applicant would have reasonably foreseen his detention on the basis of the doctrine of necessity, however, it found that the

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49 Kucheruk v. Ukraine (Application no2570/04) Fifth Section 6 September 2007 at para 177.
50 Storck v Germany no. 61603/00, ECHR 2005-V, of 16 June 2005 at para 72, H.L. v. the United Kingdom no. 45508/99, ECHR 2004-IX.
51 H.L. v. the United Kingdom no. 45508/99, ECHR 2004-IX.
52 *H.L. v. the United Kingdom* no. 45508/99, ECHR 2004-IX at para 90.
53 *Shulepova v. Russia (Application no. 34449/03)* 11 December 2008 at para 45.
54 *Erkalo v. The Netherlands* (89/1997/873/1085), 2 September 1998.
55 *S.W. v. the United Kingdom*, judgment of 22 November 1995, Series A no. 335-B, at paras 35-36; *Steel and Others v. the United Kingdom*, judgment of 23 September 1998, Reports 1998-VII, at para 54; and *Kawka v. Poland*, no. 25874/94, 9 January 2001 at para 49, *H.L. v. the United Kingdom* no. 45508/99, ECHR 2004-IX at para 114.
56 Jacobs and Whyte, *The European Convention on Human Rights*, Oxford University Press, 4th edition, 2006, page 128.
57 *H.L. v. the United Kingdom* no. 45508/99, ECHR 2004-IX.

further element of lawfulness, the aim of avoiding arbitrariness, had not been satisfied.[58]

Any deprivation of liberty should be in keeping with the aim of Article 5, namely to protect the individual from arbitrariness.[59] This was recently repeated in the February 2009 decision of the ECtHR in *Khadisov and Tsechoyev v Russia.*[60]

In other words, the detention cannot be considered as "lawful" within the meaning of Article 5.1 if the domestic procedure does not provide sufficient guarantees against arbitrariness.[61] No detention that is arbitrary can ever be regarded as "lawful" for the purposes of the Convention.[62] The ECtHR has said:

> "To avoid being branded as arbitrary, detention under Article 5 § 1(f) must be carried out in good faith; it must be closely connected to the ground of detention relied on by the Government."[63]

(c) Substantive and procedural safeguards

The broad condition that detention be "in accordance with a procedure prescribed by law", requires the existence in domestic law of adequate legal protections and "fair and proper procedures".[64] The ECtHR has found that while detention may be legal under domestic law it may be an illegal detention in violation of the Convention.

In the case of *Erkalo v. The Netherlands,*[65] an order to hold the applicant in involuntary detention expired, and a period of 2 months elapsed before the next court order issued due to an administrative error. Under Dutch law this was not an illegal detention but despite this the ECtHR held that the lack of administrative and judicial safeguards (which was demonstrated by fact that the absence of any legal basis for the detention only came to light when the applicant applied to court) rendered this detention arbitrary and unlawful under Article 5.1.

In *HL v United Kingdom*, which case preceded the introduction of the Mental Capacity Act 2005 and the Mental Health Act 2007 in England and Wales, the ECtHR was critical of the inadequate protections under UK law at the time for

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[58] *H.L. v. the United Kingdom* no. 45508/99, ECHR 2004-IX at para 199.
[59] *Tokic and Others v Bosnia and Herzegovina* (Applications nos. 12455/04, 14140/05, 12906/06 and 26028/06) 8 July 2008 at para 63, *Winterwerp v. the Netherlands*, judgment of 24 October 1979, Series A no. 33 at paras 39 and 45; *Bizzotto v. Greece*, judgment of 15 November 1996, Reports 1996-V, p. 1738, at para 31; and *Aerts v. Belgium*, judgment of 30 July 1998, Reports 1998-V, pp. 1961-62, at para 46.
[60] *Khadisov and Tsechoyev v Russia* (Application no. 21519/02) 5 February 2009 at para 38.
[61] *Shtukaturov v Russia* (Application No. 44009/05) 27 March 2008 at para 113.
[62] *Ashingdane v. the United Kingdom*, judgment of 28 May 1985, Series A no. 93 at para 44.
[63] *Saadi v. the United Kingdom* [GC], no. 13229/03, ECHR 2008 at para 74.
[64] *H.L. v. the United Kingdom* no. 45508/99, ECHR 2004-IX at para 155, *Winterwerp v. the Netherlands*, judgment of 24 October 1979, Series A no. 33 at para 45, and *Amuur v. France*, judgment of 25 June 1996, *Reports* 1996-III, at para 53.
[65] *Erkalo v. The Netherlands* (89/1997/873/1085), 2 September 1998.

