

**RETHINKING THE USE OF CIVIL COMMITMENT WITH PROTECTIVE STANDARDS
IN THE JURISPRUDENCE OF THE CRPD: *PERSPECTIVES FROM ONTARIO (CANADA),
ENGLAND & WALES (UK), GHANA AND SOUTH AFRICA'S MENTAL HEALTH LAWS***

By Isaboke Moraa Wilmah

Submitted to

Central European University

Department of Legal Studies

In partial fulfillment of the requirements for the degree of Doctor of Juridical Science

Supervisor: Prof. Károly Bárd

Budapest, 2017.

This dissertation contains no material accepted for any other institution and no materials previously written and/or published by another person unless otherwise acknowledged.

s/Isaboke M. Wilmah

Abstract

The following dissertation examines protective substantive and procedural standards that can curb abuse of rights and arbitrary detentions in civil commitment process otherwise known as involuntary detention and involuntary treatment of persons with mental illness in four jurisdictions. The central argument of this proposal is that there is a need to rethink the Convention on the Rights of Persons with Disabilities (hereafter CRPD) abolitionist perspective on mental health legislations that sanction the use of civil commitment process and call for the promotion of and the use of effective protective substantive and procedural standards to curb abuse and arbitrary detentions in accessing mental health care access and services as provided in various facilities. The dissertation claims that civil commitment with its challenges is a useful method for certain individuals in certain circumstance in the access of mental health care. It is legislatively recognized as an accepted method of providing treatment in the four countries mental health framework and beyond. However, arbitrariness and abuse of rights as evidenced by the prevalent historical and current documentation on abuse of human rights of persons with mental disabilities, makes it an inadequate process.

As a consequence of the abuse, the thesis concedes that it is reasonably justified to have the call on the absolute ban of civil commitment of persons with mental disability, presently implemented through the prohibition of deprivation of liberty based on a disability by the paradigm changing treaty- the CRPD and the strong anti-civil commitment standpoint of the CRPD Committee. The Committee calls upon States to reform their mental health legislations that allow for “involuntary commitment of persons with disabilities in mental health institutions based on actual or perceived impairment” because “involuntary commitment of persons with disabilities on health care grounds contradicts the absolute ban on deprivation of liberty on the basis of impairments (article 14(1)(b))[right to liberty and security of person] and the principle of free and informed consent of

the person concerned for health care (article 25[right to health]).”¹ The alternatives proposed by the Committee include access to and use of mental health voluntarily services, deinstitutionalization and providing mental health care services within the communities. However, current State practices in many jurisdictions contradict these calls by continuing to sanction civil commitment in their mental health legislation with more substantive and procedural standards. The practice also shows slow deinstitutionalization processes but more of refurbishment of institutions and slow establishment of community mental health services. At the same time, in many jurisdictions, mental health care remains to be the least funded and staffed. Care and treatment continues to be provided in deprived infrastructure environment and where arbitrary detentions and abuse remain prevalent. The prevalence of abuse and arbitrary detentions continue to manifest in mental health hospitals, psychiatric facilities, and care homes, traditional and spiritual mental health centers prevalent in many African and Asian countries including our private homes. The conclusion that can be drawn from all these, is an indication of disparity between the requirements of the Convention, State practice and the stark reality of many human rights violations taking place in respective domestic jurisdictions. Therefore, for these reasons there is an overriding imperativeness for researching standards and to persuasively engage the CRPD Committee towards rethinking its absolute prohibitionist perspective and to accept standards as an alternative to its current position and a solution to the ongoing problem of human rights abuse and arbitrariness.

¹ See, CRPD Committee, Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities, The Right to Liberty and Security of Persons with Disabilities, Adopted during the Committee’s 14th session, (September 2015), para 10.

Acknowledgement

Oh Lord almighty thank you for at last it is done, at the very minimum what was set to be achieved. It has been a tremendous journey of intellectual learning, social relations and growth, not to forget the many empty coffee mugs! This journey has been possible with sheer will and most importantly with the encouragement and support of many dear ones.

There are many to list, but I particularly would like to begin my sincerest gratitude to my supervisor Prof. Károly Bárd, whose has been an exceptional adviser and supervisor. Besides my supervisor, I would like to make known my appreciation to Prof. Csilla Kollonay-Lehoczky, Prof. Renáta Uitz, Prof. Eszter Polgári, Prof. Mathias Moschel and Prof. Oliver Lewis for all the instances in which your insightful commentaries and encouragement helped shape my research. Lea Tilles, the rest of the CEU Legal Studies Department and Student Life Office thank you for all the instances in which your assistance made it easier to keep up with the academic life. I would also like to thank all my colleagues in the PHD Lab, who provided support in various ways.

I am very grateful to my family starting with my Son Joel Solymos-Isaboke, your mere being champions/ed everything I do. My parents, Mr. Mark M. Isaboke and Mrs. Hellen K. Isaboke thank you for everything and for being there for me selflessly. Thank you Sisters, Summer Isaboke, Zawadi Isaboke and Brother Brezhnev Isaboke for your never ending support and love. Mr. László Solymos, Mrs. László Solymos, Eszter Solymos, Péter Solymos and Zsuzsa Tóth, words cannot describe the indebtedness and respect I have towards you. Thank very much for your constant firm support, for taking care of me and my son, enabling me the opportunity to read, enjoy motherhood and providing the space when I needed to vent out. Above all, I recognize individuals with mental disabilities. This research is about promoting and safeguarding human rights of us, all individuals with mental health concerns in the access of mental health care.

Table of Contents

Abstract	iii
Acknowledgement.....	v
PART ONE: AN INTRODUCTION.....	1
1. Background to the Field of Research	1
2. Rationale for the Research	8
3. Research Question.....	11
4. Roadmap	14
5. Choice of Jurisdiction	17
6. Scope and Delimitations.....	21
7. Terminology.....	21
CHAPTER ONE	23
1.1. The Benchmark: CRPD and Civil Commitment.....	23
1.1.1. Opposing Reasons to Compulsory Measures including Civil Commitment.....	28
1.1.2. Supporting Reasons on Compulsory measures including Civil Commitment	36
1.2. Civil Commitment in Other International and Regional Human Rights Instruments.....	46
1.2.1. Civil Commitment and The Right to liberty and Prevention of Arbitrary Detention..	48
1.2.1.1. International Instrument: The ICCPR	49
1.2.1.2. Regional Instruments: The ECHR, ACHPR & ACHR.....	56
1.2.1.3. Persuasive International Instruments: MI principles and Basic Principles.....	72
1.2.2. Civil Commitment and the Right to Health: CRPD & ICESCR Perspectives	83
1.2.3. Civil Commitment and The Right to be Free from Il-Treatment and Torture: UNCAT, ECHR, ACHPR & ACHR Perspectives.....	96
1.3. Conclusion.....	112
PART TWO: COMPARATIVELY SEARCHING FOR STANDARDS IN THE CHOSEN JURISDICTIONS.....	116
CHAPTER 2: CIVIL COMMITMENT: ADMISSIONS AND TREATMENTS.....	116
2.1. Introduction.....	116
2.2. Statutory Overview of Access to Mental Health Treatment and Care.	120
2.2.1. England (United Kingdom)	121
2.2.2. South Africa	132
2.2.3. Ontario (Canada)	138

2.2.4. Ghana.....	148
Sum Up.....	153
2.3. Criteria for Admission and Treatment	154
2.3.1. Introduction	154
2.3.2. England (United Kingdom)	157
2.3.2.1. Compulsory admission for Assessment.....	157
2.3.2.2. Compulsory Admission for Treatment	163
2.3.3. South Africa	168
2.3.3.1. Compulsory admission for Assessment.....	168
2.3.3.2. Compulsory Admission for Care, Treatment and Rehabilitation	169
2.3.4. Ontario (Canada)	171
2.3.4.1. Admission for Psychiatric Assessment.....	171
2.3.4.2. Compulsory Admission	174
2.3.4.3. Compulsory admission for Treatment	176
2.3.5. Ghana.....	179
2.3.5.1. Compulsory Admission and Treatment	179
2.3.6. Sum Up.	182
2.4. Community Treatment Orders.....	183
2.4.1. Brief Introduction	183
2.4.2. England (United Kingdom)	184
2.4.3. South Africa	186
2.4.4. Ontario (Canada)	187
2.4.5. Ghana.....	190
2.4.6. Sum Up.....	190
2.5. Substantive & Procedural Safeguards - Involuntary Admission, Treatment & CTO..	191
2.5.1. England (United Kingdom)	191
2.5.2. South Africa	201
2.5.3. Ontario (Canada)	206
2.5.4. Ghana.....	215
2.5.5. Sum Up.....	219
2.5.5. Conclusion.....	220
CHAPTER 3: CAPACITY, CONSENT AND CIVIL COMMITMENT	223

3.1. Introduction.....	223
3.2. International Perspectives & National Standpoints	227
3.2.1. The ICCPR	227
3.2.2. The ICESCR.....	230
3.2.3. The MI Principles	234
3.2.4. The CRPD	236
3.3. Jurisdictional Perspective: (UK, Canada-Ontario, South Africa & Ghana).....	250
3.3.1. England & Wales (UK)	250
3.3.1.1. Introduction: Statutory Background	250
3.3.1.2. Capacity & Civil Commitment.....	257
3.3.1.3. Consent & Civil Commitment	261
3.3.1.4. Substantive and Procedural Safeguards.....	269
3.3.1.5. Sum Up	279
3.3.2. South Africa	279
3.3.2.1. Introduction-Statutory Framework	279
3.3.2.2. Capacity & Civil Commitment.....	289
3.3.2.3. Consent & Civil Commitment	298
3.3.2.4. Substantive & Procedural Safeguards	301
3.3.2.5. Sum Up	305
3.3.3. Ontario (Canada)	306
3.3.3.1. Introduction: Statutory Framework	306
3.3.3.2. Capacity & Civil Commitment.....	312
3.3.3.2.1. Substitute Decision Making.....	318
3.3.3.3. Consent & Civil Commitment	324
3.3.3.4. Substantive & Procedural Safeguards	330
3.3.3.5. Sum up	334
3.3.4. Ghana.....	335
3.3.4.1. Introduction: Statutory Framework	335
3.3.4.2. Capacity & Civil Commitment.....	339
3.3.4.3. Consent & Civil Commitment	342
3.3.4.4. Substantive & Procedural Safeguards	347
3.3.4.5. Sum Up.....	349

3.4. CONCLUSION.....	349
CHAPTER 4: REVIEW, DISCHARGE & CIVIL COMMITMENT	355
4.1. Introduction.....	355
4.2. International Perspective	356
4.2.1. CRPD.....	357
4.2.2. UN Working Group on Arbitrary Detention	360
4.2.3. ICCPR	362
4.2.4. The MI Principles	364
4.3. Review and Discharge in the Regional Systems (ECHR, ACHR & ACHPR).....	367
4.4. Jurisdictional Perspectives	372
4.4.1. England & Wales (UK)	372
4.4.1.1. Review	372
4.4.1.1.1. By Tribunal & Country Court arising from: Individual, Representatives & Nearest Relatives Applications, Hospital manager’s referrals & Secretary of State Referrals.....	372
4.4.1.1.2. Review via Habeas Corpus & UKHRA (Compatibility of Legislative Schemes and Governmental Body Actions).	380
4.4.1.2. Discharge	384
4.4.1.3. Sum Up.....	388
4.4.2. South Africa	389
4.4.2.1. Review	391
4.4.2.1.1. Review by Review Board	391
4.4.2.1.2. Judicial Review by High Court of Involuntary Care, Treatment and Rehabilitation.....	393
4.4.2.1.3. Review and Discharge through Appeal procedures.....	393
4.4.2.1.4. Periodic Review and Annual Reports.....	394
4.4.2.1.5. Review through Other Mechanisms such as Habeas Corpus.....	396
4.4.2.2. Discharge	396
4.4.2.3. Sum Up.....	397
4.4.3. Ontario (Canada)	398
4.4.3.1. Review through the Jurisdiction of the CCB.....	399
4.4.3. 2. Review under Mental Health Legislations	402
4.4.3.2.1. Review by CCB	403

4.4.3.2.2. Judicial Review through Habeas Corpus	405
4.4.3.2.3. Judicial review through appeal	406
4.4.3.2.5. Other Avenues for Review	410
4.4.3.3. Discharge	410
4.4.3.4. Sum Up.	412
4.4.4. Ghana’s Approach.....	413
4.4.4.1. Review & Discharge in the Basic Document	413
4.4.4.2. Review & Discharge under the GMHA.....	415
4.4.4.2.1. Review of Treatment Plan	416
4.4.4.2.2. Review by Court	418
4.4.4.2.3. Review through Appeal	419
4.4.4.3. Discharge by the Tribunal	420
4.4.4.4. Sum Up.	421
4.5. Conclusion	421
CHAPTER 5: CONCLUSION: IMPERATIVENESS OF RETHINKING	425
5.1. Lessons Learnt	425
5.2. Additional Aspects for Contemplation (Economic, Cultural & Political)	437
5.2.1. The Economic Concern	438
5.2.2. The Cultural Challenge	439
5.2.3. The Political Aspect	441
5.3. What Lies Ahead	442
5.4. A Dialogue with the CRPD Committee	443
BIBLIOGRAPHY	447

PART ONE: AN INTRODUCTION

1. Background to the Field of Research

The fact is that civil commitment or involuntary committal/placement and treatment” of persons with mental health problems is a process widely used alongside voluntary treatment in many national jurisdictions to provide mental health care. It generally involves limitation of the right to liberty of an individual with the mental disability who is confined in a mental health institution or hospital for treatment and care. The power to deprive an individual with mental disability for treatment is always prescribed in mental health legislations. In some jurisdictions the power to limit the right to liberty for mental health treatment is constitutional such as Ghana and in some countries court decisions have validated the constitutionality of mental health legislations and processes of civil commitment such as in Canada. The purpose of such legislation is obviously to sanction treatment and offer protection for persons with mental disability in the course of their treatment. As such, mental disability is the predicate for laws that sanction the limitation of an individual’s liberty for purposes of treatment upon a finding of a mental disability that causes danger to self or others and involves involuntary hospitalization and treatment. It is enforced where certain criteria normally- “the presence of a mental disorder of a nature that will likely cause a bodily harm to the patient, or to another person, or cause physical impairment of the patient,, the need for treatment unless the patient remains in custody of a psychiatric or mental health facility.” There are additional qualifying standards in certain jurisdictions. Besides these there are substantive and procedural processes and protections that must be enforced whose purpose is to prevent any violation of rights of those detained.

However, the practice of civil commitment is currently challenged. Especially with the coming in of the Convention on the Rights of Persons with Disability (CRPD) which requires “not only a re-

thinking of mental health laws (that simultaneously legitimize and limit coercive state power in relation to confinement and psychiatric treatment of people labelled with a mental illness), but rethinking of the concept of mental health law”.² The CRPD essentially “recognize [es] that disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with other.”³ It places principles of autonomy, human dignity, equality and non-discrimination at the epicenter of the rights therein,⁴ resultantly ‘embracing the aim of making persons with disabilities visible as different but equal members of society.’⁵

From this context and construing civil commitment as part of mental health care, the CRPD principally promotes equal access to mental health care and services by persons with disabilities under article 25 which provides for the right to the enjoyment of the highest standard of health.⁶ It however prohibits acts of discrimination and the imposition of compulsory measures such as civil commitment on the basis of best interest on an individual with a disability, calling upon State parties “to require all health and medical professionals (including psychiatric professionals) to obtain the free and informed consent of persons with disabilities prior to any treatment.”⁷ Furthermore and “in conjunction with the right to legal capacity on an equal basis with others [article 12], States parties have an obligation not to permit substitute decision-makers to provide consent on behalf of

² See, Tina Minkowitz, *Abolishing Mental health Laws to Comply with the Convention on the Rights of Persons with Disabilities* in Bernadete McSherry & Penelope Weller ed., *Rethinking Rights- Based Mental Health Laws*, Oxford Hart Publishing 151 (2010).

³ See CRPD (2008) preamble (e)

⁴ See, *Ibid*, Article 1 clearly posits the aims of the convention by emphatically stating *inter alia*, “the purpose of the present convention 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. Persons with disabilities include those who have long term physical mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.”

⁵ See, Kampf Annegret., *Involuntary Treatment Decisions: Using Negotiated Silence to Facilitate Change*,” in McSherry, B., & Penelope W., *Rethinking Rights- Based Mental Health Laws*, (2010) *Supra* note 2, p. 133.

⁶ See, CRPD.

⁷ See, *Ibid*, Article 25 (d) & See also, CRPD Committee, General Comment No. 1: Article 12: Equal recognition Before the Law, CRPD/C/GC/1 (2014), para 41.

persons with disabilities”⁸ but through directly engaging with the person with disability and use of other supporting mechanisms.

The convention does not make a direct reference to civil commitment processes and the requirement of what it may entail. However, the CRPD Committee in its interpretation of how the convention should be read and implemented, has discussed it in conjunction with articles 5(equality & non-discrimination) 12(equal recognition before the law), 15(freedom from torture), 16 (freedom from exploitation violence and abuse), 17(protecting the integrity of the person), 19(living independently and being included in the community), 25(right to health) and directly within article 14 in its recent guidelines.⁹ Article 14 of the CRPD concerns the right to liberty and security of persons and it provides that:

1. state parties shall ensure that persons with disability shall enjoy the right to liberty on an equal basis with others: (a) enjoy the right to liberty and security of person; (b) Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.

2. States Parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of this Convention, including by provision of reasonable accommodation.¹⁰

Thus, in its interpretation of this article and as it situates civil commitment, the Committee strongly regards this process as contrary to the principles and demands of the CRPD. In its current “Guidelines to Article 14 of the CRPD”, it emphatically underscores that:

Involuntary commitment of persons with disabilities on health care grounds contradicts the absolute ban on deprivation of liberty on the basis of impairments (article 14(1)(b)) and the principle of free and informed consent of the person concerned for health care (article 25). The Committee has repeatedly stated that States parties should repeal provisions which allow for involuntary commitment of persons with disabilities in mental health institutions based on actual or perceived impairments. Involuntary commitment in mental health facili-

⁸ See, CRPD Committee, General Comment No. 1, para 37, Ibid,

⁹ See, CRPD Committee, Guidelines on Article 14 of the CRPD, Supra note 1, paras 5, 8, 9, 12, 19&24. See also, CRPD Committee, General Comment No. 1, ibid.

¹⁰ See, CRPD Article 14.

ties carries with it the denial of the person's legal capacity to decide about care, treatment, and admission to a hospital or institution, and therefore violates article 12 in conjunction with article 14.¹¹

Instead, it presents an all-inclusive approach to human rights and requires for supportive measures to be in put in place to facilitate the exercise of equal rights, respect of dignity and autonomy of persons with disabilities. From this perspective State Parties are required at a national level to formulate, adopt coherent and comprehensive strategies in order to give meaningful impact of the convention including providing mechanisms of supervision and compliance.¹² On the practice of civil commitment, the Committee has called upon States with mental health legislations permitting coercive measures to have them repealed and recommend the construction of mental health policies, legislations and strategies that promote voluntary, community based socially inclusive treatment and care models.¹³ Including, undertaking effective deinstitutionalization strategies in consultation with organizations of persons with disabilities and actions against the stigmatization, discrimination and exclusion of persons with mental health problems.¹⁴

While the author may not agree fully that the process itself is arbitrary, acknowledgement is made to the fact that legislative changes need to be made, that civil commitment process predisposes individuals to abuse and arbitrary detention and to the suffering many have endured in the past under its structure. It can equally affect the most fundamental rights, including the right to liberty and security of the person, the right to bodily integrity and privacy, to movement among others. The CRPD viewpoint is reasonably supported by other critics of civil commitment such as Tina Minkowitz who campaigns for the complete repeal of mental health legislations, claiming that by the very nature of detention involved and the stigma associated with mental health problems in many

¹¹ See, CRPD Committee, Guidelines on Article 14 CRPD, Supra note 9, para 10.

¹² See CRPD Article 4: General Obligations.

¹³ See, CRPD Committee General Comment No. 1, Supra note 8, para 46.

¹⁴ See, CRPD Committee, Guidelines on Article 14 CRPD, Supra note 9, para 32-34, 40-42.& 46

societies, it predisposes subjected individuals to the risk of inequality and discrimination, torture, cruel, inhuman or degrading treatment or punishment.¹⁵ Critics have also focused on the coercive nature of the process not only as exercised by the State through its *parens patriae* power represented by the vast protectionist mental health legislations, but also the power in psychiatric profession that is seen to be unbridled, including the logic of a lack of clear evidence that psychiatry and compulsory treatments have any therapeutic output.¹⁶ It becomes comprehensible why the CRPD Committee as well as the United Nations Special Rapporteur for Torture among others are calling upon State parties to “revise the legal provisions that allow detention on mental health grounds or in mental health facilities, and any coercive interventions or treatments in the mental health setting without the free and informed consent by the person concerned. Legislation authorizing the institutionalization of persons with disabilities on the grounds of their disability without their free and informed consent must be abolished”.¹⁷

The above makes it hard to justify the use of civil commitment, presenting a dilemma and yet an opportunity for this research. What the CRPD Committee terms as arbitrary deprivation of liberty, State Parties and other proponents consider it as one among other processes to engage mental health care and services. Some scholars have even maintained that, indeed in some jurisdictions like the United Kingdom, commitment places a legally enforceable responsibility on local services to provide input[and in this regard, the process] not only affects negative rights but may also com-

¹⁵ See, Tina Minkowitz Esq., What Would CRPD-Compliant Mental Health Legislation Look Like? (May 11 2015). Available in <http://www.madinamerica.com/2015/05/what-would-crpd-compliant-mental-health-legislation-look-like/>. See also, Tina Minkowitz, Abolishing Mental health Laws to Comply with the Convention on the Rights of Persons with Disabilities in Bernadete McSherry & Penelope Weller ed., Rethinking Rights- Based Mental, (2010), Supra note 2, p. 151-177.

¹⁶ See, Danny Sullivan & Paul Mullen, Mental Health Rights in Secure Settings in Michael Dudley, Derrick Silove & Fran Gale ed., Mental Health and Human Rights: Vision Praxis and Courage, Oxford University Press 287-289 (2012).

¹⁷ See, UN Doc Human Rights Council General Annual Report, “Report of the Special rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Juan E. Mendez, A/HRC/22/53, (2013), para 89 (d).

mand a complement of positive rights (e.g. housing, state benefits).”¹⁸ Scholars such as John Dawson argue for the use of legal standards instances where coercive measures and substitute decision making are engaged as a more realistic approach rather than the radical interpretation of the CRPD that has not provided a clear yardstick on what is required in mental health law reforms.¹⁹ Others scholars while “agreeing fully with the argument that involuntary admissions and compulsory treatment are often overused, and have historically resulted in the rights of people being violated, [they] cannot accept that doing away completely with involuntary admission and treatment will promote the rights of persons with mental illness”.²⁰ In fact some scholars claim that CRPD position [current General Comment no.1 as it relates to coercive measures] did not reflect an inclusive accurate position of other parties since it disregarded the position of a large group of users who maintain a favor of involuntary admission in certain circumstances and the viewpoint of advocacy groups and State Parties that proposed the use involuntary treatment and of substituted decision making in limited instances.²¹

¹⁸ See, Danny Sullivan & Paul Mullen, *Mental Health Rights in Secure Settings* in Michael Dudley, Derrick Silove & Fran Gale ed., *Mental Health and Human Rights: Vision Praxis and Courage* (2012), *Supra* note 16, p. 289.

¹⁹ See, John Dawson, *A Realistic Approach to Assessing Mental health Laws Compliance with the UNCRPD*, 40 *International Journal of Law and Psychiatry* 70 (2015). He states that-“the Convention is open to a range of plausible interpretations that might resolve some of the ambiguities and inconsistencies in its text, but crucial aspects of the interpretation offered by the Committee, in the General Comment, are not at all plausible—for reasons given below and there is no evidence that state parties have any intention of following the Committee's more radical suggestions as to what is required in reform of their mental health laws. Several state parties, foreseeing the potential problems, entered reservations, on ratifying the Convention, that rejected in advance aspects of the interpretation later offered by the Committee, and other state parties, in their periodic reports to the Committee, continue to cite without apparent embarrassment aspects of their mental health laws, as evidence of compliance with the Convention, that are quite incompatible with the Committee's published views.”

²⁰ See, 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*, 2 *The Lancet* 846 (2015).

²¹ See, *Ibid*, p. 848. They claim that: “In responding to a request from the South African Department of Health on whether there should be involuntary admission and treatment, the Gauteng Consumer Advocacy Movement (GCAM), a large user group, said “The GCAM is in favour of involuntary admission...We acknowledge that there are times when we as mental health care users relapse and become mentally unstable and therefore not capable of acting in our own best interest, especially when it comes to treatment and the various ways of obtaining the necessary treatment, which may include involuntary admission. We also acknowledge that at times some of us might become verbally or physically abusive or threatening, and it is then the responsibility of the State to protect those around us and protecting us from harming ourselves” (personal communication). The GCAM did a survey of their members in 2013 and found that 99% felt that “psychiatric medication has resulted in improved mental health and improved quality of life” (personal communication).”

As for the call for deinstitutionalization and providing of services within the communities, the author agrees with other proponents of civil commitment process who acknowledge that it as “a leap forward in reaching human rights goals advanced by advocates and activists of human rights of persons with mental disabilities over many years”.²² Having mentioned this however, attention is drawn to the concern that “critics of civil commitment have at times been selective in acknowledging [that] the abolition of inpatient psychiatry units is not accompanied by reduced despair and enhanced mental health for those who might be affected by these processes. Rather it moves the problem of mental disorder elsewhere-private homes, hostels, prisons, the streets-and benefits the government which no longer need fund these expensive services.”²³ Those many reported and unreported unregulated, abusive traditional and spiritual centers of healing found in many African countries can be added to this list. Interestingly, these places for instance prisons and the centers similarly involve the deprivation of liberty of persons with mental disorders and equally predisposes individuals to arbitrary detention and abuse making a stronger case for the necessity and availability of guiding standards.

Clearly, there is an impasse in the implementation and interpretation of the CRPD. Then there is the reality of abuse of rights and arbitrary detentions of persons with mental disabilities in all forms of mental health institutions, in the communities and our homes. This dissertation joins the conversation of making mental health law reforms that uphold the rights of persons with disabilities subjected to coercive measures by comparatively searching for substantive and procedural standards that may be used to curb abuse and arbitrariness. Comparative jurisprudence on standards is limited, particularly as regards African countries. It is also limited due to the current prohibitory advocacy on civil commitment. Undertaking a comparative study into standards is driven by this backdrop

²² See, *Ibid*, p.846.

²³ See, Danny Sullivan & Paul Mullen, *Mental Health Rights in Secure Settings* in Michael Dudley, Derrick Silove & Fran Gale ed., *Mental Health and Human Rights: Vision Praxis and Courage*, (2012), *Supra* note 16, p.290.

and most importantly the desire to advance the CRPD requirements under article 16(freedom from exploitation, violence and abuse) that calls upon member states take “all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects.”²⁴

With the above in perspective, the dissertation does not correlate the process of civil commitment in itself as arbitrary and incompatible with article 14 CRPD.²⁵ But the disregard of standards set in the law, the lack of standards, poor hygienic environments and sheer inhumane actions of individuals towards those receiving care under the scheme. It acknowledges the importance of mental health legislation that define criteria’s and legal standards in promoting the provision of proper and adequate mental health treatment of those institutionalized, hospitalized, in the communities and our homes. Being of health and wellbeing is very important because it enables us human beings to enjoy the fundamental rights and freedoms we declare to hold. To therefore contribute to the balancing actions of access to mental health care vis a vis protection of rights, the dissertation undertakes to examine these safeguards the CRPD calls for, the protections activists are demanding and specifically those that the States are declaring to have comprehensively set out in their mental health legislation to ensure that civil commitment processes are not abusive, arbitrary and are compatible with their CRPD obligations.

2. Rationale for the Research

This dissertation analyzes arbitrariness as a major contributing factor in making civil commitment and general regulating mental health regulations an inadequate approach in mental health care provision because of a couple of reasons. The first rationale relates to personal experiences of and with

²⁴ See, CRPD Article 16.

²⁵ See, CRPD Article 14- Right to Liberty.

a family member suffering from a mental disorder that necessitated certain episodes of controlled care. The family member in point prefers to be civilly committed usually for short durations and she would be discharged and with the support of the family to continue her treatments as she goes on with her life. This living system of support, compulsory admission and treatment, discharge and continuous medication and support is her life and with these challenges, she lives a 'normal life'. It has not been easy to say the least because community mental health facilities are not located in her residence area, sometimes support from the family can be challenging and the psychiatric wards she gets admitted into is located in the city away from her family. The acceptance to be compulsorily admitted comes with the understanding that at times she partially consents to exercising her autonomy and that she will receive proper mental health care in a safe environment. The hospital is not a five star facility, but offers relative adequate services. With this, the author reflected, civil commitment works for some individuals, but only where there is support, respect of patients' needs and rights and adequate service in an environment that is hospitable. This family member's experience sadly does not apply to all, which brings the second reason into context.