incapacitated persons in voluntary detention as opposed to involuntary detention under the [Mental Health] Act 1983:

> "[T]he Court finds striking the lack of any fixed procedural rules by which the admission and detention of compliant incapacitated persons is conducted. The contrast between this dearth of regulation and the extensive network of safeguards applicable to psychiatric committals covered by the 1983 Act...is, in the Court's view, significant. The appointment of a representative of a patient who could make certain objections and applications on his or her behalf is a procedural protection accorded to those committed involuntarily under the 1983 Act and which would be of equal importance for patients who are legally incapacitated and have, as in the present case, extremely limited communication abilities."[66]

The ECtHR found in *HL v UK*[67] that the absence of procedural safeguards failed to protect against arbitrary deprivation of liberty on grounds of necessity and, consequently, to comply with the essential purpose of Article 5.1.[68] The Government's submission that detention could not be arbitrary within the meaning of Article 5.1 because of the possibility of a later review of its lawfulness was rejected by the ECtHR when it stated that this view:

> "disregards the distinctive and cumulative protections offered by paragraphs 1 and 4 of Article 5; the former strictly regulates the circumstances in which one's liberty can be taken away, whereas the latter requires a review of its legality thereafter."[69]

In the *Storck v. Germany*[70] case, the ECtHR noted that a claim for compensation in tort for damages caused by an unlawful detention was a retrospective measure that could not alone provide effective protection for individuals in such a vulnerable position, having regard to the importance of the right to liberty. The ECtHR also attached weight to the fact that there were numerous necessary safeguards for persons detained in a psychiatric institution following a court order but that these safeguards did not apply in the more critical cases of persons confined in a psychiatric institution without such an order.[71]

Similarly, in the recent case of *Shtukaturov v Russia*[72], the applicant claimed that his detention in the hospital was not "in accordance with the procedure prescribed by law". Under Russian law, his hospitalisation was regarded as voluntary confinement, regardless of his opinion, and consequently, none of the procedural safeguards usually required in cases of involuntary hospitalisation were afforded to him. There the ECtHR found that there should be some procedural safeguards in place, especially in this case where the person

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[66] *H.L. v. the United Kingdom* no. 45508/99, ECHR 2004-IX at para 120.
[67] *Ibid.*
[68] *Ibid.*, at para 124.
[69] *Ibid.*, at para 123.
[70] *Storck v Germany* no. 61603/00, ECHR 2005-V, of 16 June 2005.
[71] *Storck v Germany* no. 61603/00, ECHR 2005-V, of 16 June 2005 at para 105.
[72] *Shtukaturov v Russia* (Application No. 44009/05) 27 March 2008.

concerned clearly expressed his disagreement with his guardian's decision and it was determined that there was a breach of Article 5.[73]

The issue of a failure to object to admission by an incapacitated person arose in the case of *HL v UK*[74]. The ECtHR held that it:

> "did not accept as determinative the fact relied on by the Government that the regime applied to the applicant (as a compliant incapacitated patient) did not materially differ from that applied to a person who had the capacity to consent to hospital treatment, in that neither objected to admission. The Court reiterates that the right to liberty is too important in a democratic society for a person to lose the benefit of Convention protection for the single reason that he may have given himself up to be taken into detention."[75]

The ECtHR had stated that this is especially so when it is not disputed that that person is legally incapable of consenting to, or disagreeing with, the proposed action.[76]

(iii) Lawful within the autonomous meaning of the Convention

The domestic law must also be in conformity with the purpose of the restrictions permitted by the applicable subparagraphs of Article 5.1.[77] The detention may not be arbitrary or effected for an ulterior purpose, contrary to Article 5.1 read in conjunction with Article 18.[78]

In the case of *Storck v Germany*[79] the ECtHR looked specifically at certain contradictions in the domestic Court of Appeal's findings and finally concluded that the national court had failed to interpret the provisions of civil law in the spirit of Article 5 and thus found a breach of Article 5.1.[80] In determining that the applicant was detained against her will and that there was no court order authorising the applicant's confinement, it was found that her detention was not lawful within the meaning of Article 5.1.[81] The ECtHR went on to say:

> "In securing the rights protected by the Convention, the Contracting States, notably their courts, are obliged to apply the provisions of national law in the spirit of those rights...the Court reiterates that the Convention is intended to