Second, unlike the family member whose support system is aware of the mental health problem and is able to contribute protectively, emotionally, financially and socially to her wellbeing, this cannot be claimed for many individuals, particularly those in humble remote regions and who have little or no access to specialized psychiatric care. Thus, families not having the knowledge and other solutions for care may opt to chaining them in or outside the house, locking them in cages to prevent them from running away and causing harm to themselves or others. In other cases to hide them from society and the stigma associated with mental illnesses or abandon them all together. The availability of a mental health framework that defines rights, obligations, oversight and a setup of proper infrastructure including use of education may go a long way in promoting mental health care

and preventing arbitrary detentions at home and set up ramshackle centers. This is what is being advocated and claimed by this dissertation.

The third and connecting motivation to the second is the confluence of culture and health needs. This predominantly relates to many African countries, including the two case study countries where majority of the native's believe that ill health is a result of evil spirits, bewitchment, wrong doing or consequence of offending the gods. The only way to resolve this can be either through shamanic techniques or spiritual interventions or both. The wide spread abusive nature of these methods and arbitrary detentions in the centres of healing have been recently revealed (Kenya, Uganda, Zambia, Ghana, South Africa, Somalia, Indonesia, India, china Nigeria the list is long) which makes one question the responsibility to protect by our governments and humanity of fellow human beings. It also calls for serious law reforms, sensitization on mental health care and training of all stakeholders. Law reforms may be directed towards the regulation of these facilities and ensure oversight not only of the facilities but also have individuals using them understand their rights and have access to mechanisms for redress. Ghana, one of the case studies accepts the use of traditional and spiritual mental health care in its mental health statute, but there is no regulatory framework. Thus researching on standards in this dissertation aims at presenting standards that may facilitate curbing of violations in these settings.

The fourth reason is associated with current State practice. In numerous countries, nothing is being done about individuals' denial of access to basic mental health care and the treatments they need. In other countries as earlier mentioned, they continue to either use legislation that include civil commitment, have legislated on its use post CRPD or are in the process of doing the same (with notion of increased safeguards). In addition, some countries are slow in undertaking deinstitutionalization and putting up community based infrastructures while others are refurbishing closed institu-

tions and reopening them as mental health facilities. Others use both institutions and community based infrastructures. What all this indicates is the continued use of mental health institutions which are associated with gross human rights violations including arbitrary detentions, inhuman and degrading treatment and living conditions. All this concerns proves that elimination of civil commitment remains to be idealistic. A pragmatic and immediate solution that should be considered is working on standards and providing a sound effective regulatory framework.

The last rationale is also connected to current State practices. Some Countries instead of abolishing civil commitment process, they are providing a comprehensive set of standards maintaining that this will increase the prevention of any human rights violations including arbitrary detentions in civil commitment. Some of these additional changes or advancements have been as a result of judicial decisions addressing individual claims of abuse and arbitrary detentions. Moreover, where there have been constitutional challenges of civil commitment brought under individual claims of violations of liberty rights or discrimination, courts in some jurisdictions have affirmed the constitutionality of the enabling mental health laws. But where violations were found and due to the inadequacy of the law, one of the responses has been the calls for changes in the specific law with more substantive and procedural standards. This trend can be seen in the UK and Ontario and South Africa jurisdiction introducing new guarantees where there are inadequacies.

3. Research Question

To realize the objective and the research interests, the research seeks to answer one question:

What are the current and applicable protective standards to curb abuse and arbitrary detention in civil commitment processes and other settings involving similar attributes that could be adopt-

ed, expanded and effectively implemented to protect the rights of individuals and that could be situated within the CRPD Article 14 jurisprudence?

The dissertation question signifies two sets of understanding. The first is that it acknowledges the use of civil commitment and voluntary services in access to mental health care and services. This acknowledgment is further buttressed by an understanding that civil commitment processes should be provided within a mental health framework that stipulates rights and operational guidelines including provisions for review. With this, it therefore connotes that mental health legislation that provide for civil commitment are relevant at least as far as articulating rights and their implementation for those individuals subjected to the process. The second meaning that can be deduced is that the claim forwarded by this dissertation is that arbitrariness is a major concern in the discourse of civil commitment and as a concern it makes the process an inadequate method that can be used to access mental health care and treatment. Arbitrariness and abuse in fact is a concern in any system that delivers physical and mental care services and in this view it is not limited in institutions but also in our communities and homes. It does not stop merely because mental health frameworks with civil commitment are repealed. Instead the lack thereof, presents the opportunity for further impunity on persons with mental disabilities by depriving them the legal protection of their rights, an imposition of obligations to carers and service providers including oversight on the service as a whole. This absence of frameworks for example in societies where mental health laws do not exist, are outdated or lack organized support systems such as many African countries, enforcing these calls perpetuates serious violations. Furthermore, deinstitutionalization processes while a step forward in preventing abuses in institutions, in themselves do not guarantee that arbitrariness will not occur in alternative care services such as in the community, in our homes, social care homes and other mental health care facilities.

Thus, the research question in determining arbitrariness as a concern does not dispute that enforcement of civil commitment can affect the most fundamental rights and predispose individuals to risks of various forms abuse and arbitrary detentions. What it purports to do is to contribute to the protection of rights of those accessing mental health care and treatment in any setting by way of determining substantive and procedural protective standards in civil commitment. These standards could perhaps be situated within the jurisprudence of the CRPD articles 14(right to liberty and security of persons), and as a consequence become a solution on how mental health law could be reformed to be CRPD compliant.

To therefore answer this question and at the same time support the claim forwarded in the research, the author would embark on a comparative study of how the mental health legislation in UK (England & Wales), Ontario (Canada), South Africa and Ghana, specifically the process of civil commitment and targeting the substantive and procedural safeguards therewith as set out to support rights vis a vis provision of compulsory mental health care and treatment. Here, chosen key thematic process in civil commitment shall be examined with the author's intent of presenting methods that the States are using in their legislation to guarantee promotion of rights in the access of mental health care and the guarantee of preventing arbitrariness. This shall also include the use of judicial decisions that shall try to bring out elements of arbitrariness and how the courts provide redress to the aggrieved.

To persuasively hold the claim, the dissertation shall present out the position of the CRPD on civil commitment as the benchmark including the diverse reasons in support and against the process and enabling legislation as well as other international and regional human rights systems standpoints on the matter. This shall specifically concentrate on the right to liberty and security of persons, the requirements under that right, exceptions and more accurately the position of civil commitment.

Interrelated subjects- right to health and right from torture shall also be examined to determine how they stand within this discussion of civil commitment. The intent of the author is to present an argument that implies that all reasons for and against hold relevance because of their importance in informing the enactment and implementation of effective policies. Moreover, it is important to acknowledge the diversity in individuals seeking mental health care and the component of dealing with individual preferences and circumstances that may involve the choice and use of voluntary or involuntary mental health services.

4. Roadmap

With the above understanding the dissertation is divided into five chapters. Chapter one introduces the benchmark standards set out in the CRPD particularly on the right to liberty as it relates to civil commitment, the contentious debates between support for and against civil commitment process and the general outlook of the process in international and regional human rights systems. The discussion of the themes in this chapter shall be presented in form of literature review. The author argues that civil commitment is a recognized process that falls within the exceptions of the right to liberty and security of persons as presented in international and regional instruments. This argument is supported by a comparative analysis of the international and regional normative standards in the text including interpretation jurisprudence. The author proposes that international perspectives offer normative frameworks from which authorities can be derived. That, they additionally, recognize and anticipate that limiting the right to liberty presents the risk or challenge of arbitrary detentions and abuse of other rights. In this regard, the normative framework offered is established on the construction that the limitation of the right to liberty is counter balanced with the use of substantive and procedural safeguards. To this end, the author claims that this perceptiveness applies to civil commitment processes. Furthermore, the author would argue, that besides the CRPD, there is

an existing, specific and longstanding soft international document that sets out protection on civil commitment. Since it is longstanding, it advantageous and important that it is compared to current trends in order to be able to conclusively state that the substantive and procedural standards being proposed are current and effective in curbing arbitrary practices.

While chapter one contends with foundational and conceptual issues, the next three chapters will be legislative case studies presented in a thematic format. Chapter two will provide an introduction to the legislative framework and will analyze the similarities and differences in substantive and procedural guarantees involving admissions and treatment in civil commitment in the four research countries. The analysis shall also utilize case law where available to illustrate the claim of the thesis. In addition, the examination shall try to compare where possible these countries jurisprudence with those found out in chapter two, international standards. The rationale is to find out those applicable substantive and procedural standards imperative in curbing abuse and arbitrary detentions, beginning from the initial processes within civil commitment. The author limits the content of this chapter to procedures and standards aspects of compulsory admission and treatment, community treatment orders and traditional and spiritual mental health care.

Chapter three is similar to chapter two as it deals with a procedural and a more challenging topical aspect of civil commitment. This is themed consent, capacity and civil commitment. Consent and capacity are contentious issues in civil commitment as is known and discussed under article 12 of the CRPD. The chapter argues for the use of guardianship, substituted and support decision making mechanisms for individuals unable to make autonomous decisions concerning mental health care. The argument is reasoned by the preposition of individual circumstances concerning decision making, current State practice that supports all the three mentioned mechanisms(short of CRPD requirements) and the CRPD requirements of supported decision making. Like admissions and treat-

ments where abuse have been revealed, the same have been in cases of these mechanisms and it is because of these that the chapter contends substantive and procedural protections should also be used to safeguard an individual's right to autonomous decision making and those made through representatives. It therefore begins with an introduction to the relevant legislative framework, then international perspectives and national standpoints of CRPD article 12 and finally followed by an analysis of the topic in the research jurisdictions. The consideration here is that different individuals may prefer different methods depending with their relevant circumstance. At the end of the chapter the intention is to have those safeguards that offer protection to the right of autonomy when exercised autonomously or through representatives in the stated mechanisms. The author notes here that article 12 is not discussed in its entirety.

Chapter four will be the last topical chapter and will be used to discuss the substantive and procedural right to review of detention and discharge in civil commitment. This chapter will argue that the enforcement of the right to review as articulated in various international and national human rights documents is central in ensuring that the purpose of detention is carried as such and that it affords the avenue for claiming redress where human rights violations have been committed. Discharge has to be exercised where the individual detained need not be detained anymore, where the patient decides or representatives and in accordance with the ethical and clinical standards in place as set by law. Therefore the chapter explores these rights by first looking at the international human rights framework, followed by the national legislative scheme. The various mechanisms of review shall also be analyzed as to their accessibility to individuals placed under compulsory measures. Illustration on how abuse and arbitrary manifests and dealt with shall be revealed through judicial decisions where available. It is intended that this chapter shall demonstrate that the availability and quality of review and discharge processes ensures that checks and balances are guaranteed when an

individual's liberty is curtailed and is placed under civil commitment. It also ensures monitoring as required by the CRPD.

Chapter five will review the research findings in the study chapters and draw a number of recommendations by way of conclusion. This chapter will also emphasize the positive duty of States to guarantee access to mental health care through proper financial support to the sector, employment of adequate staff and sensitization of its citizenry on mental health care including establishment and maintenance of proper mental health facilities that embody provision of care in a hospitable environment and in a humane manner. In addition, the author anticipates that the dissertation shall be able to contribute to the current discourse of access to mental health care through the use of civil commitment and particularly, by providing the findings in form of substantive and procedural standards, the standards that shall be able to be situated within the jurisprudence of the CRPD article 14, or be enough to ensure that they are promoted to protect those placed or would opt to be placed under civil commitment from abuse and arbitrary detentions.

5. Choice of Jurisdiction

To substantiate the claims in this research, a comparative study of four jurisdictions- Canada(Ontario), UK(England and Wales), South Africa and Ghana to determine how the mental health legislation, including judicial decisions regarding standards in civil commitment processes have been developed or evolving to handle abuse or rights and prevent arbitrary detentions. The selection of these jurisdictions is based on a number of factors. In terms of using civil commitment processes, these countries have a legal mental health framework that that accepts its usage within the set out comprehensive legal safeguards. Of course there are differences in the safeguards set out in their legislations. For example, it can be maintained that the UK (England and Wales) and prov-

ince of Ontario have more comprehensive set out safeguards in the mental health statutes including the provision of more protection to relating rights linking with the right to liberty by using other legislation that are crucial such as those that govern consent, information, decision making and treatment of those under the criminal system.²⁶ The jurisdictions also offer guidelines on how these statutes should be applied and have oversight bodies to ensure compliance.²⁷ In addition, their legislations keep evolving due to a number of reasons but the most influential initiative is the activism of the judicial institutions whose decisions constitutional or otherwise has led to crucial changes or gap filling in legislation by requiring more specific and detailed safeguards for those placed under civil commitment.²⁸ South Africa can be compared lightly to the two jurisdictions as it includes some of the safeguards connecting in its Mental Health Care Act and its legislation has been termed one of the best in Africa, while Ghana's post CRPD legislation has basic protections. Differences can be made out as regards institutions as well, with South Africa and Ghana lacking.

Another important factor for the choice of these countries is the fact that they are all party to the CRPD. And because of this aspect, they have an obligation to comply with the requirements of the CRPD generally and specifically as regards the protection of article 14, right to liberty and as it is connected to the access to the right to health in article 25. As mentioned above, these countries legislation have undergone changes mostly post-CRPD and some like Ghana enacted a whole new legislation on mental health, yet allowing civil commitment processes contrary to the CRPD juris-

²⁶ See The Constitution Act 1982, Canadian Charter of Rights and Freedom, Ontario Human Rights Code 1990, Ontario Health Care Act 1996, Ontario mental Health Act 1990, Substitute Decisions act 1992, Part XX.I of the Criminal Code of Canada and The Personal Health Information. See also, The Mental Health Act 2007 & The Mental Capacity Act 2009 as amended..

²⁷ See, UK Department of Health, Mental health Act 1983: Code of Practice, The Stationery Office (2015) & Ontario Hospital Association, A Practical Guide to Mental health and the Law in Ontario, Ontario Hospital Association (October 2012).

²⁸ See HL V United kingdom (Bourne wood Case) [2004] ECHR 471[led to the enactment of Mental Capacity Act, so as to fill in the gap in the law by creating procedural safeguards for those individuals considered incapacitated patients]. See also P.S. v. Ontario, 2014 ONCA 900, (CanLII)[led to changes in the Mental health Act, powers of the tribunal were revised to determine cases of long term stay incarcerated patients, including reducing detention duration from 12 years to six] or Fleming V Reid Fleming v. Reid, 1991 CanLII 2728 (ON CA)[that brought changes to the powers of substitute decision makers under Substitute Decisions Act (1992) as amended & OMHA (1990)].

prudence. Hence making it relevant to examine how these mental health laws are being reconceptualised as laws compliant with the CRPD requirements, particularly using substantive and procedural standards in civil commitment processes.

A further factor in relation to the selection of these jurisdictions is inclusivity of African countries in the promotion of the right to access to mental health care and protection of rights of persons with mental disabilities. Many a times researchers focus on “western countries” leaving behind African countries which vitally need research for policy making and legislative changes. African countries similarly have individuals with mental health needs, who face stigma, discrimination abuse, arbitrary detentions in hospitals, traditional and spiritual centres of healing and within homes and who need to be included in the discourse that involves supporting their rights and obligations. This dissertation will therefore fill in the lacuna caused by the inadequacy of research works on a comparative analysis of mental health legislations sanctioning civil commitment, specifically standards in preventing abuse of rights by bringing perspectives from the two research developing African nations and the two developed western nations. Understood from this standpoint, this study is an extension of the existing work achieved by scholars in this field.

Thus, South Africa’s is selected because it is an African State and whose Mental Health Care Act “has been hailed as being one of the most progressive in the world in its legislating of human rights for the mentally ill”, meaning it sets out considerable protections to those compulsorily subjected under the Act, making it an appropriate scheme to include in the research.²⁹ Furthermore its citizenry utilize unregulated spiritual and traditional mental health centers for care. The choice of Ghana adds more to the research even though it cannot be conclusively compared to the UK and Ontario.

²⁹ See, Ramlall S., The Mental Health Care Act No 17 –South Africa. Trials and triumphs: 2002-2012, 15 African Journal of Psychiatry 408 (2012).

The choice of Ghana is interesting because of its post-CRPD statute that sanctions civil commitment and the new interesting bit in it that recognizes the role of spiritual and traditional mental health specialists and facilities.³⁰ Bear in mind, abuse and arbitrary detention of persons with mental disabilities is not a new phenomenon in Ghana both in psychiatric hospitals, traditional and spiritual centers of healing.³¹ And in this centres abuse have been going on for long without protection of rights and oversight. Having legislated on this aspect, the Ghanaians have taken a step forward than most African States in setting standards, a positive response to the calls of the CRPD and World Health Organization.³² It also presents a fresh dynamic between conventional psychiatric treatments and spiritual analysis that is beyond the scope of this research. However, the statute does not provide operating standards and since the aim of this thesis is to comparatively examine standards, the substantive and procedural standards from the other three jurisdictions can be recommended for Ghana. This could benefit Ghana and other African States undergoing or intending to undertake legislative changes.

Finally, the jurisdictions are chosen because of their comparative legal system which is common law and the standard language used in these countries is English which is within the author's linguistic capabilities. In addition and since the research will be primarily achieved through library based research and review. The literature about these jurisdictions is more accessible, save for the judicial decisions in Ghana, a lack of which is a limitation for this thesis but can be justified by the novel nature of its legislation.

³⁰ See, Mental Health Act of Ghana 2012, Section 51

³¹ See, Doku V., A Wasu-Takyi & J Awakame, Implementing the Mental Health Act in Ghana: Any Challenges Ahead? 46 Ghana Medical Law Journals 1-10 (2012).

³² See, WHO Regional Committee for Africa, Promoting the Role of Traditional Medicine in Health Systems: A strategy for African Region, AFR/RC50/R3 (9 March 2014). See also, WHO Traditional Medicine Strategy 2014-2013, World Health Organization (2013).

6. Scope and Delimitations

In this dissertation research analyses the substantive and procedural standards in civil commitment processes as set out in the selected countries mental health legislative frameworks and discussed in light of the CRPD article 14 requirements. These processes include admission and treatment, consent and capacity and review and discharge of detention in civil commitment. The goal is to present protective standards that may facilitate in preventing abuse and arbitrary detentions in civil commitment process applicable. The dissertation does not attempt to review in detail the right to legal capacity, community living but reflects on it as far it is connected to standards in civil commitment and as presented in the selected countries legislative scheme including their reservations under the CRPD. The omission of these discussions is because these topics have been covered extensively in other studies, time constraint and space limitation. In addition, psychiatry as a field, psychiatric medication and categorization of mental illness shall not be presented in this study. Due to the number of selected jurisdiction, the dissertation may not be the whole representation of standards in other jurisdictions and what is available out there. This dissertation also does not explore forensic systems as it focuses solely on civil commitment process, however in certain instances judicial decisions brought through forensic stream has been used.

7. Terminology

For the purpose of this dissertation the following recurring terminology and their meanings shall be constituted as such throughout the dissertation:

Arbitrary/arbitrariness; refers to actions “not done according to reason or judgment; depending on the will alone; absolutely in power; capriciously; tyrannical; despotic.....ordinarily, arbitrary is synonymous with bad faith or failure to exercise honest judgment...”³³

³³ See, Henry C. Black, Black’s Law Dictionary, 5th Ed. West publishing Co. (1979).

Consent; means ones voluntary and informed agreement to a proposed treatment, obtained without misrepresentation, deception or duress. This means before consent is given all necessary information about the proposed treatment including risks, potential side effects, alternative treatment options and possible consequence of not receiving the proposed treatment.

Institutions: refers to State operated mental hospital (except specified otherwise), State social care residential facilities, nongovernmental organization-operated residential facilities, including Traditional or spiritual healing centers.

Legal Capacity; refers to what a person can do within the framework of a legal system

Mental Capacity: refers to an individual's decision making ability

Mental disability/persons with disability; Due to the various definition of disability and to avoid repetition, the dissertation chooses to make reference to the subjects of the thesis as “persons with disabilities & mental disability”. This is made in the spirit of the CRPD which provides that- “persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.”

Mental illness/Mental disorder; Due the similarities in definition of mental illness or disorder in the research countries, it shall be referred as “any disorder or disability of the mind”.

Treatment; refers to anything that is done for a therapeutic, preventative, palliative,

Traditional and Spiritual healing centres; are centers often run by traditional or faith healers who practice “healing” techniques involving the use of herbal concoctions, incantations, Quranic oration, chaining and whipping. These centres mainly cater for persons with mental health needs believed to be associated with possession by the devil or evil spirits, bewitchment, bad luck, and bad relationship with the god's thus divine punishment. Individuals in these centres are normally placed there by their families and in some instances voluntarily.

CHAPTER ONE

1.1. The Benchmark: CRPD and Civil Commitment

This chapter introduces the main principles set out in the CRPD article 14 (the right to liberty and Security of persons) that establishes the applicable standards of what entails lawful deprivation of liberty including the surrounding contentious debate. It also presents the perspective of other international instruments as it relates to deprivation of liberty for civil commitment purposes and prevention of unlawfulness and arbitrariness. It presents the discussion in light of the following understanding; civil commitment under specific chosen international and regional instruments, civil commitment in chosen persuasive non-binding international documents and arbitrary detention under international and regional instruments. The author argues that civil commitment is a recognized process that falls within the exceptions of the right to liberty and security of persons as presented in international and regional instruments. The author proposes that international perspectives offer normative frameworks from which authorities can be derived. That, they additionally, recognize and anticipate that limiting the right to liberty presents the risk or challenge of abuse of other rights and arbitrary detentions. In this regard, the normative framework offered is established on the construction that the limitation of the right to liberty is counter balanced with the use of substantive and procedural safeguards.

Thus, to begin the CRPD has been and continues to be described as one of the exiting and successful international developments in the historical endeavour towards the promotion and protection of the rights of persons with disabilities. Never in the history of law has a convention been so widely praised as a landmark convention³⁴ and ground-breaking,³⁵ among other remarkable attributes. The

³⁴ See, UN Press Release: Secretary General Hails Adoption of Landmark convention on rights of People with Disabilities, 13 December 2006, Ref SG/SM/10797, HR/4911, L/T/4400. Available at: www.un.org/News/Press/docs/2006/sgsm10797.doc.htm.

former United Nations Secretary General Kofi Annan described its adoption as “the dawn of a new era-an era in which disabled people will no longer have to endure the discriminatory practices and attitudes that have been permitted to prevail for all too long”.³⁶ Scholars and activists such as Gerald Quinn have also remarked that “it is the single most exciting development to take place in the disability field for many decades [and that] it reflects this ongoing and worldwide process of law reform in the field of disability”.³⁷ Its adoption with its eloquently articulated purpose -“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”³⁸ continues to be strongly welcomed taking into account the historical lacuna in international human rights law on specific treaty focusing on rights of persons with disabilities. Indeed it is a remarkable treaty widely accepted with 163 signatories and in the future more countries are anticipated to join this seismic treaty. The treaty has received considerable activism not only from the initial stage of encouraging States to join and implement it,³⁹ but extended further for example by the CRPD Committee clarification of the underlying values of the convention necessary to facilitate accelerated reforms in national laws through general comment,⁴⁰ guiding principles⁴¹ and various concluding observations on State practice.⁴²

³⁵ See, UN Press Release: Arbour Welcomes Entry into Force of ground-breaking Convention on Disabilities, 4 April 2008. Available at:

www.unhcr.ch/hurricane/hurricane.nsf/view01/1AD533A6AB95F873C1257421003A8DA8?opendocument.

³⁶ See, UN Press Release: Secretary General Hails Adoption of Landmark convention on rights of People with Disabilities, Supra note 34.

³⁷ See, Gerald Quinn, A Short Guide to the United Nations Convention on the Rights of Persons with Disabilities, in Gerald Quinn & Lisa Waddington (eds), European Year Book Of Disability Law, 1 Intersentia Oxford-Portland 90 (2009).

³⁸ See, CRPD (2008) Article 1.

³⁹ See, Comments made by Louise Arbour, “we need to get moving on the implementation now, which means transposing the provisions of the CRPD into national laws [,] changes to the law help speed up changes of attitude.” In UN Press Release: Arbour Welcomes Entry into Force of ground-breaking Convention on Disabilities, Supra note 35.

⁴⁰ See, CRPD Committee on the Rights of Persons with Disabilities, General Comment No. 1: Article 12: Equal recognition Before the Law, CRPD/C/GC/1 (2014).

⁴¹ CRPD Committee, Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities, The Right to Liberty and Security of Persons with Disabilities, Adopted during the Committee’s 14th session, (September 2015).

⁴² See, CRPD (2008), Article 3 on articulated underlying principles: “The principles of the present Convention shall be: (a) Respect for inherent dignity, individual autonomy including the freedom to make one’s own choices, and independence of persons; (b) Non-discrimination; (c) Full and effective participation and inclusion in society; (d) Respect for

This is quite an achievement and no one really seeks to undermine this remarkable achievement. However, even ten years after entering into force, not all pieces fit the puzzle. Scholars continue to fervently debate and provide different interpretation of CRPD articles and its application. At the same time, the CRPD Committee's strong rhetoric in the general comments, guidelines and concluding State observations continue to stir forward thinking yet challenging discussions on its application. For example, the interpretation of article 12-equal recognition before the law in the General Comment 1, the CRPD Committee, rejects predominant notions of mental and legal capacity and intrinsically, calls for the abolition of all forms of guardianship mechanisms or substituted decision making including involuntary hospitalization and treatment under any circumstances without free and full consent.⁴³ One of the controversial topics still debated is the use of the process of civil commitment on some persons with mental health problems. The discussion on this topic is currently and extensively featured in Article 14 by CRPD Committee interpretation.⁴⁴ The article is set out as follows:

1. States Parties shall ensure that persons with disabilities, on an equal basis with others:
 - a. Enjoy the right to liberty and security of person;
 - b. Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.
2. States Parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of this Convention, including by provision of reasonable accommodation.⁴⁵

Realize that the CRPD has no explicit set out provision on the issue of civil commitment or any position regarding forced psychiatric treatment of persons diagnosed with a mental health illness or

difference and acceptance of persons with disabilities as part of human diversity and humanity; (e) Equality of opportunity; (f) Accessibility; (g) Equality between men and women; (h) Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

⁴³ See, CRPD Committee General Comment No. 1, Supra note 40.

⁴⁴ See, CRPD Committee, Guidelines on Article 14 CRPD, Supra note 41. Take note that it is similarly discussed in relation to other rights such as article 3, 5, 12, 16, 17, 19& 25 among others.

⁴⁵ See, CRPD (2008).

problem. The article promotes liberty and security of persons with disabilities however recognizes that the right is not absolute.⁴⁶ Even then, it does not offer guiding principles on permissible grounds of limitation, it requires that in any procedures involving deprivation of liberty, there is an absence of unlawfulness or arbitrariness, the limitation is not based on an existence of a disability and it is not contrary to international human rights standards [this shall be discussed later].⁴⁷ It can be articulated that it leaves a wide margin of appreciation for the States to limit the right provided it is in accordance with international human rights laws, objectives of the convention and with reasonable accommodation.⁴⁸

Oliver Lewis presents the reason for the omission claiming that “the global disability movement fought hard for the CRPD to include an explicit prohibition against psychiatric interventions and the text is quite clear on the prohibition of detention, with article 14 stating that ‘the existence of a disability shall in no case justify a deprivation of liberty’.”⁴⁹ Note however, article 25 on the right to health promotes the right to exercise autonomy in accessing and receiving health care on account of free and informed consent by placing an obligation upon State parties to:

require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care.⁵⁰

As is self-evident from the wordings of the two articles, civil commitment is not articulated and an argument that can be forwarded at this point is that mental health care which is inclusive of psychiatric treatment and care can pass the CRPD standards as long as it is accessed and received on a

⁴⁶ See, *Ibid*, Article 14.

⁴⁷ See, *Ibid*.

⁴⁸ See, *Ibid*.

⁴⁹ See, Oliver Lewis, *The Expressive, Educational and Proactive Roles of Human Rights: An Analysis of the United Nations Convention on the Rights of Persons with Disabilities*, in Bernadette McSherry & Penelope Weller, (eds.), *Rethinking Rights Based Mental Health Laws*, Hart Publishing 103 (2010).

⁵⁰ See, CRPD (2008) Article 25 (d).

voluntary basis. This argument can be substantiated by the currently furnished CRPD Committees “Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities, The Right to Liberty and Security of Persons with Disabilities” (hereafter The Guidelines).⁵¹In view of the central significance of the Guidelines an extended excerpt is appropriate, it states that it:

1 “Reaffirms that the right to liberty and security of persons is one of the most precious rights to which everyone is entitled, including persons with disabilities”⁵²

2. Article 14 is “a non-discrimination provision. It specifies the scope of the right to liberty and security of the person in relation to persons with disabilities, prohibiting all discrimination based on disability in its exercise.”⁵³

3. Absolute prohibition on “practices in which States parties allow for the deprivation of liberty on the grounds of actual or perceived impairment.”⁵⁴ In this regard calls on states parties to repeal all legislations “including mental health laws, [that] still provide instances in which persons may be detained on the grounds of their actual or perceived impairment, provided there are other reasons for their detention, including that they are deemed dangerous to themselves or others. This practice is incompatible with article 14; it is discriminatory in nature and amounts to arbitrary deprivation of liberty.”⁵⁵

4. In connection to the above, “Involuntary commitment of persons with disabilities on health care grounds contradicts the absolute ban on deprivation of liberty on the basis of impairments (article 14(1)(b)) and the principle of free and informed consent of the person concerned for health care (article 25).” Hence, continues to maintain that “States parties should repeal provisions which allow for involuntary commitment of persons with disabilities in mental health institutions based on actual or perceived impairments.”⁵⁶

5. Free and informed consent must be exercised in access to health care, support must be given in the exercise of will and preference of the individual which excludes the determination of best interests and the use of substitute decision making.⁵⁷ “Involuntary commitment in mental health facilities carries with it the denial of the person’s legal capacity to decide about care, treatment, and admission to a hospital or institution, and therefore violates article 12 in conjunction with article 14.”⁵⁸

6. The right in Article 14 “is central to the implementation of article 19 on the right to live independently and be included in the community.”⁵⁹ In this regard, the committee continues to express “its concern about the institutionalization of persons with disabilities and the lack of support services in the community and recommend[s] implementing support services and effective deinstitutionalization strategies in consultation with organizations of persons with disabilities. In addition, it calls for the allocation of more financial resources to ensure sufficient community-based services.”⁶⁰

⁵¹ See, CRPD Committee, Guidelines on Article 14 CRPD, Supra note 41.