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[73] *Storck v Germany* no. 61603/00, ECHR 2005-V, of 16 June 2005 at para 102.
[74] *H.L. v. the United Kingdom* no. 45508/99, ECHR 2004-IX.
[75] *De Wilde, Ooms and Versyp v. Belgium*, judgment of 18 June 1971, Series A no. 12, p. 36, paras 64-65.
[76] *HL v United Kingdom* (Application no. 45508/99) 5 October 2004 at para 90.
[77] *Gulub Atanasov v Bulgaria* (Application no. 73281/01) 6 November 2008 at para 73.
[78] *Kucheruk v. Ukraine* (Application no. 2570/04) 6 September 2007 at para 177.
[79] *Storck v Germany* no. 61603/00, ECHR 2005-V, of 16 June 2005.
[80] *Storck v Germany* no. 61603/00, ECHR 2005-V, of 16 June 2005 at para 98.
[81] *Storck v Germany* no. 61603/00, ECHR 2005-V, of 16 June 2005 at para 108.

guarantee not rights that are theoretical or illusory but rights that are practical and effective".[82]

Quite separately from the requirements of Article 5(1), the ECtHR will find a violation of Article 5 where there is no independent periodic review of a person's detention under Article 5(4) of the ECHR. As noted earlier, the introduction of the system of Mental Health Tribunal review of involuntary patient detention under Irish law was aimed at satisfying the requirements of Article 5(4) of the ECHR.

3.3 Article 5(4)

In summarising the requirements of Article 5(4) of the ECHR the Mental Health Commission has stated:

> "The European Court of Human Rights has stated that all detained persons must have a right of access to a judicial body independent of the executive and with the powers of a court including the power to order discharge. The Court dated that the judicial body does not have to be a traditional court so long as it is independent and the person has a right to be heard and a right to be legally represented."[83]

In the case of *Megyeri v. Germany* the ECtHR emphasised that Article 5(4) does not require that persons committed to care on the grounds of being of unsound mind "should themselves take the initiative in obtaining legal representation before having recourse to a court".[84] The ECtHR stressed the fact that the applicant would not have been able to make his case effectively without the support of medical or legal expertise.

In *Shtukaturov v. Russia*, the ECtHR held that the domestic courts enjoy a certain margin of appreciation in cases involving a mentally ill person to ensure, *inter alia*, the good administration of justice and protection of the health of the person concerned. However, such measures should not affect the very essence of the right to a fair trial as guaranteed by Article 6 of the ECHR.[85] In that case, the ECtHR held that there had been a violation of Article 5(4) where the applicant did not have legal capacity to initiate the review of detention.[86] In addition, the ECtHR has emphasised that special procedural safeguards may be called for in order to

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[82] *Storck v Germany* no. 61603/00, ECHR 2005-V, of 16 June 2005 at para 93, *Artico v. Italy*, judgment of 13 May 1980, Series A no. 37 at para 33, and *Von Hannover v. Germany*, no. 59320/00, ECHR 2004-VI, at para 71.

[83] Mental health Commission, *Reference Guide to the Mental Health Act 2001*, at page 3.

[84] *Megyeri v. Germany*, Judgment of 12 May 1992, at para. 21.
See also Winterwerp v. The Netherlands, at para. 66.

[85] *Shtukaturov v. Russia*, at para. 68. The CPT has also stressed that the procedure by which involuntary placement is decided should offer guarantees of independence and impartiality. *CPT 8th General Report*, at para. 52.

[86] *Shtukaturov v. Russia*, at para. 123. In that case, the ECtHR found that the fact that the applicant fully depended on his mother's substitute decision-making powers and that she had requested his placement in hospital and opposed his release meant that the remedy was not directly accessible to him. *See* para. 124.

protect the interests of persons who, on account of their mental disabilities, are not fully capable of acting for themselves.[87]

On the basis of the ECtHR's jurisprudence, it would appear that admissions to an approved centre for treatment in circumstances where the person's decision making capacity is impaired may result in a violation of Article 5(4) unless an automatic independent review of the person's ongoing stay in the institution occurs. This requirement will arise irrespective of the designation at national level of whether the person is a voluntary or involuntary patient if this does not coincide with the requirements of Article 5(1) (i.e. if the person's stay amounts to a deprivation of liberty within the meaning of that provision).

The International Covenant on Civil and Political Rights (ICCPR)

Article 9 paragraphs 1 and 4 of the International Covenant on Civil and Political Rights mirror the provisions of Article 5 of the ECHR and states as follows:

> "1. Everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law...
>
> 4. Anyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings before a court, in order that court may decide without delay on the lawfulness of his detention and order his release if the detention is not lawful."

4 THE NEED FOR CRITERIA BY WHICH ONE'S CAPACITY CAN BE DETERMINED

At present methods of assessing one's capacity are imprecise and do not reflect international standards. While there are provisions to improve the situation under the proposed Mental Capacity Bill 2008, the IHRC considers that those provisions could be further improved. Further, the specific situation governing children who lack legal capacity may require further attention.

i) The United Nations Convention on the Rights of Persons with Disabilities (CRPD)

International human rights law standards on the rights of persons with disabilities are most fully set out in the CPRD which was adopted by the UN General Assembly on 13 December 2006. Its fundamental purpose is to:

> "promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity."[88]

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[87] *Winterwerp v. The Netherlands*, at para. 60.

The CRPD encompasses a range of rights that affect the everyday lives of persons with disabilities, such as, accessibility (Article 9), personal mobility (Article 20), health (Article 25), education (Article 24), work and employment (Article 27), habilitation and rehabilitation (Article 26), participation in political and public life (Article 29) and equality and non-discrimination (Article 5).

The CRPD was deemed necessary because of the near-invisibility of persons with disabilities as subjects of human rights law.[89] While the UN had developed a number of Declarations, Resolutions, and Principles that elaborated on the application of human rights of persons with mental illnesses and developmental disabilities, the international human rights treaties did not explicitly focus on the rights of persons with disabilities. The UN therefore consolidated established standards contained in Principles for the protection of persons with mental illness and for the improvement of mental health care ("the MI Principles") and the Standard Rules on the equalisation of opportunities for persons with Disabilities ("the Standard Rules").

Ireland signed the UN Convention on the Rights of Persons with Disabilities when it opened for signature on 30 March 2007. The Government has indicated its intention to ratify the Convention as quickly as possible and as noted has stated that the reforms proposed in the 2008 Scheme of Mental Capacity Bill will enable the State to meet its obligations under the UN Convention on the Rights of Persons with Disabilities, insofar as it relates to legal capacity issues.[90]

The CRPD model of capacity represents the current legal trend toward the "functional approach" to persons with disabilities, which supports their involvement in their decision-making and discourages the substitution of their judgment by others. Its treatment of capacity is in stark contrast to those jurisdictions which still utilise the "medical model" by placing persons with disabilities under overly broad guardianships that may deprive or disempower them of the right to make decisions affecting their daily lives. In addition, under the "functional approach" capacity is both time-specific and decision-specific. Thus, a person may be found to lack capacity only during a particular time, and not permanently, and in relation to a particular matter, not all matters.

Article 12 also addresses situations where persons with disabilities may need support to express their will and preferences, for instance, support and concrete assistance to exercise their legal capacity. In such instances, there is an obligation on the State to provide access to such support and establish safeguards to prevent abuse and ensure its appropriateness to meet individual rights. Support must "...respect the rights, will and preferences of the person..." and must be "... free of conflict of interest and undue influence." Therefore, persons with disabilities must be provided with the support they

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[88] United Nations Convention on the Rights of Persons with Disabilities, 13 December 2006, Article 1.

[89] Amicus Brief in the European Court of Human Rights by The European Group of National Human Rights Institutions, *D.D. v. Lithuania*, Application no.13469/06, 21 February 2008.

[90] Irish Human Rights Commission, Observations on the Scheme of the Mental Capacity Bill 2008, November 2008 at page 4.

need but cannot be required to accept support against their will.[91] Further, Article 12 explicitly protects the rights of a person with disabilities in relation to their property and their financial affairs.[92]

Article 12 of the CRPD entitled "equal recognition before the law" guarantees that States must recognise the legal capacity of persons with disabilities "on an equal basis with all others in all aspects of life". Capacity, as defined in the CRPD includes both the capacity for a right to recognition everywhere as persons before the law ("legal recognition") and the capacity to "exercise" those rights. Both of these elements are integral to the concept of legal capacity because they establish the rights and responsibilities of persons with disabilities to make their own decisions. It is also noted that without legal capacity it is not possible to obtain the rights guaranteed under the CRPD. For example, persons with disabilities may technically have the right to health, however, without the legal capacity to choose or consent to treatment the person's rights are rendered practically non-existent.[93]

ii) Recommendations by the Committee of Ministers of the Council of Europe

The Recommendations from the Committee of Ministers of the Council of Europe illustrate a clear European level of convergence on certain values, as well as relevant law and policy.