⁵² See, Ibid, para 3.

⁵³ See, Ibid, para 4&5.

⁵⁴ See, Ibid, para 6&7.

⁵⁵ See, Ibid, para 6, 10, 13, 14 &15.

⁵⁶ See, Ibid, para 10.

⁵⁷ See, Ibid, para 8, 22 &23.

⁵⁸ See, Ibid, para 8, 10 & 11.

⁵⁹ See, Ibid, para 9.

⁶⁰ See, Ibid para 9.

7. Places of detention, prisons must be accessible and are of humane living conditions.⁶¹ This includes State parties protecting the security and personal integrity of those detained by “eliminating the use of forced treatment, seclusion and various methods of restraint in medical facilities, including physical, chemical and mechanic restrains.”⁶² According to the “the Committee [it]has found that these practices are not consistent with the prohibition of torture and other cruel, inhumane or degrading treatment or punishment against persons with disabilities pursuant to article 15 of the Convention”⁶³

8. In conjunction with article 16 (3)- Freedom from exploitation, violence and abuse) and 33(National implementation and monitoring), States must implement monitoring and reviewing mechanisms which must be accessible to those detained. However, according to the committee “monitoring existing institutions and review of detentions does not entail the acceptance of the practice of forced institutionalization.”⁶⁴

From the above, the prohibitory and abolitionist position on civil commitment can be contended to be discussed within article 14 and within other interlinking rights such as equal recognition before the law(as presented in general comment 1), freedom from torture, right to community living, right to health among other rights. But what are the reasons for the prohibitory viewpoint? The subsequent subheadings provide opposing and supporting reasons respectively with a caveat that the reasons presented may not constitute all.

1.1.1. Opposing Reasons to Compulsory Measures including Civil Commitment

The prohibitory nature of any compulsory measures has many reasons that is centrally inclusive of the purpose of the Convention which establishes a social model of approach to disability,⁶⁵ through “recognizing that disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others.”⁶⁶ The social model of disability is essentially grounded in the notion that a disability is created by the way the society or environ-

⁶¹ See, Ibid, para 12 &17.

⁶² See, Ibid, para 12.

⁶³ See, Ibid.

⁶⁴ See, Ibid, para 19.

⁶⁵ See, CRPD Committee Concluding Observation to Peru, UN Doc, CRPD/C/PER/Co1 (2012), para 6.

⁶⁶ See, CRPD (2008) Preamble (e)

ment is organized rather than by an individual's difference or impairment.⁶⁷ It strongly supports removing obstructions that constrain the life choices of persons with disabilities such as discrimination, with the certainty that when these obstructions are removed, PWDs can be capable of living independently, participate in the society, make their own choices and control their lives on an equal basis with others.⁶⁸ The social approach is promoted in difference from the traditional 'paternalistic' medical model, a model whose methods are considered to limit the self-determination and development of individuals with disabilities by looking at fixing the impairment or difference using medical techniques and other treatments rather than the needs of the person.⁶⁹ Individuals with disability under this model are deprived of their independence and their right to self-determination all together.⁷⁰ Consequently, this explains the very nature of the self-determining rights espoused in the convention,⁷¹ the strong call for governments to deinstitutionalize, to abolish mental health legislation that support coercive measures and create laws that protect and promote the autonomy of persons with disabilities including persons with mental disorders.⁷²

In continuation to the above, Tina Minkowitz provides another prohibitory standpoint by articulating "that article 14 is framed in terms of non-discrimination and is not dealing with separate or spe-

⁶⁷ See, Gabel, S. L., & Peters, S., Presage of a paradigm shift? Beyond the Social Model of Disability toward a Resistance Theory of Disability 19 Disability and Society 571-596 (2004).

⁶⁸ See CRPD (2008) Article 3.

⁶⁹ See, Krahn G and Campbell. VA, "Evolving Views of Disability and Public Health: The Roles of Advocacy and Public Health," 4 Disability and Health Journal 13 (2011).

⁷⁰ See, Ibid, p.12-18.

⁷¹ See, CRPD (2008). These rights include: the right to equal recognition before the law(Art.12),⁷¹ access to justice(Art. 13),⁷¹ right to liberty and security of persons(Art. 14), freedom from torture, inhumane or degrading treatment and punishment(Art.15), freedom from exploitation, violence and abuse(Art.16), right to integrity of person(Art.17), liberty of movement and nationality(Art. 18), living independent and being included in the community(Art.19),⁷¹ personal mobility(Art.20), respect for privacy(Art.22), respect for family life(Art.23), right to education(Art.24), right to health(Art.25), habilitation and rehabilitation(Art.26), right to work and employment(Art.27), right to adequate standard of living and social protection(Art. 28), right to participate in political and public life(Art.29) and right to participate in cultural life, recreation, leisure and sport(Art.30).

⁷² See, Tina Minkowitz, Abolishing Mental health Laws to comply with the Convention on the Rights of Persons with Disabilities, in Bernadette McSherry & Penelope Weller, (eds.), Rethinking Rights Based Mental Health Laws, Hart Publishing 177 (2010).

cial standards that uniquely apply to persons with disabilities.”⁷³Hence, the disability neutral ground ensures that any lawful arrest and detention by the State is undertaken on an equal basis for all individual irrespective of their status.⁷⁴ As is known and as the CRPD Guidelines provides, persons with mental disability are often and selectively detained based on their actual and perceived impairment even when they do not need to be deprived of their liberty for treatment.⁷⁵From this perspective, an absolute prohibition on that ground is justified. A further connecting reason for the objection of civil commitment is the coercive nature of the process, including the treatment that many users, scholars and activists contend that it is counterintuitive to the purpose it seeks to achieve- treatment- since the “one undesired outcome of coercion or its failure is abandonment”.⁷⁶Moreover, the Special Rapporteur on Torture Juan Mendez, in his report on analyses of forms of mistreatment and abuses in health care settings, buttresses the overhead point by pointing out additional reason involving the ills caused and “justified on the basis of health care policies, under the common rubric of their purported justification as “health- care treatment”.”⁷⁷One of these areas where he maintains his justification is the use of mental health policies and legislations that sanction the use of coercive and non-consensual treatment of persons with disabilities in psychiatric institutions, mental health facilities and other social care homes including “religious-based therapeutic boarding schools, boot camps, private residential treatment centers or traditional healing centers”.⁷⁸According to the Rapporteur, deprivation of liberty based on a disability and the practice of coercion,⁷⁹ non-consensual treatments, the use of solitary confinement and prolonged restraint of

⁷³ See, *Ibid.*

⁷⁴ See, *Ibid.*, p.103.

⁷⁵ See, CRPD Committee, Guidelines on Article 14 CRPD, *Supra* note 41, para 6&7.

⁷⁶ See, Michael Dudley, *Mental Health, Human rights, and Their Relationship: An Introduction*, in Derrick Silove & Fran Gale, (Eds.), in *Mental Health Human Rights: Vision, Praxis, and Courage*, Oxford University Press 33& 34 (2012).

⁷⁷ See, United Nations General Assembly, UN Doc, A/HRC/22/53, Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez (2013), para 13.

⁷⁸ See, *Ibid.*, paras 57& 67.

⁷⁹ See, *Ibid.*

persons with disabilities in psychiatric institutions,⁸⁰ are discriminatory in nature,⁸¹ and to the extent they inflict severe pain and suffering they violate the absolute prohibition of torture and cruel, inhuman and degrading treatment (A/63/175, paras. 38, 40, 41).⁸² The Rapporteur's narratives can be substantiated by the use of electroshock treatments which severely impact on the brain, involving complete damage and memory loss.

In connection to the highlighted, an extra strong source for the opposing perspectives is that rooted in the dark history of the medical profession and persons with disabilities. Tina Minkowitz explains that this history "had its peak expression in the eugenics movement that called for sterilization and [that it] culminated in systematic murder during the Nazi era [with] psychiatrists [having been] ac-

⁸⁰ See, *Ibid*, para 63 that states that: "The mandate has previously declared that there can be no therapeutic justification for the use of solitary confinement and prolonged restraint of persons with disabilities in psychiatric institutions; both prolonged seclusion and restraint may constitute torture and ill-treatment (A/63/175, paras. 55-56). The Special Rapporteur has addressed the issue of solitary confinement and stated that its imposition, of any duration, on persons with mental disabilities is cruel, inhuman or degrading treatment (A/66/268, paras. 67-68, 78). Moreover, any restraint on people with mental disabilities for even a short period of time may constitute torture and ill-treatment.⁷⁸ It is essential that an absolute ban on all coercive and non-consensual measures, including restraint and solitary confinement of people with psychological or intellectual disabilities, should apply in all places of deprivation of liberty, including in psychiatric and social care institutions. The environment of patient powerlessness and abusive treatment of persons with disabilities in which restraint and seclusion is used can lead to other non-consensual treatment, such as forced medication and electroshock procedures."

⁸¹ See, *Ibid*, para 20 which describes that: "The mandate has stated previously that intent, required in article 1 of the Convention, can be effectively implied where a person has been discriminated against on the basis of disability. This is particularly relevant in the context of medical treatment, where serious violations and discrimination against persons with disabilities may be defended as "well intended" on the part of health-care professionals. Purely negligent conduct lacks the intent required under article 1, but may constitute ill-treatment if it leads to severe pain and suffering (A/63/175, para. 49)." See also para 32 where further connection is made to the effect that: "The mandate has recognized that medical treatments of an intrusive and irreversible nature, when lacking a therapeutic purpose, may constitute torture or ill-treatment when enforced or administered without the free and informed consent of the person concerned (*ibid.*, paras. 40, 47). This is particularly the case when intrusive and irreversible, non-consensual treatments are performed on patients from marginalized groups, such as persons with disabilities, notwithstanding claims of good intentions or medical necessity. For example, the mandate has held that the discriminatory character of forced psychiatric interventions, when committed against persons with psychosocial disabilities, satisfies both intent and purpose required under the article 1 of the Convention against Torture, notwithstanding claims of "good intentions" by medical professionals (*ibid.*, paras. 47, 48)."

⁸² See, *Ibid*, in para 64 he emphasizes that: "The mandate continues to receive reports of the systematic use of forced interventions worldwide. Both this mandate and United Nations treaty bodies have established that involuntary treatment and other psychiatric interventions in health-care facilities are forms of torture and ill-treatment.⁷⁹ Forced interventions, often wrongfully justified by theories of incapacity and therapeutic necessity inconsistent with the Convention on the Rights of Persons with Disabilities, are legitimized under national laws, and may enjoy wide public support as being in the alleged "best interest" of the person concerned. Nevertheless, to the extent that they inflict severe pain and suffering, they violate the absolute prohibition of torture and cruel, inhuman and degrading treatment (A/63/175, paras. 38, 40, 41). Concern for the autonomy and dignity of persons with disabilities leads the Special Rapporteur to urge revision of domestic legislation allowing for forced interventions."

tive participants in the selection of patients for killing, and euphemized the killing as ‘treatment’.⁸³ Thus, as Minkowitz describes it, the field of psychiatry in particular has been marked by ‘a search for great and desperate cure’ unchecked by the subjective suffering of their patients [and additionally] compromised by its use of legally protected force to compel compliance with treatment and to detain people against their will.”⁸⁴ The Special Rapporteur on Torture sums it all by asserting that these coercive actions may constitute torture, considering that it is “the most serious violation of the human right to personal integrity and dignity,[and] presupposes a situation of powerlessness, whereby the victim is under the total control of another person”.⁸⁵ Factually, “patients in health-care settings [including those receiving psychiatric treatment and care] are reliant on health-care workers who provide them a service”, which predisposes them to the risk of abuse, arbitrary detention including ill treatment and torture.⁸⁶

A further supplementary cause for the dissident to compulsory detention and treatment is well lodged in the relationship between the expansion of disorders, pharmaceutical companies and their influential relationship with psychiatry. The contentions here are that the psychiatric profession and the pharmaceutical industry are in cohorts to profit and experiment. By these assertions it is meant that with the psychiatrists expanding psychiatry or mental disorders through claiming their increase and since the disorders are biologically determined, treatment becomes imperative, consequently paving way for the pharmaceutical industry goals which is not driven by the well-being of person using their medication but profiteering.⁸⁷ Thus, you have unnecessary expansions, provisions and

⁸³ See, Tina Minkowitz, *Abolishing Mental health Laws to Comply with the Convention on the Rights of Persons with Disabilities*, in Bernadette McSherry & Penelope Weller, (eds.), *Rethinking Rights Based Mental Health Laws*, Supra note 72, p.169-170.

⁸⁴ See, *Ibid*, p.103.

⁸⁵ See, Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez, Supra note 77, para 31.

⁸⁶ See, *Ibid*, para 31.

⁸⁷ See, Philip Mitchell, *Psychiatrists and the Pharmaceutical Industry: On the Ethics of a Complex Relationship* in Derrick Silove & Fran Gale, (Eds.), *In Mental Health Human Rights: Vision, Praxis, and Courage*, Oxford University Press 347-358 (2012).

subscriptions of drugs compulsorily without due regard to the side effects of the drugs that have severe outcomes to the people who receive them. This is exacerbated by the allegation of putting profits ahead, than protecting and promoting the wellbeing of persons taking the medication by “minimising the adverse effects of their products” as well as impeding the right to information on their adverse effects and outcomes by minimising the relevant information or completely refusing to publish the outcomes.⁸⁸ Relating additional lines of reasoning here include that some mental illnesses do not need medication, it is not about chemical imbalances in the brain that needs balancing through the use of drugs, medications are unsafe, and that “they present life-limiting outcomes like chronic low functioning, metabolic syndrome and a type of chemical dependency which becomes apparent when a person tries to reduce”.⁸⁹ To end, as Joanna Moncrieff puts it, it is about control, limiting autonomies through medicalizing social problems, and which is sustained by the interests of the psychiatry profession and pharmaceutical industries and not promotion of rights and wellbeing.⁹⁰

An additional and last argument against the compulsory interventions is the use of legislation to oppress and control. In this case a connection with civil commitment is made by the nature of mental health legislations that are premised on the concepts that mental disorders are biologically

⁸⁸ See, Joanna Moncrieff, *Is Psychiatry for Sale? An Examination of the Influence of the Pharmaceutical Industry on Academic and Practical Psychiatry*, Prepared as a MAUDSLEY DISCUSSION PAPER (Published June 2003). Available at: <http://www.critpsynet.freeuk.com/pharmaceuticalindustry.htm>.

⁸⁹ See, Robert Nikkel, *Reflections on Myth Machines, “Mental Illness,” and the Perils of Good Intentions* (Published May 11, 2016). Available in: <http://www.madinamerica.com/2016/05/reflections-myth-machines-mental-illness-perils-good-intentions/>.

⁹⁰ See, Joanna Moncrieff, *Psychiatric Diagnosis as a Political Device*, 8 *Social Theory of Health* 381 (2010). She maintains that: “Pilgrim rightly concludes that the interests of the psychiatric profession and the pharmaceutical industry have helped to sustain the practice of psychiatric diagnosis (Pilgrim, 2007). However, the current analysis suggests there are more fundamental reasons for its survival, as highlighted by theories of medicalization and social control (Conrad, 2009). Psychiatric diagnosis forms a key part of the framework that supports the existing social response to certain problematic behaviours. It is a vital step in the medicalization of social problems. By purporting to indicate the presence of an objectively identifiable bodily disease, psychiatric diagnosis is able to re-designate social problems as medical ones, and the social responses to those problems as medical treatment. By concealing the political nature of the responses to the situations that are labelled as ‘mental illness’, psychiatric diagnosis prevents these responses from being questioned and scrutinized. It allows the state to delegate a difficult area of social policy to supposed technical experts, and thus to remove it from the political and democratic arena.”

caused, are conceptualized as medical diseases within modern diagnostics systems and are treatable.⁹¹ Hence, compulsory measures involving detaining and treating are “presented as serving the best interests of the patient because treatment will restore them to normal functioning [or,] ‘treatment’ that will benefit the individual by alleviating their illness or disorder.”⁹² The counter argument here is that in many cases it is not as such because the issue is whether mental illness is treatable and the fact that for some individual’s experiences it is possible to recover without treatment and to live meaningful life. For this reason it justifies the prohibition of using civil commitment and psychiatric diagnosis. This position is evidentially supported by Robert Van Voren’s analysis on the repression of political dissidents in the soviet society through the use of expanded psychiatric disorders together with civil commitment and its attendants of unavoidable risk of abuse and mistake.⁹³ Other scholars such as Richard Bonnie and Svetlana Polubinskaya accentuate Roberts’ analysis by asserting that the “repression of political and religious dissidents was only the most overt symptom of an authoritarian system of psychiatric care in which expansive and elastic view of mental disorder encompassed all forms of unorthodox thinking, and in which psychiatric diagnosis was essentially an exercise of social power”.⁹⁴

The abridged reasons aforesaid are predominantly on anti-psychiatric sentiments and taken as a whole would without a doubt validate the CRPD Committee’s position. However, for all that, civil commitment in this day and age continues to be a legally and socially conventional means of accessing and providing mental health care and treatment. Supporters of civil commitment have claimed the abolitionist position particularly in light of the CRPD, fails to give an “indication of what an adequate legal landscape would look like following the repeal of such laws—one that would

⁹¹ See, *Ibid*, p. 371.

⁹² See, *Ibid*, p. 375.

⁹³ See, Robert Van Voren, *The Abuse of Psychiatry for Political Purposes* in Derrick Silove & Fran Gale, (Eds.), *In Mental Health Human Rights: Vision, Praxis, and Courage*, Oxford University Press 239-240 (2012).

⁹⁴ See, Richard Bonnie & Svetlana Polubinskaya, *Unravelling Soviet Psychiatry*, 10 *Journal of contemporary Legal Issues*, 284-285 (1999).

protect all people's human rights, including the negative and positive rights of persons with disabilities under the convention."⁹⁵ Unsurprisingly the abolitionist approach is neither a position that State parties are inclined to take considering the continued State practice that can be considered to reflect *opinio juris*.⁹⁶ This practice is not only demonstrated by their legislation but from their protective positions presented as registered reservations on ratifying the convention on the use of compulsory measures, forced interventions and substitute decision making.

In expatiating the above, Australia reservation for example declares that it "understands that the convention allows for compulsory assistance or treatment of persons, including measures taken for the treatment of mental disability, where such treatment is necessary, as a last resort and subject to safeguards".⁹⁷ Other State Parties though having not registered on the aspects, in their periodic reports submitted to the Committee continue to affirm that their mental health laws encompassing provisions on compulsory measures and safeguards are evidence of compliance with the CRPD.⁹⁸ For others, the acceptance is observed by the CRPDs Committees own concluding observations.⁹⁹ It is worth mentioning that some of these legislations are newly enacted, revised post-CRPD and still constitute the same prohibited compulsory measures and substituting decision making mechanisms suggested by the CRPD committee.¹⁰⁰

The obvious question that would arise and considered hereafter is why the tenacity to continue with these legislations and practices that are very much criticized?

⁹⁵ See, John Dawson, A Realistic Approach to Assessing Mental health Laws Compliance with the UNCRPD, 40 International Journal of Law and Psychiatry 79 (2015)

⁹⁶ State practice which is accepted as binding – see Vienna Convention on the Law of Treaties, Article 34.

⁹⁷ See, Texts of Reservation to the CRPD, Available in: https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-15&chapter=4&lang=en.

⁹⁸ See, Texts of Periodic Reports to the CRPD Committee, Available in: http://tbinternet.ohchr.org/_layouts/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=4&DocTypeID=29.

⁹⁹ See, Texts of Concluding Observations by the CRPD Committee, Available in: http://tbinternet.ohchr.org/_layouts/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=4&DocTypeID=5.

¹⁰⁰ See, For Instance Mental Health Legislations of Ghana, Singapore, England & Wales, Canada etc.

1.1.2. Supporting Reasons on Compulsory measures including Civil Commitment

According to scholars and policy makers, the use of such laws and processes by States is justified under the traditional *parens patriae* principle or the power conferred in the States to look after the welfare of those individuals incapable of looking after themselves, in their best interest, especially when there is a likelihood of significant harms to themselves and others.¹⁰¹ This approach is considered paternalistic especially when carried out on persons with mental illness, bearing in mind as mentioned earlier in the text that the formulation of many mental health legislation are grounded in the same notions of presence of mental disorder, risk of harm to self and others, lack of capacity and the unavailability of less restrictive means. Nevertheless, it has been argued that even though it can be considered a heightened form of paternalism particularly to persons with mental illness, “such paternalism is in line with much other medical treatment”.¹⁰²

Additional justification for compulsory measures is constructed on the duty of States in regards to positive and negative rights of individuals. John Dawson in his critique of the CRPD considers its text ambiguous and the CRPD Committees interpretation of the text as it relates to civil commitment and exercise of legal capacity as discussed in general comment one unrealistic.¹⁰³ He contends that “ the text leaves considerable uncertainty as to the circumstances in which negative or positive rights of a person should prevail [,] in particular when are negative rights of a person with disabilities-such as their rights to autonomy, physical and mental integrity, and generally to be free of interference by agents of State-to prevail over their positive entitlements-to full social inclusion and participation, the highest attainable standard of health, and a minimum standard of living- when

¹⁰¹ See, Danny Sullivan & Paul Mullen, Mental Health and Human Rights in Secure Settings, in Derrick Silove & Fran Gale, (Eds.), In Mental Health Human Rights: Vision, Praxis, and Courage, Oxford University Press 287(2012).

¹⁰² See, Ibid.

¹⁰³ See, John Dawson, A Realistic Approach to Assessing Mental health Laws Compliance with the UNCRPD, *Supra* note 95.

those rights conflict?”¹⁰⁴ His critique is generally pointing out that reasonably there are certain circumstances when the interference with certain rights such as autonomy, but within carefully defined conditions and subject to adequate safeguards may lead to the enjoyment of other rights. In connection to involuntary psychiatric treatment, he insists that it “could both limit a person’s autonomy and promote social inclusion, health and standard of living”.¹⁰⁵ He thus forwards the question ‘whether enforcing this compulsory measure would be in violation or promotion of a person’s rights under the convention, and given that in many jurisdictions balancing the two is accomplished through capacity or consent legislations that again promote the exercise of autonomy and also vests power on the State or other individuals to intervene to promote their positive entitlements?’¹⁰⁶ These are the big questions that continue to stir debate. In case of seeking answers from the CRPD Committee, it may be a moot task, considering its negatory standpoint in the Guiding document.

Other scholars such Melvyn Freeman et al, in their reaction to the CRPD Committee’s abolitionist interpretation present the same viewpoints like Dawson, but by relying on the right to life.¹⁰⁷ The claim here is that the conventions article 10 that stipulates that “every human being has the inherent right to life, [and that States] shall take all necessary measures to ensure its effective enjoyment with persons with disabilities on an equal basis”, should trump all other rights when in conflict.¹⁰⁸

¹⁰⁴ See, Ibid, p. 73.

¹⁰⁵ See, Ibid.

¹⁰⁶ See, Ibid.

¹⁰⁷ See, Melvyn 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, 2 *Lancet Psychiatry* 847 (2014).

¹⁰⁸ See, Ibid, 847. They claim verbatim: “Article 10 (right to life) asks States Parties to “reaffirm that every human being has the inherent right to life and shall take all necessary measures to ensure its effective enjoyment by persons with disabilities on an equal basis with others. Despite this affirmation, the General Comment seems to prohibit attempts to prevent suicide of a person with mental disability by family, communities, or clinicians if these attempts include admission or treatment without consent. In some cases, this limitation would close viable options for saving lives and is especially tragic where the suicidal ideation is directly linked with impaired decision-making capacity and could have been changed through admission or treatment. In the event that a life could be saved from suicide, we submit that the Committee’s assertion that involuntary treatment should never be allowed is wrong. Similarly, in rare instances others might be harmed or their lives taken in select circumstances, whereas admission or treatment of a person with mental disability might prevent this. When there is a conflict between different rights, the right to life should trump other rights.”

The reasoning here is that if an individual for example attempts to commit suicide, clinicians, family members or communities should be able to intervene even if it means compulsory admission or treatment without consent. For these scholars, the CRPD Committees prohibitory position of non-interference and inapplication of compulsory measures in such situations where lives could be saved is flawed.¹⁰⁹ Furthermore, they broaden their argument for compulsory measures in some circumstances by asserting that the interpretation by the CRPD Committee, does not favour the advocacy against discrimination and stigma. Their persuasive analysis in this regard is that the general comment (No. 1 on article 12) prohibiting compulsory measures in hospitals or institutions of mental health care or interventions using substitute decision making, may have the “unintended consequences of public calls for the locking up of people with mental disabilities or human rights violations of untreated persons with severe mental illness in the community, [even though] the best available evidence-based intervention to reduce stigma is social contact with people with mental illness, [and] contact with people with untreated, severe mental illness might well have the opposite effect”.¹¹⁰ Like Dawson, they prudently emphasize that with such strong views by the Committee, “the impact of the Convention might indeed be paradoxical and instead of enhancing human rights, several fundamental rights, such as the enjoyment of the highest attainable standard of health, access to justice, the right to liberty, and even the right to life, might instead be violated and subject to unintended consequences”.¹¹¹

In a further connection to the above, moral obligations and *parens patrie* powers can be observed to rationalize involuntary measures in the Drafting of the General Comment No.1 by various commentators (users, human rights institutions, individuals and Member States). It should be noted that the CRPD’s opinion in the draft is reflected in the current final copy and it is in disregard of these

¹⁰⁹ See, Ibid.

¹¹⁰ See, Ibid.

¹¹¹ See, Ibid, p.844.

contributions.¹¹² Therefore, if a look is given to some of the contributions there are two aspects emerging, one is the recurring acclaim for the CRPD as a platform of condemning and remedying serious abuses, the humiliating and distressing aspect of civil commitment processes, recognition and admonition of the historic abuses perpetrated by members of the medical profession and the promotion of the rights of persons with disabilities through the exercise of their right to autonomy in all aspects of their lives(including mental health). The second aspect emerging is the support for compulsory measures within circumscribed situations and with due respect to safeguards as equally considered by the aforementioned scholars. Most of the contributors to the text were concerned with the taken position to the point that others termed it absolutist in nature for ruling out interventions when necessary and taking “this absolutist approach [which] appears to base the minimum acceptable standard on the maximum desired conduct, rather than taking a more pragmatic approach which reflects the state of *opinio juris*,¹¹³ the complexity of the issues and the emerging nature of supportive decision making regimes.”¹¹³ Others basically asserted that the position “goes against a widely held moral intuition that sometimes others ought to step in when a person who is clearly unable to make a judgement about their predicament is faced with a serious threat to his or her well-being”.¹¹⁴ Many relied on the provisions of other instruments and asserted that the position taken by the Committee in the Draft that “states that all forms of forced treatment by psychiatric professionals violate of the CRPD” is inconsistent with other international and regional human rights instruments, including national legislations that have tried and continue to try to develop hu-

¹¹² See, CRPD Committee on the Rights of Persons with Disabilities, General comment No.1, Supra note 40.

¹¹³ See, Joint submission from the Equality and Human Rights Commission, the Equality Commission for Northern Ireland, the Northern Ireland Human Rights Commission and the Scottish Human Rights Commission, UN Committee on the Rights of Persons with Disabilities, Draft General Comment on Article 12, (28th February 2014), p.4. Available at: <http://www.ohchr.org/EN/HRBodies/CRPD/Pages/DGCArticles12And9.aspx>.

¹¹⁴ See, The Danish Institute for Human Rights, Drafts General Comment to Article 9 and 12, (21 February 2014), p.2. Available at: <http://www.ohchr.org/EN/HRBodies/CRPD/Pages/DGCArticles12And9.aspx>.

See also, Swedish National Association for Social and Mental Health (RSMH), Reflections upon the Draft prepared by the Committee on the Rights of Persons with Disabilities in the form of General Comment on the Convention of Rights of Persons with Disabilities Article 12: Equal recognition before the law, (19 February 2014), p.2. They concur that: “in our view, under some circumstances an unacceptable level of risk for the individual with seriously diminished mental capacity in the exercise of full agency to the point of self-harm or the right to veto necessary decisions when *periculum in mora*.”

man rights based approaches to their legislations.¹¹⁵ Relatedly, and equally reacting to the ills of the medical profession presented earlier as a position of opposition to compulsory measures, some commentators provided a reminder that “while recognising historic abuses perpetrated by members of the medical profession it should not be overlooked that these professionals also have much to offer people with disabilities.”¹¹⁶

Indeed the medical profession and professions should be acknowledged for their work taking into account that not all are “leviathans”. This aspect presumably opens the discussion on social model and medical model of disability, and the importance of the latter, which is at the centre of the debate of using compulsory measures as they are intrinsically connected. The importance of the medical model of disability, is essentially an abstract traditional model relied upon to address the needs of persons with disabilities by focusing on biological realities of impairment which acts as the central preliminary point of reference and decision making.¹¹⁷ “Biological reality is taken to be the foundation of all forms of illness and impairment whether “mental” or “physical”.”¹¹⁸ As such the required rehabilitation process principally focuses on improving the functional limitation of an individual’s everyday activities and tries to “find ways of preventing, curing or caring for disabled people” including use of compulsory measures.¹¹⁹ Scholars who are in support of this model, do not oppose the actuality that disability can be socially constructed and contributed by the medical model itself,¹²⁰ but they counterbalance the same by asserting disability cannot be only construed as a

¹¹⁵ See, Ibid, p.2. Available at: <http://www.ohchr.org/EN/HRBodies/CRPD/Pages/DGCArticles12And9.aspx>.

¹¹⁶ See, University of Cambridge, Cambridge Intellectual & Developmental Disabilities Research Group, Draft General Comment on Article 12 of the Convention (31st January 2014), p.3. Available at: <http://www.ohchr.org/EN/HRBodies/CRPD/Pages/DGCArticles12And9.aspx>.

¹¹⁷ See, Gareth Williams, *Theorizing Disability* in Gary Albrecht, Katherine Seelman & Michael Bury et al., *Handbook of Disability Studies*, Sage Publication London 123 (2001)

¹¹⁸ See, Ibid, p.125.

¹¹⁹ See, Deborah Marks, *Models of Disability, Disability and Rehabilitation* 85-91 (1997).

¹²⁰ See, Dimitris Anatsiou & James Kauffman, *The social Model of Disability: Dichotomy Between Impairment and Disability*, 38 *Journal of Medicine and Philosophy* 444 (2013). They state that: “they ‘do not reject the general idea that a supposed disability condition can be entirely a social construct[because] in the past ignorance, intolerance, prejudice, and political expediencies led to the abuse of others justified by concepts such as the drapetomia (the supposed mental

social construct,¹²¹ because from contemporary scientific constructs of disabilities such as in cases of autism, deafness, physical disabilities and speech impairments, justifiable truthful evidence of biological components are made.¹²² In the criticism of the social model, scholars like Shakespeare and Watson contend that having a social construct delinks and denies the biological function in disability and in doing so it actually fails short of understanding the complexities of the lives of persons with disabilities.¹²³ It also rejects the distinctiveness of individual's biology and psychology which establishes the defining characteristics of certain disabilities(cognitive), that forms the everyday experiences of persons with disabilities and forms the relationship between society and biology.¹²⁴ The argument here is that for many people with disabilities, their mental or physical concerns constitute an important fragment in their sense of identity, and explicates on the several constraints they encounter.¹²⁵

Adam Samaha, in support of the above gets specific and points out that social or environmental changes cannot remedy all societal disability conditions because "severe pain or constant hallucinations are surely felt by their victims, usually with negative impact [and] these experiences can at most be ameliorated but not eliminated by adjustments to environments".¹²⁶ These experiences can be ameliorated with proper therapeutic treatments and care. Even though some mental disorders cannot be cured they can be managed through support and care. In this respect, majority of these scholars agree that there must be an inclusive and holistic approach that takes into account both aspects of social and medical, with the majority referring to the existing approach taken by the

disease that makes slaves run away from their masters and sometimes by social attitudes toward a concept e.g. homosexuality once considered the love that dare not speak its name and once considered a psychiatric disorder."

¹²¹ See, Ibid.

¹²² See, Mario Bunge, *Chasing Reality: Strife over Realism*, University of Toronto Press Canada (2006).

¹²³ See, Tom Shakespeare & Nicholas Watson, *The Social Model of Disability: An Outdated Ideology*, 2 *Research in Science and Disability* 9-28 (2002).

¹²⁴ See, Michael Palmer & David Harley, *Models and Measurements in Disability: An International Review*, Oxford University Press 358-359 (2011).

¹²⁵ See, Ibid, p.358.

¹²⁶ See, Adam Samaha, *What Good is the Social Model of Disability*, 74 *The University of Chicago Law Review* 1256 (2007).

World Health Organization International Classification of Functioning, Disability and Health (ICF).¹²⁷ The ICF proffers a synthesis of the social and medical disability models with the objective of presenting “a coherent view of three different perspectives on health: biological, personal, and social”.¹²⁸ This inclusive relational approach presented by the ICF has supporters such as Nenad Kostanjsek who emphasizes that:

‘Second generation’ classification, ICF is concept driven. Apart from classifying the universe of disability, ICF also provides a conceptual framework for understanding disability. At the core of the ICF concept of health and disability is the notion that disability is a multi-dimensional and universal phenomena placed on a continuum with health. Human functioning is understood as a continuum of health states and every human being exhibits one or another degree of functioning in each domain, at the body, person and society levels. ICF conceptualizes disability not solely as a problem that resides in the individual, but as a health experience that occurs in a context. Disability and functioning are, according to the ICF model, outcomes of interactions between health conditions (diseases, disorders and injuries) and contextual factors. The bio-psychosocial model embedded in the ICF broadens the perspective of disability and allows medical, individual, social, and environmental influences on functioning and disability to be examined.¹²⁹

The above approach is welcomed, yet how far it can be used to balance conflicting rights and at the same time ameliorate suffering is to be determined. To finalize the argument for the use of civil commitment, it is worth mentioning the position of the medical professions themselves given that many of the discussed arguments mention the ills committed under their care. To explain, reference is made to the joint statement of the American Psychiatric Association and World psychiatric Association in response to the Special Rapporteurs on Torture Juan Mendez, which “focused on –certain abuses in health care settings that may constitute forms of torture or cruel, inhuman degrading

¹²⁷ See, World Health Organization (WHO), International Classification of Functioning, Disability and Health, Geneva (2001).

¹²⁸ See, Han Magnus Solli & Antonio Barbosa Da Silva, The Holistic Claims of the Biopsychosocial Conception of WHO’ s International Classification of Functioning, Disability, and Health (ICF): A Conceptual Analysis on the Basis of a Pluralistic – Holistic Ontology and Multidimensional View of the Human being, 37 *Journal of Medicine and Philosophy* 278 (2012).

¹²⁹ See, Nenad Kostanjsek, Use of The International Classification of Functioning, Disability and Health (ICF) as a Conceptual Framework and Common Language for Disability Statistics and Health Information Systems, 11 *BMC Public Health* 2 (2011).

treatment or punishment”.¹³⁰The associations in their written response to the report showed concern that the Rapporteurs definition of torture as encompassing compulsory measures including civil commitment may “be detrimental to the interests of individuals with serious mental disorders, and likely to cause serious harm to the very groups it intends to protect.”¹³¹Note that this may not represent the views of all medical professionals, for there are some who oppose compulsory measures.

Briefly, the two associations according to their statement acknowledge the use of compulsory measures including the use of civil commitment, substitute decision making mechanisms and other accepted legal mechanisms and use of restraints where absolutely necessary, implemented within the shortest time possible and with regard to protections.¹³²Their line of reasoning is akin the various views above, as they recognize that therapeutic treatments including involuntary psychiatric intervention when, “used in appropriate circumstances and when medically indicated, can restore the functional and decisional capacity of persons with severe psychiatric disorders, and can protect them and others from the behavioral consequences of their conditions”.¹³³Hospitalization or institutionalization of persons with psychiatric disorders [those who qualify according to the criteria’s and when unavoidably imperatively] is also acceptable since it can be life-saving and can facilitate the

¹³⁰ See, American Psychiatric Association & World Psychiatric Association Joint Response Letter to the Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez, UN Doc, A/HRC/22/53 (2013). Available at: http://antitorture.org/wp-content/uploads/2014/05/12a_APA-WPA-Joint-Response-on-Torture.pdf

See also, Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez, Supra note 77.

¹³¹ See, American Psychiatric Association & World Psychiatric Association Joint Response Letter to the Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez, , Supra note 130, p.1. They State that: “The **American Psychiatric Association (APA)** and the **World Psychiatric Association (WPA)** are providing a joint statement in response to the report of Special Rapporteur on Torture (A/HRC/22/53), Juan E. Mendez, submitted to the 22nd Session of the United Nations’ Human Rights Council (UNHRC). Mr. Mendez’s report focused on —certain forms of abuses in health-care settingsl that may constitute forms of torture or cruel, inhuman or degrading treatment or punishment. The APA and WPA wish to express great concern regarding the possibility of the definition of —torturel encompassing a range of practices employed by psychiatrists, including (1) the use of involuntary civil commitment, (2) the provision of treatment delivered under the auspices of guardianship and other currently accepted legal processes, and (3) the use of restraint. The APA and WPA are greatly concerned that the adoption of these perspectives and recommendations may be detrimental to the interests of individuals with serious mental disorders, and likely to cause serious harm to the very groups it intends to protect.”

¹³² See, Ibid, p.2-6.

¹³³ See, Ibid, p. 3&4.

resulting effect of restoring a person with ability to direct his or her life.¹³⁴ Once again, this argument can be seen to be rationalized by the supremacy of the right to life over others as other scholars have done.

The joint association furthermore addressed the recurrent issue of paternalism and iniquitous intentions of interventions that many including the Special rapporteur and the CRPD Committee have linked it to involuntary psychiatric interventions in healthcare settings and constituted them as forms of torture or ill treatment, by totally disagreeing with this perception.¹³⁵ They claim psychiatry professionals have a social contract with humanity in which the respect and protection of the patient comes first.¹³⁶ Moreover, it is a profession with a duty in public health relating to prevention of diseases and harm, as such the duty of intervention forms part of their vocation with the 'psychiatric profession taking a leadership role in prevention, diagnoses and treatment of als.'¹³⁷ This role is inclusive of applying appropriate psychiatric knowledge and practice, including taking in a patients 'biopsychosocial factors in their assessment' and ensuring abuse of psychiatry is avoided by shunning any 'morally illegitimate organizational social or political objectives', by reporting the abuse and having it reviewed and penalized.¹³⁸ Hence, with all these, the associations continue to maintain that compulsory measures are essential and called upon the rapporteur to reconsider his definition,¹³⁹ and to ensure that the promotion of the rights of individual with psychiat-

¹³⁴ See, Ibid.

¹³⁵ See, Ibid, p. 3.

¹³⁶ See, Ibid, p. 8&9.

¹³⁷ See, Ibid.

¹³⁸ See, Ibid, p.7, 8 &9.

¹³⁹ See, Ibid, p. 4 where they argue: "There is disagreement with the conclusion of the last two sentences of paragraph 68 regarding the abolishment of institutionalization legislation. The hospitalization of persons with psychiatric disorders can be life-saving, and result in restoring a person with the ability to direct his or her own life..... There is disagreement with the statement that the —severity of...mental illness is not by itself sufficient to justify detention. It should be noted that the severe impairment and suffering as a result of mental illness can be an appropriate basis for involuntary hospitalization. There also seems to be some inconsistency with the statement in paragraph 68 calling for the —repeal of provisions authorizing institutionalization and paragraph 69 which states that institutionalization is unacceptable —if its basis is discrimination or prejudice against persons with disabilities. This may leave the door

ric disorders are guaranteed by encouraging countries to develop clear guidelines on the use of compulsory interventions, development of procedures designed to safeguard rights such as judicial review of requests and executions of incapacity and civil commitment ,including measures to investigate and penalize any abuses.¹⁴⁰

To sum up this discourse on civil commitment, it appears that the pendulum continues to swing between the CRPD absolutism and abolitionist interpretation of involuntary measures given by the CRPD Committee in contrast to the qualified and supportive position of member States of both autonomy and compulsory interventions. When the pendulum will stop is a matter of waiting yet in the meantime, protection of rights and access to mental health care has to be balanced. It can be balanced through addressing this constant emerging issue of misuse of compulsory measures and psychiatric abuse by directing implementation of measures that provide effective protections. This aspect essentially solidifies the importance and reason for this research, since its objective is to ascertain standards that can be useful in combating abuse and arbitrary detentions in civil commitment processes. With the understanding that the above presentation was sufficient to make an introduction on civil commitment and surrounding debate, it would be appropriate to bring it in together by providing an understanding of what the thesis refers to abuse and arbitrariness in deprivation of liberty in the coming section.

open to the use of involuntary hospitalization when —necessary to protect the safety of the person or others| after this notion was apparently rejected in the previous paragraph.”

¹⁴⁰ See, Ibid, p.7. Here they state: “that involuntary interventions for psychiatric disorders be recognized as appropriate when persons are incapable of making decisions about their treatment and/or present a serious risk of harm to themselves or other people, and when no less intrusive means are likely to be effective”.

1.2. Civil Commitment in Other International and Regional Human Rights Instruments

At this juncture it is anticipated that the above discussion has offered a basic understanding of the civil commitment process, the contentious debate surrounding its application and most importantly, the benchmark perspective underscored in the CRPD and expounded by the CRPD's Committees definite unambiguous interpretation of article 14. Following this, the thesis transitions into examining what arbitrary deprivation of liberty constitutes in light of the right to liberty, right to health and freedom from torture as they correlate with civil commitment within other international and regional instruments that have existed before the CRPD. International law is a fundamental source of law that represent the will, legal obligation of nations, and current trend in various fields of law. Human rights legal obligations and trends in various regional and/or national jurisdictions are informed by international human rights law which forms part of international law through public international law branch.¹⁴¹ Like any other branch of international law, its formal sources are regulated by State consent and the list articulated in article 38 (1) of the statute of the International court of Justice (ICJ).¹⁴² This includes 'conventions, international custom, general principles of law recognized by civilized nations, teachings of most highly qualified publicists of various nations and judicial decisions and teachings of the most highly qualified publicists of the various nations, as a subsidiary means for the determination of the rule of law'.¹⁴³

Accordingly, current international human rights law, standards and practices essentially draw from international and regional treaties entered into by consent of States through accession or ratification and by depositing of the ratified or acceded instrument with the relevant body, such as with the

¹⁴¹ See, Christine Chinkin, International Law Sources in Daniel Moeckli, Sangeeta Shah & Sandesh Sivakumaran (eds.), International Human Rights Law, Oxford University Press 75 (2014).

¹⁴² See, Javaid Rehman, International Human Rights Law, 2nd Ed Pearson Education Limited 19 (2010).

¹⁴³ See, Statute of the International Court of Justice, (1945), Article 38 (1)

United Nations Secretary General for United Nations human rights treaties (hereafter UN).¹⁴⁴In addition to the formal sources mentioned above, there other forms of subsidiary human rights law (also known as soft law) such as resolutions of international organizations such as the United Nations Human Rights Council, general comments and statements of UN treaty bodies.¹⁴⁵These instruments though law, are mostly persuasive and not binding. In the human rights field, just like the formal sources that are hugely derived from the UN human rights regime, so are soft sources such as general comments from specialized UN treaty committees that remain very fundamental in assisting States in the interpretation of human rights treaty obligations during implementation. An example is the CRPD Committees general comment one already mentioned. In the course of this chapter both formal sources and subsidiary sources relating to the subject at hand shall be engaged.

The end objective of this analysis is to consider current perspectives by asking the question whether international human rights law promotes the use of involuntary commitment of individuals with mental disability and if yes what are the parameters and authorities that can be derived? Moreover, this inquiry is done in view of two issues. The first is that the CRPDs preamble recalls other international human rights treaties that have jurisprudence on the matter at hand.¹⁴⁶The second is that in the presentation on support for compulsory interventions, recognition was given to other international and regional human rights law instruments that acknowledge these measures and are continuously applied by State Parties alongside the CRPD despite its unambiguous abolitionist stand-

¹⁴⁴ See, Christine Chinkin, International Law Sources in Daniel Moeckli, Sangeeta Shah & Sandesh Sivakumaran (eds.), International Human Rights Law, Supra note 141, p.77.

¹⁴⁵ See, Ibid, p. 90-93.

¹⁴⁶ See, CRPD (2008), preamble (d). It states: “(d) Recalling the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, the International Convention on the Elimination of All Forms of Racial Discrimination, the Convention on the Elimination of All Forms of Discrimination against Women, the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, the Convention on the Rights of the Child, and the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families,”

point.¹⁴⁷ The discussion on these rights shall be presented in two ways, through the lens of international formal and secondary instruments and secondly through the perspectives of the regional instruments. Conclusions shall be drawn in the ending.

1.2.1. Civil Commitment and The Right to liberty and Prevention of Arbitrary Detention

The right to liberty and security of persons is a right embedded in various international, regional and national legal instruments. Its purpose is to guarantee the enjoyment of this right and to conversely prohibit against arbitrary deprivation of liberty and security of a person.¹⁴⁸ It should be noted straightaway that the substantive analysis of this right is presented comparatively in three perspectives, initially by examining the approach of the International Covenant on Civil and Political Rights article 9 (hereafter ICCPR).¹⁴⁹ Then by considering regional instruments that include the European Convention on Human Rights and Fundamental Freedoms (hereafter ECHR),¹⁵⁰ African

¹⁴⁷ See, Joint submission from the Equality and Human Rights Commission, the Equality Commission for Northern Ireland, the Northern Ireland Human Rights Commission and the Scottish Human Rights Commission, UN Committee on the Rights of Persons with Disabilities, Draft General Comment on Article 12, *Supra* note 113, p.6. See Also, The Danish Institute for Human Rights, Drafts General Comment to Article 9 and 12, *Supra* note 114.

¹⁴⁸ See, Article 9 of the Universal Declaration of Human Rights (1948) article 9 of the International Covenant on Civil and Political Rights, Article 14 of the CRPD (2008), Article 16 of the Convention on the Protection of the Rights to Migrant Workers(1990), and Article 7 of the Declaration on the Rights of Indigenous Peoples(2007). Regional instruments such as the (1953) European Convention on Human Rights article 5 extensively articulates on this right, the (1986) African Charter on Human and Peoples Rights (African Charter or ACHPR) under Article 6, the American Convention on Human Rights (The America Convention or ACHR) under Article 7(1978), The (2008) Arab Charter on Human Rights(Arab Charter) under article 14 and the Charter of Fundamental Rights of the European Union provides for it under article 6(2000/C 364/01). In addition to these, there other soft law instruments that function to particularize upon the implications of the UN General Assembly Principles for the Protection of Persons with Mental illness and the Improvement of Mental Health Care (MI Principles)(1991), UN Basic Rules for the Treatment of Prisoners GA Res45/111 (1990), UN Body Principles for the Protection of all Persons under any Form of Detention or Imprisonment GA Res 43/173 (1988), UN Rules for the Protection of Juveniles Deprived of their Liberty GA Res 45/113 (1990) The Inter-American Commission of Human Rights Principles and Best Practices on the Protection of Persons Deprived of Liberty in the Americas OEA/Ser/L/V/II.131 doc 26 (2008), and the Council of Europe Minimum Rules for the Treatment of Prisoners Res (73)5 (1973). It is also noteworthy to mention General comments such as General comment No.8 and General comment No.35 articulated by the Human Rights Committee on the right to liberty (UN Human Rights Committee, General comment 8, HRI/GEN/1/Rev.9 (Vol I) (1982) & UN Human Rights Committee, General Comment 35, CCPR/C/GC/35 (16 December 2014) and those deliberations by the Working Group on Arbitrary detention, a body created by the UN Commission on Human Rights in 1991 with a mandate to consider communications involving possible situations of arbitrary detention(See CHR Res 1991/42 (5 March 1991) & UN General Assembly, Report of the Working Group on Arbitrary Detention: United Nations Basic Principles and Guidelines on Remedies and Procedures on the Right of Anyone Deprived of Their Liberty to Bring Proceedings Before a Court, A/HRC/30/37 (July 6th 2015).

¹⁴⁹ See, International Covenant on Civil and Political Rights (1976).

¹⁵⁰ See, The European Convention on Human Rights and Fundamental Freedoms (1953).

Charter on Human and Peoples Rights (African Charter or ACHPR) under Article 6¹⁵¹ and American Convention on Human Rights (Hereafter America Convention or ACHR).¹⁵² And the final analysis from the persuasive jurisprudence of the United Nations Working Group of Arbitrary Detention and UN General Assembly Principles for the Protection of Persons with Mental illness and the Improvement of Mental Health Care (Hereafter MI Principles)¹⁵³. This means therefore that the thesis limits itself to the aforementioned key instruments.

1.2.1.1. International Instrument: The ICCPR

Accordingly the **ICCPR** guarantees civil and political rights to every individual regardless of their status through recognizing that all people are equal before the law and are entitled to the equal protection of the law.¹⁵⁴ States Parties to the covenant under article 2 are obligated ‘to respect and ensure the rights recognized by the covenant have immediate effect [and] to adopt legislative, judicial, administrative, and educative and other appropriate measures in order to fulfil their legal obligations.’¹⁵⁵ Furthermore, the covenant obliges Member States to provide mechanisms to investigate violations of individual’s rights and to offer reparations to those whose rights have been violated.¹⁵⁶ State Parties are also required to make reports on the implementation of the covenant rights to the Human Rights Committee.¹⁵⁷ The treaty does not mention disability as a protected right or mental health, but provides certain rights that are interlinked.¹⁵⁸ Monitoring and implementation of these

¹⁵¹ See, African Charter on Human and Peoples Rights (1986).

¹⁵² See, American Convention on Human Rights (1978).

¹⁵³ See, UN General Assembly Principles for the Protection of Persons with Mental illness and the Improvement of Mental Health Care (1991) & See, CHR Res 1991/42 (5 March 1991) & UN General Assembly, Report of the Working Group on Arbitrary Detention: United Nations Basic Principles and Guidelines on Remedies and Procedures on the Right of Anyone Deprived of Their Liberty to Bring Proceedings Before a Court, A/HRC/30/37 (July 6th 2015).

¹⁵⁴ See, ICCPR (1976).

¹⁵⁵ See, General comment No. 31: The Nature of the General Legal Obligation Imposed on States Parties to the Covenant in Compilation of General of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, UN Doc HRI/GEN/1/Rev.9 (Vol. I) 27 (May 2008), p. 243, paras 5&7.

¹⁵⁶ See, Ibid, p. 243, paras 16.

¹⁵⁷ See, Ibid, p.242, para 1-6.

¹⁵⁸ See, ICCPR (1976) in articulated rights as the right to life(Art. 6), freedom from torture and cruel, inhuman, or degrading treatment or punishment and non-consensual medical or scientific experimentation(Art.7), right to liberty and security of the person(art.9), and the right to recognition as a person before the law (Art.16) .

rights are undertaken by the UN Human Rights Committee.¹⁵⁹ Under the ICCPR first optional protocol, individuals are empowered to seek redress for any covenant violations from the Committee, however, this mechanism is only available to individuals whose States have ratified the convention.¹⁶⁰ In addition to the protections offered through monitoring and implementation of the covenant by the Committee, further protection is provided through the interpretation guidelines of relevant covenant provisions produced by the Committee which become part of soft law previously stated such as General Comment 35, concluding observations and annual reports.¹⁶¹

The right to liberty, security of person and prohibition of arbitrary detention are proscribed in article 9.¹⁶² The right to liberty which essentially means “liberty of person concerns freedom from confinement of the body, not a general freedom of action [and] security of person concerns freedom from injury to the body and the mind, or bodily and mental integrity” is a guarantee to every person irregardless of their status.¹⁶³ Inversely, the right is not absolute.¹⁶⁴ The “idea is that no one should

¹⁵⁹ See, ICCPR (1976) Articles 28-43.

¹⁶⁰ See, ICCPR Optional Protocol Adopted by General assembly Resolution 2200A (XXI) (16 December 1966) (1976) article 1-5.

¹⁶¹ See ICCPR (1976) Articles 44&45 & Optional protocol article 6. See also, Compilation of General of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, UN Doc HRI/GEN/1/Rev.9 (Vol. I) 27 (May 2008), p.178, 179, 195 & 202 respectively For general comment number 20 discusses article 7 on Prohibition of torture or cruel, inhuman or degrading treatment or punishment.¹⁶¹ General comment number 8 provides interpretation guidelines on article 9 which is on the right to liberty and security of persons, general comment 18 on non-discrimination, and general comment number 21 provides content on article 10, humane treatment of person deprived of their liberty. These general comments are relevant to persons with mental disability that provides guidelines on the application of some provisions and which indicate the position of the committee relevant to establish international standards –and relevant for this thesis.

¹⁶² See, ICCPR (1976), Article 9 states “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. 2. Anyone who is arrested shall be informed, at the time of arrest, of the reasons for his arrest and shall be promptly informed of any charges against him. 3. Anyone arrested or detained on a criminal charge shall be brought promptly before a judge or other officer authorized by law to exercise judicial power and shall be entitled to trial within a reasonable time or to release. It shall not be the general rule that persons awaiting trial shall be detained in custody, but release may be subject to guarantees to appear for trial, at any other stage of the judicial proceedings, and, should occasion arise, for execution of the judgement. 4. Anyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings before a court, in order that that court may decide without delay on the lawfulness of his detention and order his release if the detention is not lawful. 5. Anyone who has been the victim of unlawful arrest or detention shall have an enforceable right to compensation.”

¹⁶³ See, ICCPR (1976) Article 9 (2) & UN Human Rights Committee, General Comment 35: Article 9(Liberty and security of person) CCPR/C/GC/35 (2014), para 3&9. See also, Human Rights Committee General Comment 8, HRI/GEN/1/Rev.9 (Vol I) (1982), para 1.

be deprived of their liberty; however there may be valid reasons for a State to assume custody of an individual".¹⁶⁵ Even then, deprivation of liberty must be achieved in a lawful manner without arbitrariness in accordance with the due process of law dependent on, condition of detentions, lawful challenge and periodic review. The covenant does not provide an exhaustive list of permissible reasons for depriving an individual's liberty, what it expressly recognizes is the detention on criminal charges upon arrest and prohibition of imprisonment based on inability to fulfil contractual obligation under article 11.¹⁶⁶ Regardless of the non-inclusion, the Human Rights Committee in its recent interpretation of this right in General Comment 35, includes involuntary hospitalization in its expanded list of those ground that may constitute permissible exceptions as follows:

Deprivation of liberty involves more severe restriction of motion within a narrower space than mere interference with liberty of movement under article 12.2 Examples of deprivation of liberty include police custody, *arraigo*, remand detention, imprisonment after conviction, house arrest, administrative detention, involuntary hospitalization, institutional custody of children and confinement to a restricted area of an airport, as well as being involuntarily transported. They also include certain further restrictions on a person who is already detained, for example, solitary confinement or the use of physical restraining devices. During a period of military service, restrictions that would amount to deprivation of liberty for a civilian may not amount to deprivation of liberty if they do not exceed the exigencies of normal military service or deviate from the normal conditions of life within the armed forces of the State party concerned.¹⁶⁷

These enumerated grounds are not exhaustive but constitute the most widespread practices. In lieu of this fact and in the expectation that enjoyment of the right to liberty may be restricted it is also foreseeable that protective frameworks must be in place to guarantee that arbitrary detentions do not occur. The Committee emphasizes that "other regimes involving deprivation of liberty must also be established by law and must be accompanied by procedures that prevent arbitrary detention

¹⁶⁴ See, UN Human Rights Committee, General Comment 35: Article 9(Liberty and security of person) CCPR/C/GC/35 (2014), para 10. It states: "The right to liberty of person is not absolute. Article 9 recognizes that sometimes deprivation of liberty is justified, for example, in the enforcement of criminal laws. Paragraph 1 requires that deprivation of liberty must not be arbitrary, and must be carried out with respect for the rule of law."

¹⁶⁵ See, Sangeeta Shah, *Detention and Trial in Daniel Moeckli, Sangeeta Shah & Sandesh Sivakumaran (ed.), International Human Rights Law*, 2nd ed. Oxford University Press 260 (2014).

¹⁶⁶ See, ICCPR (1976), Art. 9 & 11. See also, UN Human Rights Committee, General Comment 35, *Supra* note 163, para 14.

¹⁶⁷ See, UN Human Rights Committee, General Comment 35, *Supra* note 163, para 5.

[and that] the grounds and procedures prescribed by law must not be destructive of the right to liberty of person.”¹⁶⁸

In addition to the mentioned, the permissibility to restrict the right to liberty can be seen to intrinsically connect with the prohibition of offending the security of persons and arbitrary deprivation of liberty and detention. As alluded in the introduction, “the right to security of persons is a right intended to protect individuals against intentional infliction of bodily harm or mental injury, irregardless of whether the victim is detained or not”.¹⁶⁹ It is therefore incumbent upon Member States to take appropriate measures to prevent intrusions into the security of persons, together with corresponding appropriate and responding measure to redress patterns of violence against categories of victims such as persons with disabilities.¹⁷⁰ The same principles and obligations are required of States in preventing arbitrariness and unlawfulness in the processes of arrest or/and of detention. Understand that the prohibition of arbitrariness is an internationally recognized non-derogable principle.¹⁷¹ Arbitrariness may occur where there is no legal basis for the arrest, detention or commitment of an individual. However this does not represent all that may entail the prohibition of arbitrariness. The Human Rights Committee explains that in article 9 paragraph one, arbitrary arrest and detention is prohibited and this prohibition overlaps with the second paragraph which provides

¹⁶⁸ See, *Ibid*, para 5.