In 1999, the Committee of Ministers adopted a landmark Recommendation on the "Principles concerning the legal protection of incapable adults" ("the1999 Recommendation"). The underlying principle of the 1999 Recommendation is "respect for the dignity of each person as a human being." It specifically states that all practices put into place to assist incapable adults should be based on "respect for their human rights and fundamental freedoms."[94]

Of relevance in the context of the present paper is the call in the 1999 Recommendation for measures of protection to be established to support individuals and not to deprive the individual of his or her voice. [95] The 1999 Recommendation states that a measure of protection should not automatically deprive the person concerned of the right to consent or refuse consent to any intervention in the health field.[96] Thus even if an adult is subject to a measure of protection, but is still able to give free and informed consent, an intervention in the health field may only be given with that consent.[97]

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[91] *See also Quality Framework for Mental Health Services in Ireland*, Standards 2.2, 3.1 and 3.2 referred to in footnote 10 above.
[92] Amicus Brief in the European Court of Human Rights by The European Group of National Human Rights Institutions, *D.D. v. Lithuania*, Application no.13469/06, 21 February 2008.
[93] Ibid.
[94] Council of Europe (1999) *Recommendation No R (99)4*, Adopted 23 February 1999, Part 2, Principle 1.
[95] Part 2, Principle 6(2).
[96] Part 2, Principle 5(1).
[97] Part 5, Principle 22(1).

A further Recommendation "Concerning the protection of the human rights and dignity of persons with mental disorders" was adopted by the Committee of Ministers in 2004 ("2004 Recommendation").[98] It updates a similar instrument dated back to 1983 in the field of legal protection of persons with a mental illness placed as involuntary patients.[99] The 2004 Recommendation insists that mechanisms must be established for those who do not have the capacity to consent and that those mechanisms should not unduly infringe on the person's human rights.[100] Similarly, in terms of treatment, whenever it is possible, the 2004 Recommendation requires that the person's opinion should be taken into account as much as possible, and if the person has capacity to consent that the treatment is only provided with the person's consent.[101]

In 2006 the Committee of Ministers adopted an "Action plan to promote the rights and full participation of people with disabilities in society: improving the quality of life of people with disabilities in Europe 2006-2015" ("the 2006-2015 Action Plan"). This further re-emphasises that there should be no automatic loss of legal capacity simply on account of disability and connected this to the need to maintain social cohesion. Similar to the 1999 recommendations the 2006-2015 Action Plan concedes that assistance may be necessary in order for some individuals to exercise their legal capacity, and therefore safeguards may need to be put in place.[102]

It may be questioned therefore whether the exclusion of incapacitated compliant patients and wards of court from the procedural protections in relation to admissions to approved centres, meets the standards set down in the various recommendations of the Committee of Ministers of the Council of Europe. While such recommendations do not have the full force of law, nonetheless they may be of significance in assessing the State's compliance with the ECHR. In this regard it is noted that the 1999 Recommendation was referred to extensively by the ECtHR in the *Shtukaturov* case, where it was stated that:

> Although the principles have no force in law in the Court, they may define a common European Standard in this area.[103]

On this basis, the ECtHR expanded its interpretation of the protections available under Articles 6 (right to fair hearing) and 8 (right to respect for private life) of the ECHR in light of these standards.

Thus the ECtHR has held that it is not enough to merely protect an individual, but rather, to truly guarantee respect for private life a person's interactions with society must also be protected under Article 8 of the ECHR. The ECtHR has held that Article

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[98] Council of Europe (2004) *Recommendation No R (2004)10.* Strasbourg. Adopted 22 September 2004, at Ch. 2, Art. 1(1).

[99] Council of Europe (1983) *Recommendation No R (83)2*, concerning the legal protection of persons suffering from mental disorder placed as involuntary patients. Strasbourg. Adopted 22 February 1983.

[100] *Recommendation No R (2004)10,* at Chapter. 2, Art. 7(1).

[101] *Recommendation No R (2004)10,* at Chapter 2, Art. 12(1)(2).

[102] Council of Europe (2006) *Recommendation No R (2006)5,*. Council of Europe, Strasbourg, adopted 5 April 2006, at paragraph 3.12(1).

[103] *Shtukaturov*, at para. 95.

8 also protects a right to personal development, and the right to establish and develop relationships with other human beings and the outside world.[104]

Furthermore, in the aforementioned *Shtukaturov* Judgment of 2008, the ECtHR held that as the deprivation of legal capacity constitutes a "very serious" interference with a person's right to respect for private life, there must be sufficient reason and also a "tailor-made" and proportionate response for removing an individual's legal capacity.[105] This position is fully congruent with the approach taken under Article 12 of the CRPD.