¹⁶⁹ See, *Ibid*, para 9.

¹⁷⁰ See, *Ibid*.

¹⁷¹ See, UN Human Rights Committee, General Comment 29: States of Emergency (article 4), CCPR/C/21/Rev.1/Add.11 (2001), para 11 states that: “The enumeration of non-derogable provisions in article 4 is related to, but not identical with, the question whether certain human rights obligations bear the nature of peremptory norms of international law. The proclamation of certain provisions of the Covenant as being of a non-derogable nature, in article 4, paragraph 2, is to be seen partly as recognition of the peremptory nature of some fundamental rights ensured in treaty form in the Covenant (e.g., articles 6 and 7). However, it is apparent that some other provisions of the Covenant were included in the list of non-derogable provisions because it can never become necessary to derogate from these rights during a state of emergency (e.g., articles 11 and 18). Furthermore, the category of peremptory norms extends beyond the list of non-derogable provisions as given in article 4, paragraph 2. States parties may in no circumstances invoke article 4 of the Covenant as justification for acting in violation of humanitarian law or peremptory norms of international law, for instance by taking hostages, by imposing collective punishments, through arbitrary deprivations of liberty or by deviating from fundamental principles of fair trial, including the presumption of innocence.”

for deprivation of liberty that is not arbitrary and in conformity with the procedure as set out in the law.¹⁷² It emphasizes that:

Drafting history of article 9, paragraph 1, confirms that "arbitrariness" is not to be equated with "against the law", but must be interpreted more broadly to include elements of inappropriateness, injustice, lack of predictability and due process of law. As the Committee has observed on a previous occasion, this means that remand in custody pursuant to lawful arrest must not only be lawful but reasonable in all the circumstances. Remand in custody must further be necessary in all the circumstances, for example, to prevent flight, interference with evidence or the recurrence of crime.¹⁷³

The above construction of arbitrariness continues to be characterized in the current jurisprudence of article 9 as evidenced by the General Comment 35, including regional courts.¹⁷⁴ In addition, the Comment sets out extra circumstances such as 'conditions of detention' that may amount to arbitrary deprivation of liberty by explaining that "detention may be arbitrary if the manner in which the detainees are treated does not relate to the purpose for which they are ostensibly being detained."¹⁷⁵ Furthermore "the imposition of a draconian penalty of imprisonment for contempt of court without adequate explanation and without independent procedural safeguards is arbitrary [including] the decision to keep a person in any form of detention is arbitrary if it is not subject to periodic re-evaluation of the justification for continuing the detention."¹⁷⁶ The construction of arbitrariness is comparatively similar to that construed for the purpose of this thesis.

¹⁷² See, UN Human Rights Committee, General Comment 35, *Supra* note 163 para 9.

¹⁷³ See, *Mukong V Cameroon*, Communication No. 458/1991, in UN Doc. GOAR, A/49/40 (Vol II), p. 181, para 9.8.

¹⁷⁴ See, UN Human Rights Committee, Draft General Comment 35 *Supra* note 162, para 13. See also *Garcia v. Peru*, Case 11.006, Report No. 1/95, Inter-Am.C.H.R. Where the Inter-American Commission of Human Rights held that arrest and detention of Former president Garcia wife and children by the Peruvian army was arbitrary contrary to the American Convention of Human Rights (ACHR) because the army lacked a constitutional mandate to undertake the arrests and that the arrests were not based on a court order, thus in violation of the prohibition against arbitrary detention. See also, *Van Der Leer v The Netherlands*, Application No 11509/85 ECHR (1990). In this case the Court found a violation of articles 5(1,2& 4) and 6(1) of the European Convention on Human Rights on grounds that the applicant had been confined by a judge in a psychiatric hospital for six months without a hearing and without being informed of the reasons for the confinement or proceedings.

¹⁷⁵ See, UN Human Rights Committee, General Comment 35, *Supra* note 163, para 14 .

¹⁷⁶ See, *Ibid*, para 12&14.

The aforementioned aspects highlight the jurisprudential understanding of arbitrariness. As shall be seen further below, this interpretation is much more in line with that provided by the ECHR jurisprudence, and thus far more than what the CRPD has provided in its interpretation of Article 14. The CRPD Committee in the Guiding Principles of article 14 articulates that forced interventions through detentions and treatment and the use of substitute decision-making mechanisms, amount to arbitrary deprivation of liberty and offends articles 12 and 14 of the CRPD.¹⁷⁷ The question that arises is whether in light of the ICCPR jurisprudence, provision of mental health care and treatment to persons with mental disability through involuntary hospitalization and forced treatment of persons with disability based on the presence of mental disorder is permissible? The answer can be construed as permissible since involuntary hospitalization is highlighted as a permissible ground by the Human Rights Committee. It can also be interpreted in the affirmative from the following General Comment 35 excerpt that enunciates as follows:

States parties should revise outdated laws and practices in the field of mental health in order to avoid arbitrary detention. The Committee emphasizes the harm inherent in any deprivation of liberty and also the particular harms that may result in situations of involuntary hospitalization. States parties should make available adequate community-based or alternative social-care services for persons with psychosocial disabilities, in order to provide less restrictive alternatives to confinement. 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. The procedures should ensure respect for the views of the individual and ensure that any representative genuinely represents and defends the wishes and interests of the individual. States parties must offer to institutionalized persons programmes of treatment and rehabilitation that serve the purposes that are asserted to justify the detention. Deprivation of liberty must be re-evaluated at appropriate intervals with regard to its continuing necessity. The individuals must be assisted in obtaining access to effective remedies for the vindication of their rights, including initial and periodic judicial review of the lawfulness of the detention, and to prevent conditions of detention incompatible with the Covenant.¹⁷⁸

¹⁷⁷ See CRPD Committee, Guidelines on Article 14, Supra note 41, para 7,8 &9.

¹⁷⁸ See, UN Human Rights Committee, General Comment 35, Supra note 163, para 19.

From the given excerpt, it can be argued out that it is a pragmatic and balanced approach. It is argued as such since on one hand the ideals promoted by the CRPD such as community living and respect of individual's wishes and preferences are supported while on the other, the realities of current practices are also taken into consideration. As written, disability itself shall not justify deprivation and that there must be other justifiable qualifiers such as harm or need of treatment, qualifiers that are present in many mental health legislations and contrastingly eschewed by the CRPD. It can also be observed that the excerpt is concerned more with abuse and arbitrariness risks inherent of the process of compulsory measures. In view of this, it tries to address them by calling State Parties to revise their mental health legislations [not repeal them] and to particularly use procedural and substantive safeguards that include respecting of individuals wishes, periodic review of detention and use of judicial review mechanisms. This call for safeguards diametrically supports the objective and relevance of this thesis.

Finally on the ICCPR jurisprudence, the preclusion and permissibility of civil commitment process is illustrated by its case law.¹⁷⁹ The most significant, is the case of *A. v. New Zealand (1997)* where it was held that a nine year detention under the Mental Health Act of New Zealand was neither unlawful nor arbitrary.¹⁸⁰ In this case, the author of the communication alleged that compulsory detention under the New Zealand Mental Health Act was unlawful, arbitrary and constituted violations under articles 7, 10, 17, 18, 19 and 26 of the Covenant.¹⁸¹ In the final disposition, the majority of the

¹⁷⁹ See, *Brough v. Australia* Communication No 1184/03, CCPR/C/86/D/1184/ 2003 (2006). In this communication, the human rights committee in assessing the detention conditions and treatment of an accused mentally ill aboriginal author came to a conclusion that, the prescription of an anti-psychotic drug to the complainant without his consent was found a breach of Article 7 of the ICCPR, as it was evidently shown to have been justifiably prescribed at the recommendation of professionals to stop the complainant's self-destructive behaviour (see para 9.5). However it found a violation of ICCPR article 10 on grounds that the state failed to treat the author with respect to the requirements under article 10(3) which obligates states to provide proper rehabilitation and reformation for juvenile offenders away from adults and accorded the treatment appropriate to their age and legal status, by placing him in extended solitary confinement without his clothes, blankets, under bright lights and without the possibility of communication even though all this was done to prevent harm from himself and others (see, para 9.4).

¹⁸⁰ See, *A (name withheld) v. New Zealand*, Communication No. 754/1997, CCPR/C/66/D/754/1997 (1999).

¹⁸¹ See, *Ibid.*

members were in favour finding of a no violation. The Committee affirmed that the committal order against the author was made in accordance with the law, periodically reviewed by the required number of psychiatrists and that domestic courts had effectively reviewed his case. Therefore, his claim of arbitrariness and unfairness against the psychiatrist's decisions could not stand.¹⁸² Two dissenting Committee members however maintained that there was a violation emanating from the periods of delay of the review processes both judicially and medically.¹⁸³ Similar principles appear in the ECHR, African and American jurisdictions as discussed below.

1.2.1.2. Regional Instruments: The ECHR, ACHPR & ACHR

Among the regional conventions, the ECHR,¹⁸⁴ presents far-reaching developed legal mechanism for the protection of human rights and is binding on all those nations that have ratified it.¹⁸⁵ Individuals, non-governmental and States alleging violations of their convention rights can apply to the

¹⁸² See, *Ibid.* It held in para 7.2 & 7.3 Inter alia: "The main issue before the Committee is whether the author's detention under the Mental Health Act from 1984 to 1993 constituted a violation of the Covenant, in particular of article 9. The Committee notes that the author's assessment under the Mental Health Act followed threatening and aggressive behaviour on the author's part, and that the committal order was issued according to law, based on an opinion of three psychiatrists. Further, a panel of psychiatrists continued to review the author's situation periodically. The Committee is therefore of the opinion that the deprivation of the author's liberty was neither unlawful nor arbitrary and thus not in violation of article 9, paragraph 1, of the Covenant. (7.3) The Committee further notes that the author's continued detention was regularly reviewed by the Courts and that the facts of the communication thus do not disclose a violation of article 9, paragraph 4, of the Covenant. In this context, the Committee has noted the author's argument that the decision by Unwin J not to dismiss him from compulsory status was arbitrary. The Committee observes, however, that this decision and the author's continued detention were reviewed by other courts, which confirmed Unwin J's findings and the necessity of continuation of compulsory status for the author. The Committee refers to its constant jurisprudence that it is for the courts of States parties concerned to review the evaluation of the facts as well as the application of the law in a particular case, and not for the Committee, unless the Courts' decisions are manifestly arbitrary or amount to a denial of justice. On the basis of the material before it, the Committee finds that the Courts' reviews of the author's compulsory status under the Mental Health Act did not suffer from such defects. 7.4 As a consequence of the above findings, the author's claim under article 9, paragraph 5, is without merit."

¹⁸³ See, *Ibid.* The dissenting asserted the following; "Our concern lies in the fact that although there was periodic expert review of the author's status, his continued detention was not subject to effective and regular judicial review. In order for the author's treatment to meet the requirements of article 9, paragraph 4, not only the psychiatric review but also its judicial control should have been regular. We find a violation of article 9, paragraph 4, in the case. Various mechanisms of judicial review on the lawfulness of the author's continued detention were provided by the law of New Zealand, but none of them was effective enough to provide for judicial review "without delay". Although there were several instances of judicial review, they were too irregular and too slow to meet the requirements of the Covenant. As the following account of the various instances of judicial review will show, this conclusion does not depend on the position one takes on the effect of the entry into force of the Optional Protocol in respect of New Zealand on 26 August 1989."

¹⁸⁴ See, The ECHR.

¹⁸⁵ See, Michael L. Perlin et al, *International Human Rights and Comparative Mental Disability Law*, Carolina Academic Press 47 (2006).

European Court of Human Rights (hereafter the Court) directly seeking justice.¹⁸⁶ However, the applications are subject to fulfilling the admission criteria under articles 33, 34 and 35 respectively.¹⁸⁷ The convention presents an array of civil and political rights that include but not limited to the right to life,¹⁸⁸ to liberty and security,¹⁸⁹ to fair trial,¹⁹⁰ to respect of family and private life,¹⁹¹ to an effective remedy,¹⁹² prohibition of torture,¹⁹³ and discrimination¹⁹⁴ among others. The protection and promotion of these rights are guaranteed basically through Article 1 of the ECHR which obliges “high contracting parties to secure to everyone within their jurisdictions the rights and freedoms defined in section 1 of this convention”.¹⁹⁵ In this respect, “it establishes a general negative obligation under which the contracting State undertakes not to effect a right or freedom of any person ‘within their jurisdiction’, and if it did, it would incur international liability and an international claim could be brought as contemplated in the text of the convention”.¹⁹⁶ Negative obligations under Article 1 are also reinforced by positive obligation which “means that positive obligations set out by the convention involve a commitment to the enjoyment of the rights and freedoms set out, without interference from third parties”.¹⁹⁷ Member States “must therefore provide all appropriate means to ensure that such interferences does not take place, otherwise, third party behaviour will also generate State responsibility if the State has not provided the necessary means to prevent that behav-

¹⁸⁶ See, Javier Garcia Roca, *The Preamble, The Conventions Hermeneutic Context: A Constitutional Instrument of European Public Order* in Javier Garcia Roca & Pablo Santolaya (ed.), *Europe of Rights: A Compendium on The European Convention of Human Rights*, Martinus Nijhoff Publishers 6 (2012).

¹⁸⁷ See, ECHR. See also, Pablo A. Fernandez-Sanchez, *The Scope of obligations Under the European Convention on Human Rights (Art1.)* in Javier Garcia Roca & Pablo Santolaya (ed.), *Europe of Rights: A Compendium on The European Convention of Human Rights*, Martinus Nijhoff Publishers 34 (2012).

¹⁸⁸ See, ECHR Article 2.

¹⁸⁹ See, *Ibid*, Article 5.

¹⁹⁰ See, *Ibid*, Article 6.

¹⁹¹ See, *Ibid*, Article 8.

¹⁹² See, *Ibid*, Article 13.

¹⁹³ See, *Ibid*, Article 3.

¹⁹⁴ See, *Ibid*, Article 14.

¹⁹⁵ See, *Ibid*, Article 1.

¹⁹⁶ See, Pablo A. Fernandez-Sanchez, *The Scope of obligations Under the European Convention on Human Rights (Art1.)* in Javier Garcia Roca & Pablo Santolaya (ed.), *Europe of Rights: A Compendium on The European Convention of Human Rights*, *Supra* note 187, p.28.

¹⁹⁷ See, *Ibid*, p.37.

our”.¹⁹⁸This is very important for persons with mental disabilities particularly those receiving services from State institutions and those from private-third party institutions.

Akin to the other regional conventions, right to liberty is provided under article 5.¹⁹⁹ The articles main objective is to protect individuals from “arbitrary attacks by the State on a person’s liberty judicial control is an essential feature of the guarantee which is intended to minimise the risk of arbitrariness and to secure the rule of law”.²⁰⁰ However unlike the other regional conventions, the ECHR extends further to provide an extensive enumeration of exemptions to the right and within this enumeration it provides for deprivation of liberty based on ‘unsoundness of mind’.²⁰¹ Despite the use of the term ‘unsoundness of mind’ which is now considered archaic, deprivation of liberty of those persons with a mental disability or illness is permissible under the convention as long as certain criteria are met as expounded by the jurisprudence of the Court. It is important to note that the jurisprudence is not very extensive but compared with the other regional systems, it has a considerably clear and uncontroversial established jurisprudence.²⁰² The leading jurisprudence on the matter is *Winterwerp v. The Netherlands (1979)*.²⁰³ In this case the court laid down three conditions

¹⁹⁸ See, Ibid.

¹⁹⁹ ECHR Article 5 (1, a-f) .It follows: “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: (a). the lawful detention of a person after conviction by a competent court; (b). the lawful arrest or detention of a person for non-compliance with the lawful order of a court or in order to secure the fulfilment of any obligation prescribed by law; (c). the lawful arrest or detention of a person effected for the purpose of bringing him before the competent legal authority on reasonable suspicion of having committed an offence or when it is reasonably considered necessary to prevent his committing an offence or fleeing after having done so; (d). the detention of a minor by lawful order for the purpose of educational supervision or his lawful detention for the purpose of bringing him before the competent legal authority; (e). *the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants*; the lawful arrest or detention of a person to prevent his effecting an unauthorized entry into the country or of a person against whom action is being taken with a view to deportation or extradition.”

²⁰⁰ See, Javier A. Garcia & Argelia Q. Jimenez, European Convention Protection of the Rights to Liberty and Security: A Minimum European Standard (Art.5 ECHR) in Javier Garcia Roca & Pablo Santolaya (ed.), Europe of Rights: A Compendium on The European Convention of Human Rights, Martinus Nijhoff Publishers 117 (2012).

²⁰¹ See, ECHR Article 5 (1, e).

²⁰² See, Javier A. Garcia & Argelia Q. Jimenez, European Convention Protection of the Rights to Liberty and Security: A Minimum European Standard (Art.5 ECHR) in Javier Garcia Roca & Pablo Santolaya (ed.), Europe of Rights: A Compendium on The European Convention of Human Rights, Supra note 200, p.116.

²⁰³ See, *Winterwerp v. The Netherland* 33 Eur. Ct. H.R. (ser.A) 1979.

upon which internment of persons with mental disability may be undertaken and in a way that guarantees that governmental powers of internment are not overreached.²⁰⁴ According to the court, involuntary or civil commitment of persons with mental illness must follow a ‘procedure prescribed by law’ and cannot be arbitrary.²⁰⁵ In any event the Court expresses the requirements as follows:

In the Court’s opinion, except in emergency cases, the individual concerned should not be deprived of his liberty unless he has been reliably shown to be of "unsound mind". The very nature of what has to be established before the competent national authority - that is, a true mental disorder - calls for objective medical expertise. Further, the mental disorder must be of a kind or degree warranting compulsory confinement. What is more, the validity of continued confinement depends upon the persistence of such a disorder.²⁰⁶

Based on the above it can be summarised that there must be an existence of a proven mental disorder of such a nature to render detention legitimate based on an objective medical report.²⁰⁷

To expatiate a little, in the case of *Johnson V UK (1997)*,²⁰⁸ a breach of the ECHR article 5(1) was found against the UK because of a lack of a scheme for discharging mental patients who no longer fulfilled the Winterwerp criterion like Johnson and whose release kept being unreasonably delayed with deferrals.²⁰⁹ The Court emphasized it is a right for patients to be discharged when they no

²⁰⁴ See, Ibid.

²⁰⁵ See, Ibid, para 39. It states that: “The next issue to be examined is the "lawfulness" of the detention for the purposes of Article 5 para. 1 (e) (art. 5-1-e). Such "lawfulness" presupposes conformity with the domestic law in the first place and also, as confirmed by Article 18 (art. 18), conformity with the purpose of the restrictions permitted by Article 5 para. 1 (e) (art. 5-1-e); it is required in respect of both the ordering and the execution of the measures involving deprivation of liberty (see the above-mentioned Engel and others judgment, p. 28, para. 68 in fine). As regards the conformity with the domestic law, the Court points out that the term "lawful" covers procedural as well as substantive rules. There thus exists a certain overlapping between this term and the general requirement stated at the beginning of Article 5 para. 1 (art. 5-1), namely observance of "a procedure prescribed by law" (see paragraph 45 below). Indeed, these two expressions reflect the importance of the aim underlying Article 5 para. 1 (art. 5-1) (see paragraph 37 above): in a democratic society subscribing to the rule of law (see the Golder judgment of 21 February 1975, Series A no. 18, pp. 16-17, para. 34, and the above-mentioned Klass and others judgment, p. 25, para. 55), no detention that is arbitrary can ever be regarded as "lawful". The Commission likewise stresses that there must be no element of arbitrariness; the conclusion it draws is that no one may be confined as "a person of unsound mind" in the absence of medical evidence establishing that his mental state is such as to justify his compulsory hospitalisation (see paragraph 76 of the report). The applicant and the Government both express similar opinions. The Court fully agrees with this line of reasoning. In the Court’s opinion, except in emergency cases, the individual concerned should not be deprived of his liberty unless he has been reliably shown to be of "unsound mind".”

²⁰⁶ See, Ibid.

²⁰⁷ See, Ibid.

²⁰⁸ See, *Johnson V The United Kingdom (1997)* ECHR 88, para 61-64.

²⁰⁹ See, Ibid, para 67.

longer suffer from mental illness and also when the reason for their confinement no longer exists, but it does not guarantee an immediate and absolute discharge because flexibility has to be given to the relevant authorities to ensure that the course of action serves the interest of the individuals and communities.²¹⁰ On the issue of medical reports, individuals must also be afforded the opportunity to have their own chosen independent expert to analyse their circumstances. The failure to do so may result in finding of a violation as in *X V Finland (2012)*, where it was considered arbitrary for not having adequate safeguards to guarantee and afford the applicant an opportunity to use an external medical expert in reviewing her case before continuing with the imposed forced medication.²¹¹ These requirements limit the possibility of arbitrariness in the arrest of persons whose conduct deviates from the customs predominant in a particular society.²¹² It also means that limitation on the right to liberty including civil commitment must be sanctioned by and must be consistent with any procedural conditions set out in domestic legislation.²¹³ For example, the ECHR in the case of *Biziuk V. Poland (2012)*, concerning an applicant with mental disability committed to a psychiatric hospital based on the criminal law of Poland maintained that:

..The national authorities have a certain margin of appreciation regarding the merits of clinical diagnoses since it is in the first place for them to evaluate the evidence in a particular case: the Court's task is to review under the Convention the decisions of those authorities. (43). The Court further recalls that the expressions "lawful" and "in accordance with a procedure prescribed by law" in Article 5 § 1 essentially refer back to national law and enshrine the obligation to conform to the substantive and procedural rules thereof. Although it is in the first place for the national authorities, notably the courts, to interpret and apply domestic law, under Article 5 § 1 failure to comply with domestic law entails a breach of the Convention and the Court can and should review whether this law has been complied with.²¹⁴

In *HL V United Kingdom (2004)* the national margin of appreciation was lower because of a lack of legitimate prescribing law. This case involved the scrutiny of the doctrine of necessity as the

²¹⁰ See, *Ibid*, para 61.

²¹¹ See, *X v Finland*, Application No. 34806/04 (2012), para 169 & 171.

²¹² See, *Winterwerp v. The Netherland* *Supra* note 203, para 39.

²¹³ See, World Health Organization (WHO), *Resource Book on Mental Health, Human Rights and Legislation*, World Health Organization Publication 47 (2005).

²¹⁴ See, *Biziuk V. Poland (No.2)* Application No. 24580/06 (2012), para 42 & 43.

ground for the detention of the applicant suffering from severe autism and challenging behaviour and who lacked capacity to make decisions on his treatment and place of residence under article 5(1).²¹⁵ Initially he was placed in a psychiatric hospital (1987-1994) and later placed with care givers in the community where he started visiting a day care center once a week (1995-1997).²¹⁶ During his stay at the day care center in 1997, he became agitated and was informally admitted to the hospital though not compulsorily as provided by the Mental Health Act 1983, because he was "compliant".²¹⁷ The Court concluded that he had been arbitrarily deprived of his liberty since he had no recourse to the protections offered by the Mental Health Act 1983, for example the capability to challenge detention and the restrictions on treatment.²¹⁸ Furthermore, he was fully under the control of the hospital staff, there was the lack of any fixed procedural rules by which the admission and detention of compliant incapacitated patients was conducted.²¹⁹ This case indicates the possibility of arbitrary human rights violation for persons with mental disability placed under compulsory hospitalization where there is a lack of legislations. The after effect of this case led to the UK amending its legislations, particularly the admissions procedures to hospitals and care home in order to protect rights of persons who lacked capacity when situations of deprivation of liberty arise.²²⁰

In addition, to these requirements, the Court in its subsequent jurisprudence set out an additional condition to the effect that there must be a connection between the reason of deprivation and place of detention, a criteria alike that given by the ICCPR.²²¹ This condition was asserted in the case of *Aerts v. Belgium (1998)* where the Court expressly maintained that "furthermore, there must be

²¹⁵ See, *HL v UK*, Application No. 45508/99, ECHR 471 (2004), para 9-11.

²¹⁶ See, *Ibid.*

²¹⁷ See, *Ibid*, para 11-22.

²¹⁸ See, *Ibid*, para 134-142.

²¹⁹ See, *Ibid*, para 121.

²²⁰ See, United Kingdom Mental Capacity Act (2005) as amended.

²²¹ See, *Aerts v. Belgium*, Application No 25357/94, Eur. Ct. HR (1998), para 46.

some relationship between the ground of permitted deprivation of liberty relied on and the place and conditions of detention [that] in principle, the “detention” of a person as a mental health patient will only be “lawful” for the purposes of sub-paragraph (e) of paragraph 1 if effected in a hospital, clinic or other appropriate institution”.²²² Any other appropriate institution may comprise social homes or community settings and all must provide environmental conditions that are at par with the reasons for detention. This is very significant when the current state of affairs of many mental health institutions is taken into account. The importance of observing these requirements was illustrated in *Stanev v Bulgaria (2012)* involving the placement of the applicant suffering from a psychosocial disability in a social care home using the Social Assistance Act and not to administer compulsory medical treatment.²²³ He alleged that while in placement he was under constant supervision and was not allowed to make decisions about his life including living in inhumane and degrading circumstances and a lack of direct access to courts to challenge his placement and his restricted legal capacity.²²⁴ The Court found a violation of article 5(1) because ‘his placement was not ordered “in accordance with a procedure prescribed by law” and that his deprivation of liberty was not justified by sub-paragraph (e) of Article 5(1)’, and therefore there was no need to place him in the social care home.²²⁵ A violation of 5 (4) was registered because, the Bulgarian law lacked the necessary safeguards and remedies for which the applicant could have ‘direct opportunity to challenge the lawfulness of his placement in the Pastra social care home and the continued implementation of that measure’.²²⁶ On article 3, the court held that the conditions upon which the applicant resided (‘provision of insufficient food, inadequately heated house in winter, sleeping on his coat, having a shower once a week in unhygienic and dilapidated bathroom as well as the use of toilets

²²² See, *Ibid*, para 46.

²²³ See, *Stanev V Bulgaria*, Application No. 36760/06 (2012) ECHR para 108.

²²⁴ See, *Ibid*, para 105 & 106.

²²⁵ See, *Ibid*, paras 148-160.

²²⁶ See, *Ibid*, para 172 & 177.

that were in an execrable state and access to them was dangerous’),²²⁷ amounted to a violation of article 3.²²⁸

In sum, it is distinct that involuntary hospitalization constitutes one of those permissible situations within the ECHR jurisprudence. The ECHR Court parallel to the ICCPR assesses the severity of the deprivation depending on its duration, effects and manner of implementation under article 5.²²⁹ The Winterwerp criteria must be met, circumstances of detention must meet reasons of detention, periodic review must be done, consent of an individual must be respected, special safeguards must be placed for instance where substitute decision making is engaged and release must be done where the purpose of detention no longer warrants it or there is a lesser alternative such as community living preferences. The following looks at the African system then followed by the American.

In the **African regional system**, persons with disabilities are presently protected by the African Charter on Human and Peoples Rights (hereafter African Charter).²³⁰ There are other protocol treaties such as the women’s, children’s and youth that have special provisions for persons with disabilities.²³¹ It is worth mentioning that currently, African States are in the process of drafting and negotiating on an African Disability Protocol to tackle African disability specific concerns, including those that were left out in the final draft of the CRPD or remain silent.²³² One key concern and of

²²⁷ See, *Ibid*, para 209.

²²⁸ See, *Ibid*, paras 206-213.

²²⁹ See, Sangeeta Shah, Detention and Trial in Daniel Moeckli, Sangeeta Shah & Sandesh Sivakumaran (ed.), *International Human Rights Law*, *Supra* note 165, p. 261.

²³⁰ See, African Charter on Human and Peoples Rights (1986).

²³¹ See, African Charter on Human and Peoples Rights on the Rights of Women in Africa (2003), Article 23 (a&b), African Charter on the Rights and Welfare of the Child (1993), Article 13 & See, African Youth Charter includes provisions for persons with disabilities (2009), Article 24(1).

²³² See, Louis. Oyaro, Africa at Crossroads: The United Nations Convention on the Rights of Persons with Disabilities, 30 *American University International Law Review*, 360-361 (2015). He states that: “The African states’ contribution during the CRPD Ad Hoc Committee sessions illustrates the regional concerns outlined above. During the negotiations, African states, as a group and individually, advanced concerns relating to: the discrimination of persons with disabilities; the intersection between poverty and discrimination; the effect of harmful traditional practices; the role of families and caretakers; abduction during conflict; forced abortions; sign language; children with disabilities; the need for inter-

relevance to the thesis is the use of traditional and spiritual methods of mental health care which also involves detention but is unregulated in many parts of Africa. The protocol is welcomed to address this and many other concerns. At present the main document is the African Charter which is analogous to the UN treaties mentioned. The African Charter does not specifically mention disability as group. However it can be inferred that they are inclusively protected under the ‘other status’ provided under article 2.²³³In addition, persons with disabilities, including those with mental disabilities their rights and freedoms are protected in the equality clause under article 3, which recognizes that “every individual shall be equal before the law and that every individual shall be entitled to equal protection of the law.”²³⁴This clause does not make any distinctions, and as such reinforces the enjoyment of rights and freedoms of all including persons with physical and mental disabilities.