5. IDENTIFYING CAPACITY

International standards require a fully human rights compliant system for determining capacity informed by the values of dignity and autonomy.[106] The current legal trend emphasises the "functional approach", which supports a person's involvement in their decision-making and discourages the substitution of their judgment by others. The functional approach is an "issue-specific and time-specific assessment of a person's decision making ability".[107] The removal of a person's legal capacity requires sufficient reason and a "tailor-made" and proportionate response.[108]

(a) Methods of Assessment

Arising from these standards, it is clear that there must exist in domestic law methods by which an assessment of one's capacity can occur. Starting from the presumption of one's capacity rather than incapacity, such methods should ensure that a patient or person is given every possible assistance to help him or her make their own decision.

It should be accepted that a person is capable of making a decision even if it is deemed by others to be an unwise decision. Further to Article 12 of the CRPD, in those measures that relate to the exercise of legal capacity respect the rights, the will and preferences of the person should result and in this regard those measures should also provide for appropriate and effective safeguards to prevent abuse. In approaching the question of capacity and decision-making, a person's rights and freedom of decision-making should only be fettered to the extent permissible under strict safeguards; in other words, it should be the exception rather than the rule.

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[104] *Pretty v. United Kingdom*, 35 EHRR 1, 29 July 2002, at para 61.
[105] *Shtukaturov*, at para. 95.
[106] See further IHRC *Observations on the Scheme of the Mental Capacity Bill 2008*, at pp. 2-3; Council of Europe (1999) *Recommendation No R (99)4*, Adopted 23 February 1999, Part 2, Principle 1.
[107] Law Reform Commission Report on *Vulnerable Adults and the Law* (2006), p. 46.
[108] *Shtukaturov*, at para. 95.

(b) Identification of the Criteria to be used when determining Capacity[109]

It is important that clear criteria should be employed when determining one's capacity. Such criteria should focus on whether the person has such a cognitive impairment or disturbance in the functioning of the brain as to render that person incapable of decision-making in specific areas of his or her life. As already stated lack of capacity should not be automatic, universal or indeterminate: persons may possess legal capacity and then suffer a mental health reverse where for a short or long period of time they may lack capacity. Or they may possess capacity to make certain day to day decisions, and yet at the same time lack the capacity to make informed decisions about financial matters.

Incapacity should never to deemed to exist merely by reference to one's age, behaviour, personality or appearance. In applying agreed criteria to the determination of capacity in an approved centre, a psychiatric opinion should be sought in the context of a multidisciplinary approach to each individual.

(c) Qualifications and expertise of the Assessor of Capacity

As stated, the person on whose opinion an assessment of capacity is made in an approved centre should be a consultant psychiatrist. The consultant should receive the support and input of a multidisciplinary team. A multidisciplinary approach should be employed to engage appropriate mechanisms which empower those with limited capacity to be involved in decision making regarding all aspects of their life in line with the State's international human rights obligations.[110]

6. CHILDREN

Article 7 of the CPRD provides that:

> 1. States Parties shall take all necessary measures to ensure the full enjoyment by children with disabilities of all human rights and fundamental freedoms on an equal basis with other children.
>
> 2. In all actions concerning children with disabilities, the best interests of the child shall be a primary consideration.
>
> 3. States Parties shall ensure that children with disabilities have the right to express their views freely on all matters affecting them, their views being given due weight in

[109] In the UK, people who lack capacity can be detained for medical reasons pursuant to a standard authorisation or an urgent authorisation for the purpose of giving them life-sustaining treatment or doing 'any vital act', provided they meet certain requirements. See footnote 20 supra.

[110] The Irish College of Psychiatrists advocates this model and most UK psychiatrists work as part of a multidisciplinary team, which the Royal College of Psychiatrists believes is important in facilitating patient independence. *See Proposed model for the delivery of a mental health service to people with intellectual disability*, Occasional paper OP58 (July 2004), at pp. 8-9, 13 and 22-23; Royal College of Psychiatrists, *Good Psychiatric Practice*, 3rd ed, 2009, at pp. 10 and 30.

accordance with their age and maturity, on an equal basis with other children, and to be provided with disability and age-appropriate assistance to realize that right.