Comparable to the ICCPR, the ECHR and the ACHR, the African Charter, promotes the right to liberty and security of all persons under article 6. It is not an absolute right and therefore anyone can be deprived of their liberty “except for reasons and conditions previously laid down by law and in particular, no one may be arbitrarily arrested or detained”.²³⁵This implies that due process guarantees enumerated in the next article must be observed.²³⁶Unlike the ECHR, the African Charter

national cooperation; availability and affordability of assistive devices; the remodeling of existing buildings and structures to suit persons with disabilities; rehabilitation of persons with disabilities in confinement; and the importance of community-based rehabilitation.⁶⁹ The final text of the CRPD addressed some of these concerns and left out or was silent on others.⁷⁰ For that reason, an African regional treaty is key to addressing these specific issues.”

²³³ See, ACHPR Article 2. It declares that: every individual shall be entitled to the enjoyment of the rights and freedoms recognized and guaranteed in the present Charter without distinction of any kind such as race, ethnic group, color, sex, language, religion, political or any other opinion, national and social origin, fortune, birth or other status

²³⁴ See, Ibid, Article 3.

²³⁵ See, Ibid, Article 6.

²³⁶ See, Ibid, Article 7. It states that: “1. Every individual shall have the right to have his cause heard. This comprises: (1). The right to an appeal to competent national organs against acts of violating his fundamental rights as recognized and guaranteed by conventions, laws, regulations and customs in force; (2). The right to be presumed innocent until proved guilty by a competent court or tribunal; (3). The rights to defense, including the right to be defended by counsel of his choice; (4) The right to be tried within a reasonable time by an impartial court or tribunal. 2. No one may be condemned for an act or omission which did not constitute a legally punishable offence at the time it was committed. No penalty may be inflicted for an offence for which no provision was made at the time it was committed. Punishment is personal and can be imposed only on the offender.”

does not enumerate the permissible grounds of limitation and neither does it preclude it as long as it is in accordance with domestic law which is in conformity with the Charter rights and is in conformity with international standards. This standpoint is illustrated in the single case on disability in the African Courts jurisprudence *Purohit and Moore V the Gambia (2003)*.²³⁷ This case is the jurisprudence that is available, but it equally highlights significant issues regarding the care and treatment of persons with disabilities such as discrimination, equality before and protection of the law, prevention of arbitrary deprivation of liberty, conditions of detention and provision of services within the communities akin the other jurisdictions. These details are discussed below.

Accordingly, in *Purohit and Moore V the Gambia* the African commission on Human and Peoples Right (hereinafter African Commission),²³⁸ found a violation of article 2(non-discrimination), 3(equality before the law), and 5(human dignity and freedom from inhuman treatment and torture) among others of the African Charter.²³⁹ The complainants, two mental health advocates submitted an application to the commission on behalf of patients of Campama, a psychiatric unit of the Royal Victoria Hospital in The Gambia, alleging that the legislation then in force in the Gambia, namely the Lunatics Detention Act (LDA), was discriminatory and that the conditions of detention appalling, hence in violation of the African Charter articles 2, 3, 5, 7(1) (a & c), 13, 16 and 18(4).²⁴⁰ The court found that the State of Gambia had failed to undertake its responsibilities to bring its domestic laws and practices in conformity with the African Charter.²⁴¹ More so it emphasized that principles of anti-discrimination (article 2) and equal protection (article 3) in the Charter embodies the spirit

²³⁷ See, *Purohit and Moore V. The Gambia* Communication No. 241/2001(2003).

²³⁸ See, African Commission was preceded by the African Court on Human and Peoples Rights established in 2004 by the Protocol to the African Charter on Human and Peoples Rights on the Establishment of an African Court on Human and Peoples Rights (1998).

²³⁹ See, *Purohit and Moore V. The Gambia* Supra note 237.

²⁴⁰ See, *Ibid.* Article 2(Right to Freedom from Discrimination), Article 3(Right to Equality Before the Law and Equal recognition Before the Law), Article 5(Prohibition of Torture and Cruel, Inhuman and Degrading Treatment), Article 7 (Right To fair Trial), Article 13(Right to Participate in the Government), Article 16(Right to Health) & Article 18(Protection of the Family and Vulnerable Groups).

²⁴¹ See, *Ibid.*, para 54.

of the Charter from which no derogation can be made.²⁴² The living situation of the claimants failed to meet the principles under article 2 & 3 and those underscored in the MI Principles on involuntary commitment and treatment of mental health patients.²⁴³ It also failed to respect and uphold their human dignity regardless of applicant's mental capabilities or disabilities, because persons with 'mental disability have hopes, dreams and goals just like any other human being to live a normal and decent life with dignity and for these reasons this right to dignity must be guarded zealously by State parties'.²⁴⁴

In responding to the claim of arbitrary detention, the court maintained that though the institutionalization procedures had fallen short of international standards and norms, it did not find a violation of article 6, the right to liberty.²⁴⁵ It however underscored that the African Charter offers protection against arbitrary deprivation of liberty under article 6 through the following reasoning:

Article 6 of the African Charter guarantees every individual, be they disabled or not, the right to liberty and security of the person. Deprivation of such liberty is only acceptable if it is authorised by law and is compatible with the obligations of States Parties under the African Charter. However, the mere mention of the phrase 'except for reasons and conditions previously laid down by law' in Article 6 of the African Charter does not mean that any domestic law may justify the deprivation of such persons' freedom and neither can a State party to the African Charter avoid its responsibilities by recourse to the limitations and claw back clauses in the African Charter. Therefore, any domestic law that purports to violate this right should conform to internationally laid down norms and standards.²⁴⁶

The excerpt evidences that the use of involuntary hospitalization is not prohibited. It is fostered only in existing authoritative system of competent supervision of individual rights, where it is safe-

²⁴² See, Ibid, para 49

²⁴³ See, Ibid, para 54.

²⁴⁴ See, Ibid, para 57 & 61.

²⁴⁵ See, Ibid, para 68. The court maintained that: "...The African Commission takes note of the fact that such general medical practitioners may not be actual experts in the field of mental health care and as such there is a possibility that they could make a wrong diagnosis upon which certain persons may be institutionalised. Additionally, because the LDA does not provide for review or appeal procedures, persons institutionalised under such circumstances would not be able to challenge their institutionalisation in the event of an error or wrong diagnosis being made. Although this situation falls short of international standards and norms, the African Commission is of the view that it does not violate the provisions of Article 6 of the African Charter because Article 6 of the African Charter was not intended to cater for situations where persons in need of medical assistance or help are institutionalised."

²⁴⁶ See, Ibid, para 64.

guarded with procedurally and substantive measures and implemented in humane conducive environment with human rights friendly services.²⁴⁷ The court also affirmed the right to enjoy a decent life that involves having access to facilities within the communities that promote this right and the right to human dignity in order for persons with mental disabilities to live a normal and decent life like all other individuals.²⁴⁸ This level of understanding is re-echoed by the CRPD. It is correspondingly affirmed by the American Convention on Human Rights,²⁴⁹ and buttressed by the Inter-American Commission on Human Rights decision on mental disability rights as discussed below.

Thus, in the **American Region**, protection of human rights is guaranteed by the American Convention (ACHR).²⁵⁰ The American Convention works together with the **Inter-American Convention on the Elimination of all Forms of Discrimination against Persons with Disabilities** (hereafter the Discrimination Convention).²⁵¹ This convention recognizes various forms of disability as those “including those with a physical, mental, or sensory impairment, whether permanent or temporary, that limits the capacity to perform one or more essential activities of daily life, and which can be caused or aggravated by the economic and social environment.”²⁵² Its very purpose is to provide human rights protection to persons with disabilities particularly “to prevent and eliminate all forms of discrimination against persons with disabilities and to promote their full integration into society.”²⁵³ The Discrimination Convention is comparable to the CRPD, particular in its overall objective including the definition of discrimination.²⁵⁴ In the view that it entered into force before

²⁴⁷ See, *Ibid*, para 65.

²⁴⁸ See, *Ibid*, para 61.

²⁴⁹ See, American Convention on Human Rights (1978), Art.1 &5.

²⁵⁰ See, ACHR

²⁵¹ See, Inter-American Convention on the Elimination of all Forms of Discrimination against Persons with Disabilities (1999).

²⁵² See, *Ibid*, Article I (1).

²⁵³ See, *Ibid*, Article II.

²⁵⁴ See, *Ibid*, Article I (2-a). It States: ““means any distinction, exclusion, or restriction based on a disability, record of disability, condition resulting from a previous disability, or perception of disability, whether present or past, which has the effect or objective of impairing or nullifying the recognition, enjoyment, or exercise by a person with a disability of his or her human rights and fundamental freedoms”. See also, CRPD Article 2 provides that:

the CRPD, it deserves to be lauded for its inclusive nature even though its effectiveness in addressing the rights of persons with disabilities remains a question for another discourse. Of relevance to the thesis, is the requirement to State Parties to take all legislative and other measures to promote economic, social and cultural rights to ensure prevention of early disability and through detection, treatment, rehabilitation education advocacy and campaigns, integration and provision of services in the society, empower persons with disabilities and the society against discrimination.²⁵⁵ Therefore, how relevant is the American Convention in terms of provision of treatment and care of mental health and through the use of compulsory measures?

Persons with or without disabilities can rely on this instrument to promote and/or challenge any infringement of their rights. The American Convention obliges States to ensure that the conventional rights are respected and promoted to every human being within their territories without any discrimination through legislative, administrative and other methods.²⁵⁶ Disability as a ground of

“Discrimination on the basis of disability” means any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable accommodation;

Reasonable accommodation” means necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms.”

²⁵⁵ See, ACHR Article III that provides: “To achieve the objectives of this Convention, the state parties undertake:

1. To adopt the legislative, social, educational, labor-related, or any other measures needed to eliminate discrimination against persons with disabilities and to promote their full integration into society, including, but not limited to: (a) Measures to eliminate discrimination gradually and to promote integration by government authorities and/or private entities in providing or making available goods, services, facilities, programs, and activities such as employment, transportation, communications, housing, recreation, education, sports, law enforcement and administration of justice, and political and administrative activities; (b) Measures to ensure that new buildings, vehicles, and facilities constructed or manufactured within their respective territories facilitate transportation, communications, and access by persons with disabilities; (c) Measures to eliminate, to the extent possible, architectural, transportation, and communication obstacles to facilitate access and use by persons with disabilities; and (d) Measures to ensure that persons responsible for applying this Convention and domestic law in this area are trained to do so. **2.** To work on a priority basis in the following areas: (a) Prevention of all forms of preventable disabilities; (b) Early detection and intervention, treatment, rehabilitation, education, job training, and the provision of comprehensive services to ensure the optimal level of independence and quality of life for persons with disabilities; and (c) Increasing of public awareness through educational campaigns aimed at eliminating prejudices, stereotypes, and other attitudes that jeopardize the right of persons to live as equals, thus promoting respect for and coexistence with persons with disabilities;”

²⁵⁶ See Ibid, Article 1 & 2. Article 1 declares: “The States Parties to this Convention undertake to respect the rights and freedoms recognized herein and to ensure to all persons subject to their jurisdiction the free and full exercise of those

discrimination is not mentioned in its text. However it does not mean it is a non-recognized ground. The conventional rights as specified are guaranteed to every human being as conditioned by subsection two of the article.²⁵⁷ Furthermore, under article 3 and 24, the convention guarantees to “everyone person the right to recognition as a person before the law”,²⁵⁸ equality before the law and to equal protection of the law without any discrimination.²⁵⁹ The right to humane treatment and respect for every person’s physical, mental and moral integrity is also a guarantee to all persons with mental disabilities.²⁶⁰ It is prohibited to expose individuals to situations that may lead ‘to torture or to cruel, inhuman, or degrading punishment or treatment’.²⁶¹ Therefore, all persons deprived of their liberty, even for the purpose of treatment- ‘must be treated with respect for the inherent dignity of the human person’.²⁶²

Analogous to the African Charter, the American Conventions article 7 does not reference grounds of deprivation of liberty, but acknowledges the right and restricting possibilities with due regards to procedural safeguards to prevent arbitrariness including promotion of the right to be informed of reason for detention, right to be presented before a judge, right to review of detention and to seek remedies in the event of unlawful detention.²⁶³ Hence it provides Member States a wider margin to specify the grounds upon which the right may be restricted in their legislation.²⁶⁴ The protection

rights and freedoms, without any discrimination for reasons of race, color, sex, language, religion, political or other opinion, national or social origin, economic status, birth, or any other social condition.

Article 2 provides that: Where the exercise of any of the rights or freedoms referred to in Article 1 is not already ensured by legislative or other provisions, the States Parties undertake to adopt, in accordance with their constitutional processes and the provisions of this Convention, such legislative or other measures as may be necessary to give effect to those rights or freedoms.”

²⁵⁷ See, Ibid, Article 1 (2). It states *inter alia* that: “For the purposes of this Convention, “person” means every human being”.

²⁵⁸ See, Ibid, Article 3.

²⁵⁹ See, Ibid, Article 3 & 24.

²⁶⁰ See, Ibid, Article 5(1).

²⁶¹ See, Ibid, Article 5(2).

²⁶² See, Ibid, Article 5(2).

²⁶³ See, Ibid, Article 7.

²⁶⁴ See, Ibid, Article 7 which is as follow: “1. Every person has the right to personal liberty and security. 2. No one shall be deprived of his physical liberty except for the reasons and under the conditions established beforehand by the constitution of the State Party concerned or by a law established pursuant thereto. 3. No one shall be subject to arbitrary arrest

under article 7(right to fair trial) and the possibility of enforcing measures involving compulsory treatment is reiterated in the case of *Victor Rosario Congo v Ecuador (1999)*, that the Inter-American Commission on Human Rights (hereafter IACHR) adjudicated over and found a violation of the American Convention.²⁶⁵The IACHR in this case found a violation of the right to humane treatment of a person with mental disability. While in detention pending the determination of his trial for robbery, Victor Rosario was diagnosed with mental disability but was denied medical treatment, struck in the head and confined in his cell for forty days.²⁶⁶

In finding a violation of the mentioned right whilst under detention, the IACHR relied on the MI Principles to underscore that “inhuman and degrading treatment or punishment should be interpreted so as to extend the widest possible protection against abuses, whether physical or mental.”²⁶⁷It also looked at other regional instruments such as the European Commission jurisprudence to emphasize that those persons detained and those with mental disability must be treated with dignity, placed and provided with better living and treatment facilities.²⁶⁸The commission emphasized that

or imprisonment.4. Anyone who is detained shall be informed of the reasons for his detention and shall be promptly notified of the charge or charges against him.5. Any person detained shall be brought promptly before a judge or other officer authorized by law to exercise judicial power and shall be entitled to trial within a reasonable time or to be released without prejudice to the continuation of the proceedings. His release may be subject to guarantees to assure his appearance for trial. 6. Anyone who is deprived of his liberty shall be entitled to recourse to a competent court, in order that the court may decide without delay on the lawfulness of his arrest or detention and order his release if the arrest or detention is unlawful. In States Parties whose laws provide that anyone who believes himself to be threatened with deprivation of his liberty is entitled to recourse to a competent court in order that it may decide on the lawfulness of such threat, this remedy may not be restricted or abolished. The interested party or another person in his behalf is entitled to seek these remedies.”

²⁶⁵ See, *Victor Rosario Congo v Ecuador* Case No. 11.427(1999) Inter-Am.C.H.R

²⁶⁶ See, *Ibid*, paras 50-68.

²⁶⁷ See, *Ibid*. Para 54 states that: “In this case the person whose physical, mental and moral integrity was allegedly violated suffered from a mental disability. Therefore, the Commission considers that in the present case the guarantees established in article 5 of the American Convention must be interpreted in light of the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care.⁸ These principles were adopted by the United Nations General Assembly as a guide to interpretation in matters of protection of the human rights of persons with mental disabilities, which this body regards as a particularly vulnerable group.”

²⁶⁸ See, *Ibid*, In para 66, the commission accentuated that : “The European Commission has established that the incarceration of a mentally disabled person under deplorable conditions and without medical treatment may be considered as inhuman or degrading treatment.¹⁴ In the case *Herczegfalvy vs. Austria* it reiterated that failure to provide medical treatment to prisoners or mental patients can constitute a violation of the provisions of the European Convention on Human Rights, regarding the infliction of inhuman or degrading treatment or punishment.” Note: At the time, the Commission worked parallel the European Court of Human Rights and its jurisprudence is reflected in this court.

“a violation of the right to physical integrity is even more serious in the case of a person held in preventive detention, suffering a mental disease, and therefore in the custody of the State is in a particularly vulnerable position.”²⁶⁹ Again, these principles under the right to liberty, the respect of human dignity, conditions of detention, judicial review of detentions are echoes of the already discussed jurisdictions.

In all, involuntary detention and treatment in the American jurisprudence is permissible as long as proper procedures are followed as provided in the law of a particular Member State along with the deprivation of liberty being done in a humane manner without degrading the human dignity of persons with mental disability. Persons with mental disability deprived of their liberty must be informed of the reason on which the deprivation is made. They have an entitlement to assistance by their loved ones or guardians, recourse to review procedures of their detention and to remedy in the event of unlawful deprivation of liberty and inhumane treatment.²⁷⁰ This is reinforced by the Discrimination Convention which protects against discriminatory conducts or prejudices and for that reason it requires States to undertake all measures possible to guarantee that it does not transpire anywhere.²⁷¹ Therefore, equality in treatment, in mental health service provision and in accessing the judiciary should all be complied with.

The above concludes the discussion on right to liberty, civil commitment and arbitrary detention from primary international human rights instruments. So far, it is revealed that there is a common understanding of permissibility to limit the right to liberty but with guarantees of standards. The subsequent evaluates the same from the perspective of two important secondary international human rights documents

²⁶⁹ See, *Ibid*, para 67.

²⁷⁰ See, ACHR Article 7.

²⁷¹ See, Inter-American Convention on the Elimination of all Forms of Discrimination against Persons with Disabilities Supra note 251.

1.2.1.3. Persuasive International Instruments: MI principles and Basic Principles

These two principles UN General Assembly Principles for the Protection of Persons with Mental illness and the Improvement of Mental Health Care (1991) (MI Principles herein after),²⁷² and United Nations Basic Principles and Guidelines on Remedies and Procedures on the Right of Anyone Deprived of Their Liberty to Bring Proceedings before a Court pursuant to Human Rights Council resolution 20/16 (2015) (Hereafter Basic Principles),²⁷³ are persuasive international human rights instruments. Even so they recommend ways of dealing with arbitrariness and unlawful abuse in circumstances of deprivation of liberty which is inclusive of civil commitment. The MI Principles (1991) are specific as they deal with involuntary commitment and treatment of persons with mental disability whereas the Basic Principles are more general covering all aspects that may constitute deprivation of liberty and particularly with arbitrariness through safeguards such as the right of judicial review of the deprivation being its main focus as shall be expounded on further down. The discussion begins with the MI Principles.

The MI Principles are currently subject to strong criticism due to their acceptance of civil commitment therein and as such has been held to be weak and must be read in light of the CRPD. In this regard they are certainly not being promoted as effective tools of safeguarding the rights of persons with mental disabilities. Paradoxically, it is the first international soft human rights instrument paralleled to the analysed that specifically and precisely acknowledges provision of mental health care, including involuntary commitment and treatment without discrimination of any “kind such as on ground of disability, race, colour, sex, language, religion, political or other opinion, national, ethnic

²⁷² See, UN General Assembly Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (1991) in Michael Perlin et al., *International Human Rights and Comparative Mental Disability Law: Document Supplement*, Carolina Academic Press 243-254 (2006).

²⁷³ See, UN General Assembly, Report of the Working Group on Arbitrary Detention: United Nations Basic Principles and Guidelines on Remedies and Procedures on the Right of Anyone Deprived of Their Liberty to Bring Proceedings Before a Court, A/HRC/30/37 (July 6th 2015).

or social origin, legal or social status, age, property or birth”.²⁷⁴Significantly it sets out substantive and procedural safeguards for those placed under civil commitment.²⁷⁵Moreover, the acceptance is equally pegged on the notion that civil commitment is strictly engaged as a last resort and only exercised on those individuals who qualify. In this regard it enunciates that “where a person needs treatment in a mental health facility, every effort shall be made to avoid involuntary admission [and that] access to a mental health facility shall be administered in the same way as access to any other facility for any other illness.”²⁷⁶Its text importantly emphasizes that it is a right for an individual to receive provision of mental health care “as far as possible in the community in which he or she lives” and near his friends and family and shall have the right to be returned to the community as soon as possible if civil commitment is carried in a mental health facility far from the community in which he or she resides.²⁷⁷This is very much in line with the CRPD requirement on community living and accessing services within the community. In view of this, it is interesting how it is presently considered a weak document.

In addition to the highlighted, the MI Principles maintains that all persons have the right to the best mental health care and that persons with mental illness shall be treated as persons with dignity and without discrimination.²⁷⁸The principles in essence provide a proper framework for the provision of mental health care with human rights values which could or should be used to articulate CRPD article 14 for persons with mental disability under compulsory commitment for treatment instead of being deemed incompatible with the CRPD. Some scholars among them Penelope Weller concur by claiming that:

On their face, the MI Principles construct a coherent human rights framework for mental health law. They require that medical treatment is provided in the least restrictive manner,

²⁷⁴ See, MI Principles, Supra note 271, p.243.

²⁷⁵ See, Ibid, p.243-254.

²⁷⁶ See, Ibid, Principle 15(1&2).

²⁷⁷ See, Ibid, Principle 7(1&2).

²⁷⁸ See, Ibid, Supra note 271, p.244.

according to an individual plan. Treatment must also reflect accepted medical standards and be delivered in a manner that is supportive of autonomy (Principle 9). Medication must be given for therapeutic purposes only (Principle 10), and all treatment is to be provided with free and informed consent (Principle 11). The principle of informed consent, however, is modified by lengthy qualifications that strongly endorse involuntary medical treatment upon persons who are subject to involuntary detention procedures, which is limited only by standards of medical practice and principle of best interests.²⁷⁹

These principles are equivalent to many national mental health legislation, including some definitions such as the description of mental health care in the MI Principles preamble where it is defined that “mental health care includes analysis and diagnosis of a person’s mental condition, treatment, care and rehabilitation for a mental illness or suspected mental illness.”²⁸⁰ Mental health care can be given in a “mental health facility [which] means any establishment, or any unit of an establishment, which as its primary function provides mental health care, [to a] patient [who is] a person receiving mental health care and includes all persons who are admitted to a mental health facility”.²⁸¹ On involuntary commitment, the MI Principles upholds with similar caveat that it should be engaged as a last resort with due regard to procedural and other safeguards in order to avoid any breach of fundamental human rights in principle 15 and 16.²⁸² The MI Principles for all intents and purposes

²⁷⁹ Penelope Weller, *Lost in Translation: Human Rights and Mental Health Law* in Bernadette McSherry and Penelope Weller (eds.), *Rethinking Rights-Based Mental Health Law*, Hart Publishing 64 (2010).

²⁸⁰ See, MI Principles, *Supra* note 272, p.243.

²⁸¹ See, *Ibid.*

²⁸² See, *Ibid.* Principle 15 & 16 provide that: Principle 15 Admission principles 1. Where a person needs treatment in a mental health facility, every effort shall be made to avoid involuntary admission. 2. Access to a mental health facility shall be administered in the same way as access to any other facility for any other illness. 3. Every patient not admitted involuntarily shall have the right to leave the mental health facility at any time unless the criteria for his or her retention as an involuntary patient, as set forth in principle 16 below, apply, and he or she shall be informed of that right. Principle 16 Involuntary admission 1. A person may be admitted involuntarily to a mental health facility as a patient or, having already been admitted voluntarily as a patient, be retained as an involuntary patient in the mental health facility if, and only if, a qualified mental health practitioner authorized by law for that purpose determines, in accordance with principle 4 above, that that person has a mental illness and considers:(a) That, because of that mental illness, there is a serious likelihood of immediate or imminent harm to that person or to other persons; or (b) That, in the case of a person whose mental illness is severe and whose judgement is impaired, failure to admit or retain that person is likely to lead to a serious deterioration in his or her condition or will prevent the giving of appropriate treatment that can only be given by admission to a mental health facility in accordance with the principle of the least restrictive alternative. In the case referred to in subparagraph (b), a second such mental health practitioner, independent of the first, should be consulted where possible. If such consultation takes place, the involuntary admission or retention may not take place unless the second mental health practitioner concurs.

2. Involuntary admission or retention shall initially be for a short period as specified by domestic law for observation and preliminary treatment pending review of the admission or retention by the review body. The grounds of the admission shall be communicated to the patient without delay and the fact of the admission and the grounds for it shall

accentuates these standards such as the use of a review body(principle17), notice of rights upon admission(principle12), Other procedural safeguards such as right to counsel, interpreter to other assistance(principle 18), access to information(principle 19), right to make a complaint (principle 21), right to live and work and be treated in the community (principles 3 and 7), right to consent(principle 11), right to receive adequate standard of care in treatment and environmental wise(principles 8,9,10) and right to exercise all their fundamental freedoms and basic rights(principle 1).²⁸³As shall be examined in the coming chapters, these standards among others are situated within the domestic legislations of the chosen jurisdictions and beyond. Compared to the CRPD, some of them are present therein.

Authentically, the MI Principles are not without limitations such as the use of statements like providing mental health care based on a “suspected mental illness” which might be used arbitrary,²⁸⁴and as such constitutes one of the strong reasons behind the CRPD Committee’s condemnation of mental health legislation that have such permitting statements.²⁸⁵ Excluding this fact, the MI Principles should not be outrightly proscribed for the utter fact that it is one of those documents that endorses involuntary commitment and treatment attributed to the medical model, without any suggestions of modification or repeal of some parts. Weller in her description of the MI Principles proceeds to illuminate that:

The MI Principles were strongly criticised by consumers and academics because of their uncritical acceptance of the medical model of disease and treatment, and their related endorsement of involuntary detention and treatment. For example, Eric Rosenthal and Leonard Rubenstein described the consent provisions in the MI Principles as an unacceptably loose standard that permits the imposition of medical treatment according to a vague and

also be communicated promptly and in detail to the review body, to the patient's personal representative, if any, and, unless the patient objects, to the patient's family. 3. A mental health facility may receive involuntarily admitted patients only if the facility has been designated to do so by a competent authority prescribed by domestic law.

²⁸³ Penelope Weller, *Lost in Translation: Human Rights and Mental Health Law* in Bernadette McSherry and Penelope Weller (eds.), *Rethinking Rights-Based Mental Health Law*, Supra note 278, p.64.

²⁸⁴ See, MI Principles, Supra note 272, p. 243.

²⁸⁵ See, CRPD Committee, *Guidelines on Article 14*, Supra note 41. See also, CRPD Committee, *Statement on Article 14 of the Convention on the Rights of Persons with Disabilities*, Geneva, (September 2014), para 1.

unlimited 'best interests' standards.²⁸⁶ Caroline Gendreau has argued that the MI Principles actually limited the scope of human rights that were thought to apply to persons living with mental illness at the time that they were adopted.²⁸⁷

The referred to scholars are but among those who have voiced their opinions against the applicability of the MI Principles before and after the CRPD. For instance during the preparation of the CRPD, firm opinions were voiced out against the application of the MI Principles. For example, International Disability Alliance (IDA) position paper on CRPD and particularly on deprivation of liberty for the purpose of commitment and treatment were of the opinion that the MI Principles support for treatment of an individual with mental illness at a mental health facility after certain conditions are met, is supplanted by article 14 (prohibiting deprivation of liberty based on a disability) and article 25 (requiring treatments administered on free and informed basis) of the CRPD.²⁸⁸ After the coming in of the CRPD, the same opposition is sustained for example by the CRPD guidelines on the application of article 14,²⁸⁹ including from other actors reports such as the interim report,²⁹⁰ and report of the Special rapporteur on torture Juan Mendez on forced psychiatric interventions. In the report, the latter declares verbatim that:

Then 2008 the mandate made significant strides in the development of norms for the abolition of forced psychiatric interventions on the basis of disability alone as a form of torture and ill-treatment (see A/63/175). The Convention on the Rights of Persons with Disabilities also provides authoritative guidance on the rights of persons with disabilities and prohibits involuntary treatment and involuntary confinement on the grounds of

²⁸⁶ See, Eric Rosenthal & Leonard Rubenstein, *International Human Rights advocacy under the Principles for the Protection of Persons with Mental illness*, 16 *International Journal of Law and Psychiatry* 257 (1993).

²⁸⁷ See, Penelope Weller, "Lost in Translation: Human Rights and Mental Health Law" in Bernadette McSherry and Penelope Weller (eds.), *Rethinking Rights-Based Mental Health Law*, *Supra* note 279, p.64.

²⁸⁸ See, International Disability Alliance, *Position Paper on the Convention on the Rights of Persons with Disabilities (CRPD) and Other Instruments*, (April 25, 2008) p. 4.

²⁸⁹ See, CRPD Committee, *General Comment No (1)*, *Supra* note 40, para. 40 & 41.

²⁹⁰ See, UN Doc, *Interim Report of the Special Rapporteur on Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, Juan E. Méndez*, A/68/295 (9 August 2013). Paragraph 32 States that: "The Special Rapporteur fully endorses the proposal by the Expert Group to include a new preamble that would include a list of the fundamental principles contained in already adopted treaties and guidelines regarding treatment in detention (see Rule 3 and E/CN.15/2012/CRP.2, sect. 4). Some proposed preambles (for example, that proposed in UNODC/CCPCJ/EG.6/2012/NGO/1), however, refer to instruments that set out standards that fall short of those recognized in subsequent instruments; these earlier instruments should not, therefore, be cited in the Rules. For instance, the standards set out in the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (1991), have, in various important respects, been superseded by the higher standards set out in the Convention on the Rights of Persons with Disabilities (see A/HRC/22/53, para. 58).

disability, superseding earlier standard such as the 1991 Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (1991Principles).²⁹¹

In keeping with the above, it can be inferred that this understanding is in line with the CRPD considering the prohibition on deprivation of liberty based on disability and from the Guidelines and General comment given by the CRPD Committee to the effect that involuntary commitment and treatment is prohibited under the convention. It can also be conjectured from the CRPD preamble together with the analysed interpretive documents that do not mention the MI Principles among those internationally binding and non-binding human rights instruments deemed pertinently interlinked as to offer protection to persons with disabilities.²⁹²

All included, the MI Principles expresses far more extensive standards on civil commitment than any other international human rights document and whose principles are not only reflected in the domestic mental health legislation, but are constantly being recited by domestic, regional and international courts. Additionally, various State Parties to the CRPD in reaction to the appeal of abolishing mental health legislation, strongly made supporting statements to the use of the MI Principles and to this end showing their reluctance to do away with civil commitment. The thesis, finds the Principles more guiding because they offer leading standards especially now when there is a lack of an acceptable guiding document on civil commitment. Despite the CRPD position on the matter and in view of the current State Practices, a guiding document to ensure protection of those subjected and being subjected to civil commitment from the CRPD would be ideal.

²⁹¹ See, Report of the Special Rapporteur on Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, Juan E.Méndez, *Supra* note 77, para.58.

²⁹² See, CRPD Preamble (a-f). See also; CRPD Committee General Comment No (1), *Supra* note 40, para, 5&6.

The following considers civil commitment and arbitrary detention as provided by the **UN Working Group on Arbitrary Detention (UNWGAD)** and its documents as it provides significant and expansive standpoints on arbitrary detention and the role of standards. UNWGAD is an organ established by the Human Rights Council by resolution 1991/42 to investigate report and resolve matters entailing arbitrary detention in those jurisdictions party to the Universal Declaration of Human Rights and the International Covenant on Civil and Political Rights.²⁹³ Accordingly, over the years as well as presently, its jurisprudence has been clear on the issue of deprivation of liberty and arbitrary detention as set out in its broad definition articulated in the recently Adopted United Nations Basic Principles and Guidelines on Remedies and Procedures on the Right of Anyone Deprived of Their Liberty to Bring Proceedings before a Court pursuant to Human Rights Council resolution 20/16 (**Hereafter Basic Principles**).²⁹⁴ Before highlighting what constitutes arbitrary detention, it is important to comparatively emphasize that parallel the previously discussed international documents, the Basic Principles equally constitutes that everybody has the right to liberty and according to international law, States have the duty to ensure that every person enjoys this right and that those deprived have the right to have a determination of whether the deprivation is lawful.²⁹⁵ The right is not absolute and as a result it can be limited without free consent. It should not be arbitrary or unlawful since “deprivation of liberty is regarded as “arbitrary” in the following cases:

- (a) When it is clearly impossible to invoke any legal basis to justify the deprivation of liberty (such as when a person is kept in detention after the completion of his or her sentence, or despite an amnesty law applicable to the detainee, or when a person detained as a prisoner of war, is kept in detention after the cessation of effective hostilities);
- (b) When the deprivation of liberty results from the exercise of the rights or freedoms guaranteed by articles 7, 13, 14, 18, 19, 20 and 21 of the Universal Declaration of Human Rights and, insofar as States parties are concerned, by articles 12, 18, 19, 21, 22, 25, 26 and 27 of the International Covenant on Civil and Political Rights;
- (c) When the total or partial non-observance of the international norms relating to the right to a fair trial, established in the Universal Declaration of Human Rights and in the relevant

²⁹³ See, UN Doc, ESC, Commission for Human Rights, E/CN.4/1992/20, “Question of the Human Rights Of all Persons Subjected to Any Form of Detention or Imprisonment, Report of WGAD” (January 1992), p.2.

²⁹⁴ See, Report of the Working Group on Arbitrary Detention, Basic principles, Supra note 273.

²⁹⁵ See, Ibid, para 1.

international instruments accepted by the State concerned, is of such gravity as to give the deprivation of liberty an arbitrary character;

(d) When asylum seekers, immigrants or refugees are subjected to prolonged administrative custody without the possibility of administrative or judicial review or remedy;

(e) When the deprivation of liberty constitutes a violation of international law for reasons of discrimination based on birth, national, ethnic or social origin, language, religion, economic condition, political or other opinion, gender, sexual orientation, disability or other status, and which is aimed at or may result in ignoring the equality of human rights.²⁹⁶

In other words, the above can be summarised that- arbitrary deprivation and detention may constitute circumstances where the deprivation and detentions have no lawful permissible basis, are intended to deprive the detainee the exercise of the fundamental guaranteed rights or could arise where necessary procedural safeguards are not present or unapplied to render the arrest and custody to gain an arbitrary character despite the legality in the first instance. This construction is comparable to the one sustained by the ECHR, ICCPR and other jurisprudence and to which the thesis relates to. This having been stated, the Basic Principles considers the risk of arbitrariness to take place in situations of permissible deprivation of liberty that encapsulates:

the period from the initial moment of apprehension until arrest, pretrial and post-trial detention periods. This includes placing individuals in temporary custody in protective detention or in international or transit zones in stations, ports and airports, house arrest, rehabilitation through labour, retention in recognized and non-recognized centres for non-nationals, including migrants regardless of their migration status, refugees and asylum seekers, and internally displaced persons, gathering centres, hospitals, psychiatric or other medical facilities or any other facilities where they remain under constant surveillance, given that may not only amount to restrictions to personal freedom of movement but also constitute the de facto deprivation of liberty. It also includes detention during armed conflicts and emergency situations, administrative detention for security reasons, and the detention of individuals considered civilian internees under international humanitarian law.²⁹⁷

As it can be seen, hospital, psychiatric centers, other medical facilities and gathering centers that may be inclusive of spiritual and traditional centers of healing resonate with what has already been established as places where detention of those deprived of their liberty may occur. Note that the

²⁹⁶ See, *Ibid*, para 10.

²⁹⁷ See, *Ibid*, para 9.

Basic Principles does not permit the exercise of involuntary commitment even though it might be construed that it does by articulating these facilities. Comparable to the CRPD language, the Basic Principles proscribes that “the involuntary committal or internment of persons on the grounds of the existence of an impairment or perceived impairment, particularly on the basis of psychosocial or intellectual disability or perceived psychosocial or intellectual disability, is prohibited [and] States shall take all necessary legislative, administrative and judicial measures to prevent and remedy involuntary committals or internments based on disability.”²⁹⁸ Therefore it requires that provision of all health services including all mental health care services be provided within the communities based on a free and informed consent with support mechanisms where appropriate, and prohibits the denial of legal capacity and use of substitute decision makers.²⁹⁹ As per the Principles, the failure to abide by these requirements shall constitute “arbitrary deprivation of liberty in violation of international law”.³⁰⁰ It appears contradictory that the Basic principles disapproves of involuntary treatment but at the same time acknowledges the mentioned mental health facilities as places where lawful deprivation may be executed including offering certain guarantees to those detained as provided below.

Therefore, on a neutral and practical ground as it may be reasoned the Basic Principles requires that those committed should be afforded equality guarantees inclusive of “reasonable accommodation and humane treatment in accordance with the objectives and principles of the highest standards of international law pertaining to the rights of persons with disabilities”.³⁰¹ Reasonable accommodation constitutes elements that guarantee, due process rights, detention that meets their need for example gender, humane living conditions, access to appropriate interpreters, to information, equal

²⁹⁸ See, Ibid, Guideline 103.

²⁹⁹ See, Ibid, Guideline 106 (b).

³⁰⁰ See, Ibid, Guideline 106 (b).

³⁰¹ See, Ibid, Guideline 103.

access to law enforcement agencies such as the judiciary and to fair compensation in ‘the case of arbitrary or unlawful deprivation of liberty’.³⁰²

Now, what constitutes arbitrariness as regards to circumstances of psychiatric detentions/ civil commitment by the Basic Principles is what has been underscored a paragraph above and comparatively related to the CRPD standpoint. The list according to UNWAGD is not exhaustive because it is not ‘possible and necessary to give an exhaustive list’ for prohibition of arbitrariness can be interpreted broadly and in a contextual manner.³⁰³ However, previously in 2005 the UNWGAD had developed a set of general guidelines for assessing arbitrariness which are not different from the substantive and procedural grounds used by the ECHR under article 5 or its own given in the context of reasonable accommodation guarantees in the present Basic Principles.³⁰⁴ In Addition to those guidelines, UNWGAD enumerated that the following minimum requirements must be met to balance out the presence of arbitrariness;

³⁰² See, Ibid, Guideline 107.

³⁰³ See, UN Doc, E/CN.4/2005/6

³⁰⁴ See, Ibid, para 55. The List includes: “(a) Psychiatric detention as an administrative measure may be regarded as deprivation of liberty when the person concerned is placed in a closed establishment which he may not leave freely. Whether the conditions of someone being held in a psychiatric institution amounts to deprivation of liberty, within the meaning of its mandate, will be assessed by the Working Group on a case-by-case basis; (b) The same applies to the deprivation of liberty of suspected criminals pending medical check-up, observation and diagnosis of their presumed mental illness, which may have an impact on their criminal accountability; (c) Law shall provide the conditions of the deprivation of liberty of persons of unsound mind, as well as the procedural guaranties against arbitrariness. The requirements in respect of such laws are set out in more detail under paragraph 45 (a) and (b) above; (d) Article 9, paragraph 3, of ICCPR shall be applied to anyone arrested or detained on a criminal charge who shows the signs of mental illness, by duly taking into account his vulnerable position and the ensuing diminished capability to argue against detention. If he does not have legal assistance of his own or of his family’s choosing, effective legal assistance through a defense lawyer or a guardian shall be assigned to him to act on his behalf; (e) Article 9, paragraph 4, of ICCPR shall be applied to anyone confined by a court order, administrative decision or otherwise in a psychiatric hospital or similar institution on account of his mental disorder. In addition, the necessity whether to hold the patient further in a psychiatric institution shall be reviewed regularly at reasonable intervals by a court or a competent independent and impartial organ and the patient shall be released if the grounds for his detention do not exist any longer. In the review proceedings his vulnerable position and the entailing need for an appropriate representation, as provided for under (d) Above has also been taken into consideration; (f) Decisions on psychiatric detention should avoid automatically following the expert opinion of the institution where the patient is being held, or the report and recommendations of the attending psychiatrist. Genuine adversarial procedure shall be conducted, where the patient and/or his legal representative are given the opportunity to challenge the report of the psychiatrist; (g) Psychiatric detention shall not be used to jeopardize someone’s freedom of expression nor to punish, deter or discredit him on account of his political, ideological, or religious views, convictions or activity.”

(a) Deprivation of liberty must not be manifestly disproportionate, unjust, unpredictable or discriminatory.

(b) Moreover, the detention is manifestly arbitrary if a person is deprived of his liberty on the pretext of his (alleged) mental disability, but it is obvious that he is detained on account of his political, ideological, or religious views, opinion, conviction or activity.³⁰⁵

From the above, it is discernible that there are informative standards which the working group applies. Then again they are persuasive and are neither universally applicable. It also remains contentious whether State Parties may abandon their stance on involuntary commitment as proposed by the Basic Principles since they are reminiscent of the CRPD perspective. Finally, what the Basic Principle and the CRPD alike do not report to is whether civil commitment may be constituted as arbitrary in circumstances where individuals actually consent to the process for instance through advance directives, living wills or via legal documents such as powers of attorney empowering their care givers to commit them where and when applicable. To this end, it can be argued that majority of the international human rights instruments such as the ICCPR, ECHR, ACHR, ACHPR and the MI Principles permit the limitation of the right to liberty in circumstances of civil commitment provided that there is an enforceable enabling law with protective standards. Imperatively, it is emphasized in their jurisprudence that the deprivation of liberty must never be arbitrary, must be enforced according to the purpose and in an environment conducive of the objective of detention. It is also required that restricted individuals must be given the opportunity to exercise their right to judicial mechanism to guarantee that the executed compulsory measures are deemed lawful.

The next analysis examines the right to health and subsequently the right from torture focusing on the recurring question how and whether civil commitment is juxtaposed within their jurisprudence. The thesis considers that this inquiry is important because the right to health encompasses the right

³⁰⁵ See, Ibid, para 54(b)

to mental and physical health. Equally, analyzing the right from torture ascertains whether civil commitment as constituted by the CRPD Committee and other actors amounts to torture.

1.2.2. Civil Commitment and the Right to Health: CRPD & ICESCR Perspectives

As discussed above, deprivation of liberty connects with other rights such as the right to be free from ill-treatment and torture. It also interlinks with the right to health through the process of civil commitment. Persons with mental disability as discussed earlier may be deprived of their right to liberty for treatment purposes. Those detained after a criminal prosecution and are found not guilty because of a mental illness, can equally be detained according to the relevant applicable law to receive therapeutic treatment. Most at times, their treatment is undertaken through the mental health legislations. Persons under detention must be guaranteed the right to the highest standard of physical and mental health. This requires a guarantee of proper detention environment, food, water, treatment and humane care. Short of these requirements any actions and omissions may amount to neglect, ill-treatment, degrading treatment and even torture as discussed under the right to be free from torture.

Thus, the right to health, particularly to mental health across many jurisdictions in the world has been described as dire at best, with health systems around the world confronting enormous challenges in providing care and safeguarding the human rights of people with mental disabilities.³⁰⁶ In 2005, mental health illnesses was estimated to contribute to 12 percent of the global burden of disease and by 2011, it had increased by 2 totalling 14 percent. Yet the provision of mental health care and services has remained relatively the same. In 2005 the special rapporteur on Economic, Social and Cultural Rights- Paul Hunt reported that:

³⁰⁶ See, World Health Organization, MhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-specialized Health Settings, World Health Organization Publication (2010), p.iii.

One in every four persons will suffer from a mental disorder at some stage in his or her life. Moreover, the incidence of such disorders is increasing. Today, about 450 million people around the world suffer from mental or neurological disorders, or from psychosocial problems. Very few of them are receiving treatment, care and support - and if they are, it is often seriously inappropriate. Mental and behavioral disorders are estimated to account for 12 per cent of the global burden of disease, yet the mental health budget of most countries is less than 1 per cent of their total health expenditure. Mental health care and support services are often not covered by health insurance. More than 40 per cent of countries have no mental health policy and over 30 per cent have no mental health programme. Over 90 per cent of countries have no mental health policy that includes children and adolescents. In short, mental health is among the most grossly neglected elements of the right to health.³⁰⁷

In 2011 and 2013, Dr. Margaret Chan the director of World Health organization provided a new estimate by stating that “fourteen per cent of the global burden of disease is attributable to these disorders and almost three quarters of this burden occurs in low- and middle-income countries.”³⁰⁸

In support, other research indicate that “there is a growing evidence concerning the substantial incidence and prevalence of severe and persistent mental disorders, such as schizophrenia, bipolar, depressive and related disorders, and also of substance misuse, dementia and intellectual disability not only in high-and medium-but low-income countries with diverse cultures.”³⁰⁹ However, “the resources available in countries are insufficient – the vast majority of countries allocate less than 2% of their health budgets to mental health leading to a treatment gap of more than 75% in many low- and middle-income countries.”³¹⁰

The consequences of this burden that outstrips the allocated budget to mental health services, is that persons with mental disabilities, majority of whom are of low means continue to have difficulties in

³⁰⁷ See, UN Economics & Social Council, Economic, Social and Cultural Rights: Report of Special Rapporteur (Paul Hunt) on the Right to Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, E/CN.4/2005/51 (2005), para.6.

³⁰⁸ See, World Health Organization, MhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-specialized Health Settings, Supra note 305. See also, World health organization, Mental Health action Plan 2013-2020, Geneva World health Organization Publication (2013), p.7&8.

³⁰⁹ See, Michael Dudley, Derrick Silove & Fran Gale ed., Mental Health, Human Rights, and their Relationship: An Introduction in Michael Dudley, Derrick Silove & Fran Gale ed., Mental Health and Human Rights: Vision Praxis and Courage, Supra note 76, p.4.

³¹⁰ See, World Health Organization, MhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-specialized Health Settings, Supra note 305. See also: World health organization, Mental Health action Plan 2013-2020, Supra note 308.

accessing and engaging services. They also continue to be a vulnerable group disadvantaged and at a greater risk of abuse. Investigative research reveals that “worldwide, persons with mental disabilities often live in the most parlous circumstances: starving, naked, destitute, and denied proper hygiene and sanitation, [including being] frequently shackled chained, caged or imprisoned without charge, they may be hidden away or, alternatively exposed to public view and ridicule”.³¹¹ An additional effect is that without support families are left alone to take care of their relatives and the task becomes difficult most at times, with the inability to cope resulting in the abandonment of their loved ones in unregulated institutions such as traditional and spiritual centers, on the streets, or caged and chained in their homes.³¹² Those detained in formal institutions are not better for they may not have the opportunity to engage with due process and review of their detention because these procedures are lacking including being housed in inhumane and unhygienic living in conditions that predispose them to abuse, arbitrary detentions, discrimination, stigmatization and other violations of their human rights and freedoms.³¹³ Finally, with the effect of deinstitutionalization process and a slow establishment of community based services, many people with mental disabilities without any alternative support end up in the streets or behind prison bars.

These estimates and narratives provide a disheartening picture but then it is the reality of the matter. It is also factual that despite the availability of various international and regional human rights treaties mentioned further along, the right to physical and mental health remains to be an illusory guarantee to many. The right to health is a right recognized by various international and regional

³¹¹ See, Michael Dudley, Derrick Silove & Fran Gale ed., *Mental Health, Human Rights, and their Relationship: An Introduction* in Michael Dudley, Derrick Silove & Fran Gale ed., *Mental Health and Human Rights: Vision Praxis and Courage*, Supra note 76, p.5.

³¹² See, Vikram Patel, Arthur Kleinman and Benedetto Saraceno, *Protecting the Human rights of People with Mental Illnesses: A Call to Action for Global Mental Health* in Michael Dudley, Derrick Silove & Fran Gale ed., *Mental Health and Human Rights: Vision Praxis and Courage*, Oxford University Press 367 (2012).

³¹³ See, Michael Dudley, Derrick Silove & Fran Gale ed., *Mental Health, Human Rights, and their Relationship: An Introduction* in Michael Dudley, Derrick Silove & Fran Gale ed., *Mental Health and Human Rights: Vision Praxis and Courage*, Supra note 76, p.5.

human rights instruments as already afore stated. What is envisaged under these instruments is that every individual is guaranteed a right to the highest attainable standard of physical and mental health. Above all, it should be within reach both in terms of the individual's capability, the social and environmental circumstances affecting the health of the individual, and due regard to health services.³¹⁴ It is regarded that, the right to health should not be construed to mean the right to be healthy.³¹⁵ This is because, there are various factors that influences an individual's health for instance risky behavior, genetics, accidents, individual susceptibility to ill health and other factors that may be generated socially or environmentally as already mentioned.³¹⁶ Thus, it is comprehensible that for such influences that extend beyond the control of any individual or State, it is not possible for the State 'to guarantee or provide complete physical, mental or social well-being for everyone within its jurisdiction'.³¹⁷ However, it does not mean that States have no obligations towards their citizens, because they do as shall be analyzed below. For purposes of this thesis, the right to health should be comprehended as the right to the highest attainable standard of health.

As aforementioned, the right to health is protected in various instruments,³¹⁸ but the thesis shall limit its discussion to the CRPD and ICESCR for their relevance and availability of expounded jurisprudence. Accordingly, the CRPD provides inter alia:

States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States

³¹⁴ See, Asbjorn Eide, Adequate Standard of Living in Daniel Moeckli, Sangeeta Shah & Sandesh Sivakumaran (ed.), *International Human Rights Law*, 2nd ed. Oxford University Press 205 (2014).

³¹⁵ See UN Committee on Economic, Social and Cultural Rights, General Comment 14, *The Right to the Highest Attainable Standard of Health*, U.N. Doc. E/C.12/2000/4 (2000), para 8.

³¹⁶ Asbjorn Eide, Adequate Standard of Living in Daniel Moeckli, Sangeeta Shah & Sandesh Sivakumaran (ed.), *International Human Rights Law*, Supra note 313, p. 204.

³¹⁷ See, Manisuli Ssenyonjo, *Economic, Social and Cultural Rights in International Law* Hart Publishing 318 (2009).

³¹⁸ See, UDHR (1948), Article 25, CEDAW (1981), Article 12, CRC (1990), Article 24, ICERD(1979), Article 5 (e-iv), ACHPR (1981), Article 16, Protocol to ACHR (1988), Article 10, ESC (1961), Article 11, & AHRD (2012), Article 29. See also other relevant documents : MI principles (1991), The Committee on Economic, Social and Cultural Rights, General Comment No. 5, *Persons with Disabilities*, U.N. Doc E/1995/22 (1995), para 34, The Programme of Action of the International Conference on Population and Development held at Cairo in 1994. P.38-39 (for persons with disabilities) and chapter VII for reproductive rights reproductive health generally and Vienna Declaration and Programme of Action of 1993, para 63-65 (rights of disabled persons).

Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall:

- (a). Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes;
- (b). Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons;
- (c). Provide these health services as close as possible to people's own communities, including in rural areas;
- (d). Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care;
- (e). Prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner;
- (f). Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability.

And the ICESCR as follows:

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
 - (a). the provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
 - (b). The improvement of all aspects of environmental and industrial hygiene;
 - (c). The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
 - (d). The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

As illustrated, the provisions of these two instruments provide substantive protections in regards to the task of guaranteeing and advocating for the right to health to all individuals and persons with disability as targeted by the CRPD. Both instruments do not mention civil commitment under this right. However from the CRPD article and Committees interpretations from its General Comment one and Guidelines on article 14, provision of health services should be based on free and informed

consent which has been further interpreted by the CRPD Committee to mean a prohibition of all forced interventions including civil commitment. The ICESCR does not expressly articulate the issue of informed consent in its text but it does through the Committee on Economic, Social and Cultural Rights (Hereafter ICESCR Committee) interpretation of the right, and more expansive jurisprudence on the understanding of the right to health than the CRPD. Before expanding more on the CRPD, the interpretation of the ICESCR is given since it provides an in-depth scope of this right, effectually providing an easy understanding of what the CRPD requires.

Accordingly, the scope of the right to health has been interpreted to involve the realization of the right to healthcare and the access to core determinants of health.³¹⁹ Access to health care and to the ‘underlying determinants of health for instance food, housing, safe and portable water, adequate sanitation, safe and health working conditions and a healthy environment’ must be provided in a timely and appropriately manner.³²⁰ An individual’s right to the right to health involves having access to healthcare that encompasses preventive and curative health care.³²¹ It also involves the right to use the essential amenities and services for the diagnosis, treatment, care and prevention of disease, provided in a system of health public or/and private.³²² This imposes an obligation of conduct upon States to take appropriate measures to ensure that the realization of the right to the highest attainable standard of health.³²³ The ICESCR Committee maintains that States have an obligation towards:

The creation of conditions which would assure to all medical service and medical attention in the event of sickness" (art. 12.2 (d)), both physical and mental, includes the provision of equal and timely access to basic preventive, curative, rehabilitative health services and health education; regular screening programmes; appropriate treatment of prevalent diseases, illnesses, injuries and disabilities, preferably at community level; the provision of essential drugs; and appropriate mental health treatment and care. A further important aspect is

³¹⁹ See, Manisulli Ssenyonjo, *Economic, Social and Cultural rights in International Law*, Supra note 317, p.324.

³²⁰ See, The ICESCR Committee General Comment No. 14, Supra note 315, para 4 & 11.

³²¹ See, Manisulli Ssenyonjo, *Economic, Social and Cultural rights in International Law*, Supra note 317, p.325.

³²² See, The ICESCR Committee General Comment No. 14, Supra note 315, para 12.

³²³ See, *Ibid.*

the improvement and furtherance of participation of the population in the provision of preventive and curative health services, such as the organization of the health sector, the insurance system and, in particular, participation in political decisions relating to the right to health taken at both the community and national levels.³²⁴

In relation to the aforementioned, States are required to provide these services in a non-discriminatory manner to all individuals (children, elderly, women, men, persons with disabilities, immigrants) within their jurisdiction by ensuring the availability of both access to functioning health care facilities and goods and the underlying determinants of health such as safe water, healthy environment, proper housing among others.³²⁵ It also encompasses having the services in an accessible manner- physically, economically, through information and without discrimination.³²⁶ In addition to availability and accessibility, health care provided or regulated by the State should be acceptable and of quality.³²⁷ Acceptability entails a guarantee that “all health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.”³²⁸ The quality aspect, requires the assurance that goods and services provided are up to standard and are made available by skilled medical personnel, drugs administered are unexpired and scientifically approved, usage of proper hospital equipment, availability of safe and potable water, and adequate sanitation.³²⁹

The afore stated principles relates to every individual within the jurisdiction of a Member State even if the individuals are accessing medical treatments or care through conventional or other means such as spiritual and traditional health services. As shall be discussed in the section on the

³²⁴ See, Ibid, para 17.

³²⁵ See, Ibid, para 12.

³²⁶ See, Ibid, para 12 (a).

³²⁷ See, Ibid, para 12 (b).

³²⁸ See, Ibid, para 12 (c).

³²⁹ See, Ibid, para 12 (d).

right from torture, certain treatments and care offered in health care settings may not be appropriate and may fall within the ambits of ill-treatment and torture. Particularly for persons detained, the risks of such arbitrary abuse are relatively high. Therefore, it is important that administration of treatments and care through conventional or otherwise are carried out in an ethical manner, in a therapeutic environment and are regulated by law. Persons with mental disability are also entitled to have access to the highest standard of physical and mental health provided by State and private bodies. Individuals under compulsory treatment and care and in detention, must by the same token be guaranteed all the above. This level of health requirements must be guaranteed in any facility, be it mental institutions, social care homes and in the community. As previously highlighted mental health services in various parts of the globe are inadequately provided. For that reason, States must respect, promote and fulfill their obligations as declared in the ICESCR, the CRPD and other instruments. The enactment or reforming of outdated mental health laws that recognize individuals with mental disability as individuals and citizens is one of the effective legal measures that States should engage. Though legislation does not always and singly guarantee respect and protection of human rights, it must be accompanied by sensitization, financial backing and monitoring.

The respect of autonomy is a key right that must equally and fundamentally guaranteed in accessing health care. The CRPD centralizes this right requiring the consideration and respect of individual's choices when it comes to decision making. It is presently a much contested concern as it relates to decision making for persons with mental disability, especially as far as civil commitment goes. For a long time, paternalistic decision making or intervention has been exercised like a norm on behalf of persons with mental disabilities, classically influenced out of concern for the patients' health or health associated safety best interests.³³⁰ Even though paternalistic actions are generally

³³⁰ See, Eriksson M. Sjöstrand et al, Paternalism in the Name of Autonomy, *Journal of Medicine and Philosophy* 4 (2013).

more common in the field of health care with contested debates of when autonomous decision making should be dispensed,³³¹ it is more common in the making of treatment decisions for those with mental disabilities. This intervention has been justified by the reasoning that uncertainties about mental capacity evolve much more often when individuals have a mental disorder, as opposed to when they have a physical ailment.³³² Even though capacity to consent for medical care can be compromised by both mental and physical ailments, it is nonetheless evidently more recurrent in individuals with mental illness and equally presents a lot of challenges such as risk of abuse.³³³ Illustration of abuse as a consequence of paternalistic actions can be drawn from some reviewed cases in the thesis such as *H.L v United Kingdom or X V Finland* discussed in the beginning.

Thus, the ICESCR Committee in its general comment 14 and the Special rapporteur report on the right to health emphasize that it is important to respect the right to information and the capacity to make one's choice through informed consent as one of the tenets of exercising autonomy in the enjoyment of the right to health.³³⁴ The ICESCR Committee's General Comment 14 touches on access to health through respect and protection of an individual's autonomy as one of the normative content of article 12 which must be understood as follows:

The right to health is not to be understood as a right to be *healthy*. The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.³³⁵

³³¹ See, Phil Fennell, *Treatment Without Consent: Law, Psychiatry and the Treatment of Mentally Disordered People* since 1985, Routledge Publishers 1 (1996).

³³² See, Felicity Callard et al, *Mental Illness, Discrimination and the Law: Fighting for Social Justice*, Wiley Blackwell Publishers 44& 45 (2012).

³³³ See, *Ibid.*

³³⁴ See, ICESCR Committee General Comment 14, *Supra* note 315, para 1, 2 & 8.