Article 1 of the UN Convention on the Rights of the Child ("CRC") defines "a child" to mean "every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier"

Article 3 of the CRC similarly provides that the "best interests" of the child be the primary consideration in all actions concerning children, while Article 12 of the CRC goes further than Article 7 of the CPRD providing that not only should children be able to express their views freely in all matters concerning them and those views be given due weight, but also that "the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law."

A number of anomalies may currently exist in relation to the detention of children in approved centres.

As already referred to, the 2001 Act applies with some variation to both adults and children; with section 2 defining a child as a person below the age of 18. However, insofar as Section 23 of the Non Fatal Offences Against the Person Act 1997 recognises that a child over 16 is capable of consenting to medical treatment, there may be a conflict between the two ages of consent in relation to medical treatment recorded in the law (16 and 18 years respectively). It is the consent of the parent rather than the consent of the child that will be decisive in deciding whether the child is to receive psychiatric treatment by being admitted as a voluntary patient where the child is 16 or 17 years of age.[111]

Thus the fact that children can be detained voluntarily on the basis of their Parents' or guardians' (rather than their own) consent, without any opportunity to have their views taken into account in relation to such an admission may be in breach of the CRC and the CPRD. This is particularly so where there is no provision for determining the capacity of the child, such that there is an automatic legal presumption of non-capacity. Similarly the lack of procedural safeguards at District Court level (where the HSE makes an application to have a child admitted to an approved centre) to ensure the views of the child are taken into account, the matter being left to the discretion of the relevant Judge, may raise similar concerns. Finally the possibility that the District Court may grant an Order for detention of a child on an *ex parte* basis for a period up to 21 days without the opportunity for a review of that Order may also be in breach of Article 5 of the ECHR.

It is noted that in the case of Nielsen v Denmark the ECtHR found that the admission of a 12 year old boy to a psychiatric hospital against his will by his

[111] *See* statistics on admission of children at footnote 22 above.

mother was not a deprivation of liberty as this was the legitimate exercise of parental rights under Article 8 of the Convention.[112] The Court did however indicate that such parental authority could not be unlimited and there is a duty on the State to protect against abuse, although there was no question of abuse in that case. In the case of DG v Ireland the Court made an important distinction between the exercise of parental authority and an Order of a Court, where Article 8 is not in play:

> "The Court recalls that in *Nielsen v. Denmark*, it found that Article 5 was not applicable to the hospitalisation of the applicant as that hospitalisation was a responsible exercise by the applicant's mother of her custodial rights (judgment of 28 November 1988, Series A no. 144, pp. 23-27, §§ 61-73). That reasoning cannot be transposed to the present case as the orders placing the applicant in St Patrick's were made by the High Court, which court did not have custodial rights over the applicant. Article 5 therefore applies in the present case (see *Koniarska v. the United Kingdom* (dec.), no. 33670/96, 12 October 2000)."[113]

Koniarski v The United Kingdom, concerned the placing of a 17 year old girl suffering from a mental disorder in secure local authority accommodation on foot of a Court Order. In its decision on admissibility the Court found that Article 5 was engaged. Therefore it would seem that Orders made under section 25 of the 2001 Act by a Court will engage Article 5, and so must comply with the safeguards already outlined above.

7. CONCLUSION AND RECOMMENDATIONS

The IHRC is concerned about the definition of a voluntary patient under section 2 of the Mental Health Act 2001 and the apparent absence of any procedural protections afforded to incapacitated compliant patients and wards of court under the Act. The IHRC is of the view that the Act, as currently formulated, may not conform to International Human Rights Standards.

A. Compliant Incapacitated Patients and Wards of Court

The emphasis under the CRPD is on the presumption of capacity and supporting a person's involvement in decision-making on their own behalf. It is important then that the decision of the person in relation to treatment is respected at first instance. He or she should not be arbitrarily categorised as voluntary or involuntary. Any question as to the person's capacity to consent or object to admission to an approved centre needs to be determined under appropriate mental capacity legislation, rather than by reference to section 2 of the Mental Health Act 2001in its current form.

In relation to determining who may be categorised as an incapacitated compliant patient it is necessary to have in place clear legal criteria to determine the

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[112] *Nielsen v Denmark*, 1989, 11 EHRR175.
[113] *DG v Ireland*, Judgment, 16 May 2002, at para 72.

capacity of the patient to make decisions in specific areas including health care. Clear criteria would eliminate any possibility for obscurity arising under the Mental Health Act 2001, as to who should be considered a voluntary or involuntary patient. In this regard the Mental Capacity Bill should provide for procedures governing the processes and criteria to be used in identifying if a person is lacking capacity, and which are directed to upholding the inviolability of the principal of autonomy. Such criteria should be included in the proposed Bill, and provide for a robust system of protection from any measures that diminish a person's legal decision making capacity (such as is currently the situation regarding wards of court).

It should be also recognised that the presumption of one's capacity under international standards suggests that the majority of persons voluntarily consenting to their admission in approved centres would continue to be categorised as voluntary patients following amending legislation. In this regard, care should be taken to avoid unnecessary categorisations of "deprivation of liberty" and referrals to Mental Health Tribunals where possible to ensure the functional presumption of capacity continues and to avoid any unnecessary stigmatisation which may ensue. It is also recognised that any increases of Mental Health Tribunal referrals arising from more patients being categorised as "involuntary" will by definition increase workload on Clinicians and that consequently this workload be taken into account when planning for the care and treatment of in-patients and the resourcing of mental health institutions generally.

The admission of incapacitated compliant patients and wards of court should thus be carefully reviewed and the same or similar safeguards be provided as are presently applicable to involuntary admissions under the Mental Health Act 2001 where the person is assessed as lacking legal capacity. It is accepted that in this situation, this would include designating the admission to an approved centre of both incapacitated compliant patients and wards of court as a deprivation of liberty and would require a periodic review of that detention by an independent tribunal as is currently available to involuntary patients. This would in effect protect individuals who do not have capacity to consent to a voluntary admission but who do not presently fulfil the criteria for an involuntary admission.

B. Children

The presumption of incapacity in relation to minors of sixteen to eighteen years under section 2 of the Mental Health Act 2001 is cause for concern in relation to the State's compliance with the CRC and the further requirements that will arise under the CRPD when ratified. This concern would appear to be further supported by the apparent contradictory manner in which domestic legislation treats the issue, with the Non-Fatal Offences Against the Person Act 1997 treating such minors as having capacity for the purpose of consenting to medical treatment, and the 2001 Act presuming that they do not.

The IHRC therefore makes the following recommendations: -

1. That the Government take steps to remedy the current lack of protection from deprivation of liberty afforded to incapacitated compliant patients and wards of court in the context of an admission to an approved centre within the terms of the Mental Health Act 2001. Specifically, the definition of a voluntary patient in the Mental Health Act 2001 should be amended to include only those persons who have the capacity to make such a decision and who have genuinely consented to their admission to a psychiatric institution and continue to consent to same. Ideally, such amendment should occur at the same time as the enactment of a comprehensive Mental Capacity Bill.

2. In the event that there is any doubt whether a person has capacity to consent or object to their admission to an approved centre, the question of the person's capacity should be referred for determination pursuant to appropriate mental capacity legislation, under an expedited procedure if necessary.

3. That care be taken in assessing one's capacity to ensure that the presumption of one's capacity (rather than incapacity) occurs and that unnecessary categorisations of "deprivation of liberty" and referrals to Mental Health Tribunal are avoided where possible.

4. That all persons who have been declared to lack legal capacity to make medical decisions, and are considered to be in need of psychiatric detention, should be admitted to approved centres in a similar manner to involuntary patients under the 2001 Act with all the ensuing safeguards necessary to ensure their lawful detention under the Constitution and Article 5 of the ECHR.

5. That the proposed Mental Capacity Bill when enacted should be extended to include provision for the situation arising in approved and non-approved centres to specifically cover the following:

   (a) Methods of Assessment of Capacity.

   (b) Identification of the Criteria to be used when determining Capacity.

   (c) Qualifications and expertise of the Assessor(s) of Capacity.

6. That the proposed Mental Capacity Bill when enacted should include appropriate mechanisms to empower those with limited capacity to be involved in decisions regarding their mental health in as far as possible, in line with international standards including Ireland's obligations under the Convention on the Rights of Persons with a Disability and the ECHR.

7. That the definition of "child" under section 2 of the Mental Health Act 2001 be amended to refer to a person under sixteen years, such that a minor of sixteen years or over could be considered an involuntary patient within the meaning of the Act if they have capacity and object to their admission to an approved centre.

8. That section 25 of the 2001 Act be amended to ensure that a child, the subject of an application under the section, is given a full opportunity in accordance with their age and capacity, to participate in the proceedings and make their views known, with appropriate representation as appropriate.

Appendix 1

Section 2, Mental Health Act, 2001

2 (1)...

"voluntary patient" means a person receiving care and treatment in an approved centre who is not the subject of an admission order or a renewal order.