³³⁵ See, *Ibid.*

The Special rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health further encapsulates it all as follows:

Guaranteeing informed consent is a fundamental feature of respecting an individual's autonomy, self-determination and human dignity in an appropriate continuum of voluntary health-care services. Informed consent in health, including (but not limited to) clinical practice, public health and medical research, is an integral part of respecting, protecting and fulfilling the enjoyment of the right to health as elaborated in article 12 of the International Covenant on Economic, Social and Cultural Rights and enshrined in numerous international and regional human rights treaties and national constitutions. Informed consent invokes several elements of human rights that are indivisible, interdependent and interrelated. In addition to the right to health, these include the right to self-determination, freedom from discrimination, freedom from non-consensual experimentation, security and dignity of the human person, recognition before the law, freedom of thought and expression and reproductive self-determination.³³⁶

The normative content can be construed to present two rights- the right of entitlement to system of health and also the right from interference. It can equally be contended that the right to entitlements comes with the State Parties obligation to positively interfere to guarantee the right to health for example through the use of compulsory measures such as civil commitment to facilitate access to mental health care and services even though they equally affect the right to liberty and autonomy. Thus, the dilemma according to the understanding of this thesis is what right supersedes when there is a clash between the right to entitlement that comes with positive State interference to provide and the right from interference or freedom to choose. The thesis holds that in such a dilemma, in many situations States responsibility is seen to supersede or has been called upon to do so through legislation and other measures. Therefore as from the above principles that particularizes on the centrality of autonomous decision making in the enjoyment of the right to health, States have the responsibility to guarantee that individuals are able to make health choices through informed consent and the availability of other mechanisms that assures the same when accessing health care systems. This is essential in protecting the patients will and correspondingly the physician against malpractice law-

³³⁶ See, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, (sixty-fourth session, 2009), UN Doc A/64/272 (2009), para 18, 19 & 20.

suits or abuse. This far, the discussion has illuminated on the essentials and scope of the right to health. With this understanding, the following evaluates the CRPDs interpretation.

In view of that, it can be comparatively rationalized that the ICESCR and the CRPD interpretation of the right to health are analogous. Despite the fact that the requirements provided in the ICESCR are less enumerated like in article 25 of the CRPD, the interpretation given in general comment 14 expounds on them. To explain further, the ICESCR, the general comment 14 and CRPD comparably require: that State Parties take all measure legislative or otherwise to guarantee the right to health, that health care services are available and provided ‘preferably at or within the community level’, that preventative measure such as early identification and appropriate response to disability are guaranteed, that principle of non-discrimination is the norm in health care access and delivery, that the quality of services and health facilities should be good and appropriate, that services should be acceptable which is inclusive of provision sanitation, having competent medical professionals, respect of patients wishes and individuals must participate in the decisions concerning their health.

The CRPD fervently emphasizes on the notion of autonomy. Therefore, as far as compulsory measures are concerned, the CRPD Guidelines has exceptionally concluded that “involuntary commitment of persons with disabilities on health care grounds contradicts the absolute ban on deprivation of liberty on the basis of impairments (article 14(1)(b)) and the principle of free and informed consent of the person concerned for health care (article 25).”³³⁷ In view of this position, and as it connects to matters of health, the CRPD imposes responsibilities on State Parties to ensure that “health professionals provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulga-

³³⁷ See, CRPD Committee, Guidelines on Article 14, Supra note 41, para 10.

tion of ethical standards for public and private health care”.³³⁸ In addition, CRPDs interpretation clarifies that the concept of autonomy in health care matters ‘requires the respect of an individual’s legal capacity to decide about care, treatment, and admission to a hospital or institution, and therefore, involuntary commitment in mental health facilities denies an individual equal recognition before the law articulated in article 12 and 14’.³³⁹

In continuation to the above, the CRPD emphasizes that autonomy to make health care decisions incorporates the respect of wishes and preferences of an individual.³⁴⁰ This perspective is specifically articulated in article 12. This is an article considered as the linchpin to other rights in the convention because it “centres the person and restores decision-making autonomy to them”.³⁴¹ The CRPD promotes decision-making substantiated by individual capacities, collective factors and wishes of the individual concerned and rejects those decisions reached at where autonomy is broadly overshadowed using legal schemes.³⁴² Legal schemes that involve ‘substitute decision making and guardianship mechanisms including all those that involve assessment of individual capacities, [according to the CRPD committees interpretation denies the individual his or her] core human right — the right to equal recognition before the law’.³⁴³

The underscored emphasizes here that “the free will and preferences of the person concerned are also of fundamental importance, [in that] the underlying reason why article 12 looks at more decision making abilities is that the CRPD has designed to counteract the power imbalances and abuse

³³⁸ See, CRPD (2008), Article 25 (d).

³³⁹ See, CRPD Committee, Guidelines on Article 14, Supra note 41, para 10.

³⁴⁰ See CRPD Article 12 (5). See also, CRPD Committee, General Comment 1, Supra note 40.

³⁴¹ See, Gerald Quinn, A Short Guide to the United Nations Convention on the Rights of Persons with Disabilities, in Gerald Quinn & Lisa Waddington (eds), European Year Book Of Disability Law, Supra note 37, p. 104.

³⁴² See, Mary Donnelly, From Autonomy to Dignity: Treatment for Mental Disorders and the Focus for Patients 37 Law in context 38 (2008).

³⁴³ See CRPD Article 12 (5). See also, CRPD Committee, General Comment 1, Supra note 40, para 15 & 23.

of people with disabilities expressed before and throughout the drafting process.”³⁴⁴ Hence, in order for individuals to exercise their conventional rights, States must undertake legislative and other measures in order to acclimatize the realization of the right to equal recognition everywhere as persons before the law.³⁴⁵ Accordingly, the starting point that is consistent with the CRPD Committees concluding observations, general comment one on article 12 and the Guidelines on article 14 is for Member States to abolish legislations that support substitute decision making, guardianship and involuntary commitment of persons with disabilities without their consent.³⁴⁶ Furthermore, any measure relating to exercising legal capacity must respect the rights and preferences of the person concerned. It must also be free of any conflict of interest and undue influence, be proportional and tailored to the person’s circumstances, apply for the shortest time possible and be subject to regular review by a competent, independent and impartial authority or judicial body.³⁴⁷

In summary, every individual requires the guarantee to the highest standard of physical and mental health. As discoursed, persons with mental disability remain to be a vulnerable group whose right to health is always threatened either by a lack of access to mental health services, lack of proper protection in the law or/ and sheer arbitrary abuse within health care settings. The ICESCR does not mention civil commitment, neither is it prohibited by the interpretation of the Committee. What is certain is that States are using civil commitment processes as one other method of promoting access and delivery to the right to mental health. International human rights law examined lay down standards which oblige Member States to effectively guarantee the right to health to all persons within their jurisdictions. States should primarily be able to guarantee these rights through legislative and

³⁴⁴ See, Annegret Kampf, *Involuntary treatment decisions: Using negotiated silence to facilitate change?* In Bernadette Mcsherry & Penelope Weller (ed), *Rethinking rights based mental health laws* 143 (2010).

³⁴⁵ See, CRPD Article. 12.

³⁴⁶ See, CRPD Committee, *General Comment 1* *Supra* note 39, para 40-42. See also CRPD Committee, *Statement on Article 14 of the Convention on the Rights of Persons with Disabilities*. Available at: <http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=15183&LangID=E>.

³⁴⁷ See, Annegret Kampf, *Involuntary treatment decisions: Using negotiated silence to facilitate change?* In Bernadette Mcsherry & Penelope Weller (ed), *Rethinking rights based mental health laws*, *Supra* note 344.

other appropriate mechanisms such as allocation of proper budgets to their health sectors. Safeguards that promote autonomy of an individual when and when not possible together with recourse to judicial mechanisms should be incorporated within the legislations. The ICESCR Committee emphasizes that, ‘the right to health includes certain components which are legally enforceable’,³⁴⁸ and on this basis States are compelled to adopt relevant legislations as part of their responsibility to guard against abuses in formal and informal health care settings. ³⁴⁹In addition, the involvement of all individual concerned such as mental health service providers, policy makers, individuals with mental disability and the wider community should be promoted because their participation remains central in ensuring the proper delivery of comprehensive physical and mental health services.

1.2.3. Civil Commitment and The Right to be Free from Ill-Treatment and Torture: UNCAT, ECHR, ACHPR & ACHR Perspectives.

The right to be free from ill-treatment and torture interrelates with the right to liberty in the sense that persons, whose liberty rights are limited, become predisposed to the risk of ill-treatment or torture that may result from stigma, discrimination and conditions in which they are placed. Persons with mental disability as a vulnerable group remain susceptible to the risk of torture and ill-treatment while in custody, in control of institutions or individuals.³⁵⁰ Involuntary detention and treatment of persons with mental disability in various settings such as hospitals, private clinics, social care homes, group homes, spiritual healing centres and traditional healing centres correspondingly predisposes them to the risk of torture and ill-treatment.³⁵¹ For this reason, it is very

³⁴⁸ See, ICESCR Committee, General Comment 14, *Supra* note 315, para 1.

³⁴⁹ See, Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, *Supra* note 336, para 18, 19 & 20.

³⁵⁰ See, The United Nations Committee Against Torture, General comment No. 2: Implementation of Article 2 by State Parties, CAT/C/GC/2 (2008), para 15&21.

³⁵¹ See, United Nations General Assembly, UN Doc, A/63/175, Interim Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Manfred Nowak, (2008), paras 38-40 states: “Persons with disabilities are often segregated from society in institutions, including prisons, social care centres, orphanages and mental health institutions. They are deprived of their liberty for long periods of time including what may amount to a lifelong experience, either against their will or without their free and informed consent. Inside these institutions, per-

important that this right is absolutely guaranteed domestically and internationally through various legislative and other measures to persons with mental disability.

The right to be free from torture and ill-treatment at present is guaranteed in various international, regional treaties and domestic legislations. The right with its ‘absolute and non-derogable character of prohibition has become accepted as a matter of customary international law’.³⁵² It is a right that cannot be abrogated in times of war, public emergencies or peace.³⁵³ It is also a rule of jus cogens, a peremptory rule of international law.³⁵⁴ Hence it is secured by the ICCPR articles 7&10, the ECHR article 3, ACHR article 5, article 5ACHPR and the UDHR article 5, including other persuasive United Nations soft laws.³⁵⁵ The United Nations Convention against Torture (hereafter UN-CAT) is distinct akin the CRPD, and because of its particularity its jurisprudence is discussed here-

sons with disabilities are frequently subjected to unspeakable indignities, neglect, severe forms of restraint and seclusion, as well as physical, mental and sexual violence.³ The lack of reasonable accommodation in detention facilities may increase the risk of exposure to neglect, violence, abuse, torture and ill-treatment. 39. In the private sphere, persons with disabilities are especially vulnerable to violence and abuse, including sexual abuse, inside the home, at the hands of family members, caregivers, health professionals and members of the community.⁴ 40. Persons with disabilities are exposed to medical experimentation and intrusive and irreversible medical treatments without their consent (e.g. sterilization, abortion and interventions aiming to correct or alleviate a disability, such as electroshock treatment and mind-altering drugs including neuroleptics.”

³⁵² See, CAT Committee, General Comment No. 2, Supra note 350, para 1. See also Prosecutor v. Furundzija (10 December 1998, case no. IT-95-17/I-T, (1999) 38, para 153. See also, Al-Adsani v United Kingdom, Application No. Application no. 35763/97, 34 EHRR 273 (2002), para 60.

³⁵³ See, United Nations Convention Against Torture (1987) Article 2(2).

³⁵⁴ See, CAT Committee, General Comment No. 2, Supra note 350 .See also, Questions Relating to the Obligation to Prosecute or Extradite (Belgium v Senegal) (2012) ICJ, para 159 & Al-Adsani v United Kingdom, Supra note 352, para 61&65.

³⁵⁵ See, The Standard Minimum Rules for the Treatment of Prisoners (1995), The Declaration on the Rights of Mentally Retarded Persons (1971), the (1975) Declaration on the Protection of all Persons from Being Subjected to Torture and other Cruel, Inhuman or Degrading Treatment and Punishment, the Declaration on the Rights of Disabled Persons (1975), the (1979) Code of Conduct for Law Enforcement Officials, the Principles of Medical Ethics relevant to the Role of Health Personnel, Particularly Physicians in the Protection of Prisoners and Detainees against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (1982), The body of Principles for the Protection of all Persons under any Form of Detention or Imprisonment (1988), the (1991) UN General Assembly Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health care, and the (2000) Principles on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment, or Punishment (Istanbul Principles). The prohibition of torture is additionally protected by international humanitarian law such as the (1949) Geneva Conventions I (articles 12 & 50), Geneva Convention II (articles 12&51), Geneva Convention III (articles 17, 87 & 130, Geneva Convention IV (articles 32 & 147), and Common Article 3(1 a-d) to all the four Geneva Conventions. The International Criminal law evidenced by the classification of torture as a war crime or/and crime against humanity by the (2002) Rome Statute (article 7 and 8). Equally, the Jurisprudence of the International Criminal Tribunal for the Former Yugoslavia and for Rwanda presents supportive guidance in establishing the normative content of the right on prohibition of ill-treatment and torture

in.³⁵⁶ The discussion as well includes the jurisprudence of the ECHR because comparatively it provides extensive jurisprudence as it relates to persons with mental disability and compulsory measures.

These instruments provide an extensive range of protection from ill-treatment and torture to all individuals, including persons with mental disabilities in various circumstances such as in times of war, when detained in prison, in healthcare settings such as hospitals, clinics, social care homes and private homes. Therefore it does not matter where the individual with mental disability is located, because prohibition of torture is expressly and absolutely prohibited. Preventative and punitive safeguards required to be present in all systems of detention and support.³⁵⁷ The UNCAT leaves a wide margin of appreciation for States to define torture and criminalize it as far as possible. In this regard, the Committee on Torture calls upon “State party to take actions that will reinforce the prohibition against torture through legislative, administrative, judicial, or other actions that must in the end, be effective in preventing it.”³⁵⁸ The key off course is to define what the terms in the prohibition entail. However, the human rights treaties cited above, including the UNCAT offer no concrete definition, except for its authoritative definition of torture under article 1.³⁵⁹ The elements within the definition involve:

- (a) Infliction of severe pain whether physical or mental,
- (b) The infliction of such pain is for particular purpose such as acquiring information or done on a discrimination basis and
- (c) The infliction of such suffering is conducted under the consent or guidance of a public official or someone acting in an official capacity.³⁶⁰

³⁵⁶ See, UNCAT (1987).

³⁵⁷ See, CAT Committee General Comment No. 2, Supra note 350, para 2.

³⁵⁸ See, Ibid.

³⁵⁹ See, UNCAT (1987). Article 1 provides that: “For the purposes of this Convention, torture means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.”

³⁶⁰ See, UNCAT (1987), Article 1.

The Committee on Torture on this issue of a definition holds that Member States should properly define torture within their domestic legislation in order to give meaning to the purpose of the Convention.³⁶¹ Thus whilst supporting the notion that States should provide extensive and distinct definitions than that provided in the convention in order to advance the purpose of the convention, uncertainty remains that ‘serious discrepancies between the Convention’s definition and that incorporated into domestic law create actual or potential loopholes for impunity’ as it may be subjective.³⁶² This fears however maybe quelled by the practices in other bodies such as the European Court of Human Rights and the Inter-American Court of Human Rights have continuously maintained that the definitions of ill-treatment and torture are dependent on constant reassessment in consideration of circumstances in the nature of things and with the changing values of democratic societies.³⁶³ The European Court of Human Rights in its jurisprudence makes a distinction between ill-treatment and torture based on the level of severity of the circumstances in question, even though it does not lay down the criteria for inhuman treatment.³⁶⁴ The African Commission on Human Rights also emphasizes the same notions and can be concluded that it aligns more with the Committee on Torture’s

³⁶¹ See, CAT Committee, General comment No. 2, Supra note 350, para 8-12.

³⁶² See, Ibid, para 9.

³⁶³ See, *Selmouni v. France*, Application No. 25803/94, ECHR (1999), para. 101. In this paragraph the Court stated as follows: “The Court has previously examined cases in which it concluded that there had been treatment which could only be described as torture (see the *Aksoy* judgment cited above, p. 2279, § 64, and the *Aydın* judgment cited above, pp. 1891-92, §§ 83-84 and 86). However, having regard to the fact that the Convention is a “living instrument which must be interpreted in the light of present-day conditions” (see, among other authorities, the following judgments: *Tyrer v. the United Kingdom*, 25 April 1978, Series A no. 26, pp. 15-16, § 31; *Soering* cited above, p. 40, § 102; and *Loizidou v. Turkey*, 23 March 1995, Series A no. 310, pp. 26-27, § 71), the Court considers that certain acts which were classified in the past as “inhuman and degrading treatment” as opposed to “torture” could be classified differently in future. It takes the view that the increasingly high standard being required in the area of the protection of human rights and fundamental liberties correspondingly and inevitably requires greater firmness in assessing breaches of the fundamental values of democratic societies.”

See also, *Cantoral-Benavides v. Peru*, Series C, No. 69 (2000) para. 99. The Commission emphasized that: “The European Court has pointed out recently that certain acts that were classified in the past as inhuman or degrading treatment, but not as torture, may be classified differently in the future, that is, as torture, since the growing demand for the protection of fundamental rights and freedoms must be accompanied by a more vigorous response in dealing with infractions of the basic values of democratic societies.”

³⁶⁴ See, *Stanev V Bulgaria*, Supra note 223. The Court in para 201 & 202 maintained as follows: “(201). Article 3 enshrines one of the most fundamental values of democratic society. It prohibits in absolute terms torture or inhuman or degrading treatment or punishment, irrespective of the circumstances and the victim’s behaviour. (202). Ill-treatment must attain a minimum level of severity if it is to fall within the scope of Article 3. The assessment of this minimum is, in the nature of things, relative; it depends on all the circumstances of the case, such as the nature and context of the treatment, the manner and method of its execution, its duration, its physical or mental effects and, in some instances, the sex, age and state of health of the victim.”

support for the widest possible interpretation in order to offer protection as envisaged under article 5 of the convention.³⁶⁵

The Committee's circumspect of the definition is spot-on particularly in the treatment of persons with mental disability. The Special rapporteur on torture provides some reasoning to the Committee's circumspection by claiming that "there is a need to highlight the specific dimension and intensity of the problem, which often goes undetected; identify abuses that exceed the scope of violations of the right to health and could amount to torture and ill-treatment; and strengthen accountability and redress mechanisms."³⁶⁶ Furthermore, "he recognizes that there are unique challenges to stopping torture and ill-treatment in health-care settings, among other things, to a perception that, while never justified, certain practices in health-care may be defended by the authorities on grounds of administrative efficiency, behaviour modification or medical necessity".³⁶⁷ Well, examples from traditional mental healing practices of chaining to tree stumps or beating individuals with mental disabilities such as in Ghana or Zambia just to mention a few countries where these practices occur clearly constitute inhumane treatments.³⁶⁸ For this reasons, the thesis considers that clear safeguards must be in place in the law to ensure that they do not occur and are not justified as means of healing.

Conventional psychiatric methods of treatment are similarly considered intrusive and even as ill treatment, inhumane and torturous when used on individuals with mental disability. Involuntary

³⁶⁵ See, Purohit and Moore V. The Gambia, Supra note 237, para 58. The Court asserts that: "In *Media Rights Agenda/Nigeria*, the African Commission held that the term "cruel, inhuman or degrading punishment and treatment" is to be interpreted so as to extend to the widest possible protection against abuses, whether physical or mental; furthermore, in *John K. Modise/Botswana*, the African Commission stated that exposing victims to "personal suffering and indignity" violates the right to human dignity. Personal suffering and indignity can take many forms, and will depend on the particular circumstances of each communication brought before the African Commission."

³⁶⁶ See, Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez , Supra note 77, para 12.

³⁶⁷ See, Ibid, para 13.

³⁶⁸ See, Human Rights Watch Report, Like a Death Sentence: Abuses against Persons with Mental Disabilities in Ghana (2012).

commitment and treatment of persons with mental disability is an example of what some scholars consider to invoke a violation of the right to be free from ill-treatment and torture. The CRPD Committee equally invokes this interpretation in its general comment one by asserting that “as has been stated by the Committee in several concluding observations, forced treatment by psychiatric and other health and medical professionals is a violation of the right to equal recognition before the law and an infringement of the rights to personal integrity (art. 17); freedom from torture (art. 15); and freedom from violence, exploitation and abuse (art. 16).”³⁶⁹ This position remains unchanged as supported in the recent Guidelines to article 14 where the Committee once again re-emphasizes that:

The Committee has called on States parties to protect the security and personal integrity of persons with disabilities who are deprived of their liberty, including by eliminating the use of forced treatment, seclusion and various methods of restraint in medical facilities, including physical, chemical and mechanic restrains. The Committee has found that these practices are not consistent with the prohibition of torture and other cruel, inhumane or degrading treatment or punishment against persons with disabilities pursuant to article 15 of the Convention.³⁷⁰

Corresponding opinion is held by the Special rapporteur on torture as follow:

The mandate continues to receive reports of the systematic use of forced interventions worldwide. Both this mandate and United Nations treaty bodies have established that involuntary treatment and other psychiatric interventions in health-care facilities are forms of torture and ill-treatment. Forced interventions, often wrongfully justified under theories of incapacity and therapeutic necessity inconsistent with the Convention on the Rights of Persons with Disabilities, are legitimized under national laws, and may enjoy wide public support as being in the alleged “best interest” of the person concerned. Nevertheless, to the extent that they inflict severe pain and suffering, they violate the absolute prohibition of torture and cruel, inhuman and degrading treatment (A/63/175, paras. 38, 40, 41). Concern for the autonomy and dignity of persons with disabilities leads the Special Rapporteur to urge revision of domestic legislation allowing for forced interventions.³⁷¹

These statements in the excerpts above, including opinions of others such as the World psychiatric association or the American Psychiatric Association earlier mentioned, sustain some legitimacy as

³⁶⁹ See, CRPD Committee, General Comment No. 1, *Supra* note 40, para 42.

³⁷⁰ See, *Ibid*, para 12.

³⁷¹ See, Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez, *Supra* note 77, para 64. See also, Interim Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Manfred Nowak, *Supra* note 351, para 38-40.

far as the fact that when involuntary treatment is applied with the intention of causing severe pain or suffering, rather than to benefit or heal the person with mental disability, it may indeed amount to inhumane and torturous treatment.³⁷² However, involuntary committal and treatment, when executed within the proper safeguards of the law and proper ethical guidelines, should not be absolutely considered as a form of ill treatment or torture. Furthermore, medical necessity for the protection of the individual and others condemned as a smokescreen of ill-treating persons with mental disability is too sweeping to make. This is because medical necessities or interventions are and should be undertaken only in those exceptional circumstances for the exclusive reason of providing relief to the relevant individual with mental disability concerned. It is required that it is not solely relied upon to violate the rights of the individual. Mental health care providers must and are compelled to abide by the code of ethics in addition to the laws concerning involuntary committals and treatments within their jurisdictions in all situations. In addition, certain jurisdictions mandate the consideration of the least restrictive treatment as an alternative option before any execution of compulsory measures such as Belgium, United kingdom, Sweden and Portugal just to mention a few.³⁷³

All the same, it is important to remain vigilant in order to ensure that arbitrary abuses do not occur under the doctrine of medical necessity as emphasized in the case of *Pleso v Hungary (2012)* where a violation of article 5(1) of the ECHR was found.³⁷⁴ The applicant, alleged that his compulsorily detention in a psychiatric hospital based on the Health Care Act and on the case-law of the Hungarian Supreme Court violated article 5 (1).³⁷⁵ The Hungarian courts in executing the decree for compulsory hospitalization were convinced that in their view since the applicant was unwilling to undergo treatment voluntarily, it amounted to him representing a significant danger to his own

³⁷² See, American Psychiatric Association & World Psychiatric Association Joint Response Letter to the Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez, *Supra* note 130.

³⁷³ See *Pleso V Hungary*, Application No. 41242/08 ECHR (2012), para 34.

³⁷⁴ See, *Ibid.*

³⁷⁵ See, *Ibid.*, para 41-48.

health within the meaning of the Supreme Court jurisprudence.³⁷⁶ The courts reached this conclusion by almost relying exclusively on the medical opinions obtained.³⁷⁷ The European Court of Human Rights in finding a violation maintained that even though Mr Pleso's forced hospitalization had a basis in law, 'the procedure followed was not entirely devoid with arbitrariness'.³⁷⁸ Moreover, 'this case warranted a more cautious approach on the side of the authorities to avoid the application of an imprecise legal notion [significant danger] to the applicant's detriment in a rather improvised manner as is particularly disturbing in the face of the undisputed fact that the applicant in no way represented imminent danger to others or to his own life or limb, and only the medically predicted deterioration of his own health was at stake'.³⁷⁹ In its judgment, the court emphasized that "it is incumbent on the authorities to strike a fair balance between the competing interests emanating on the one hand from society's responsibility to secure the best possible health care for those with diminished faculties (for example, because of lack of insight into their condition) and on the other hand, from the individual's inalienable right to self-determination (including the right to refusal of hospitalization or medical treatment, that is, his or her "right to be ill")."³⁸⁰ It therefore concluded that in this case, the fair balance was not made and neither an:

in-depth consideration given to the rational or irrational character of his choice to refuse hospitalisation, to the actual nature of the envisaged involuntary treatment or to the medical benefits which could be achieved through that treatment, or to the possibilities of applying a period of observation or requiring the applicant to pursue outpatient care. In this connection, the Court finds it regrettable that no weight whatsoever was attributed to the applicant's non-consent, although his legal capacity had not been removed, for example by placing him under guardianship. It cannot therefore be said that the decision to deprive the applicant of his liberty was based on an assessment of all the relevant factors including the therapeutic prospects or the viability of less invasive alternatives, as required also by the United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (see paragraph 38 above)."³⁸¹

³⁷⁶ See, *Ibid*, para 63.

³⁷⁷ See, *Ibid*, para 63&64.

³⁷⁸ See, *Ibid*, para 65.

³⁷⁹ See, *Ibid*.

³⁸⁰ See, *Ibid*, para 66.

³⁸¹ See, *Ibid*, para 68.

In *Pleso V Hungary (2012)*, while the case concerned a violation of article 5 because of the wrongful forced interventions on the necessity of protecting the interests of the applicant and not ill-treatment and torture, it nevertheless addresses the cautiousness articulated by the special rapporteur on torture and other activists on the danger of arbitrariness that may occur under involuntary hospitalization. Another comparable case is *HL V United Kingdom (2004)* previously reviewed, and where the doctrine of necessity was relied exclusively to detain the applicant suffering from severe autism and challenging behavior in a hospital.³⁸² The European Court of Human Rights concluded that he had been arbitrarily deprived of his liberty since he had no recourse to the protections offered by the Mental Health Act 1983—for example the capability to challenge detention and the restrictions on treatment.³⁸³ Furthermore, he was fully under the control of the hospital staff, there was the lack of any fixed procedural rules by which the admission and detention of compliant incapacitated patients was conducted.³⁸⁴ This case also does not touch on ill-treatment and torture, but as asserted, indicates the possibility of arbitrary human rights violation for persons with mental disability placed under compulsory hospitalization.

In *X V Finland (2012)*, the applicant charged with a criminal offence was placed under psychiatric assessment for the purpose of determining her mental state at the time of the alleged offence as required by Finnish law.³⁸⁵ According to the authorities, her involuntary hospitalisation was necessary to provide care because she was allegedly suffering from a delusional disorder, a serious form of psychosis and very often necessitated hospital care.³⁸⁶ However, she contended that at a specific time in her detention, she received forced treatment without being given the opportunity to seek an external opinion from a different expert from the hospital in which she was hospitalized or receive

³⁸² See, *HL v UK*, Supra note 214, para 9-11.

³⁸³ See, *Ibid*, para 134-142.

³⁸⁴ See, *Ibid*, para 121.

³⁸⁵ See, *X v Finland*, Supra note 210, para 115-119.

³⁸⁶ See, *Ibid*, para 141&142.

any doctors.³⁸⁷ Hence, contended a violation of article 5, 6, 8 and 13.³⁸⁸ The court in assessing a violation of article 5, did not find a violation when she was placed under psychiatric examination for the purpose of the criminal charge as ordered by a court order of between 11 November 2004 and 17 February 2005, as it was in accordance with article 5(1-b).³⁸⁹

It however found a violation of article 5 (1-e) for the involuntary treatment administered to the applicant by the order of an administrative body empowered under the Mental Health Act.³⁹⁰ In its judgment it stated that every individual deprived of liberty must have the lawfulness of that deprivation reviewed by a court of law.³⁹¹ In the instant case, it does not appear problematic that an administrative body empowered by law and subject to independent judicial review undertook the task.³⁹² However, there were no adequate safeguards against arbitrariness in making a continuation of such treatment in this case because the applicant was not afforded the opportunity to use an external expert in reviewing her case and furthermore, the periodic review in the mental health law was within a period of six months and only initiated by the authorities.³⁹³ In sum therefore, the national law did not meet the requirements against arbitrariness in article 5(1-e) after the first initial six months.³⁹⁴ As regards a violation of article 8, the court stated that “a medical intervention in defiance of the subject’s will gives rise to an interference with respect for his or her private life, and in particular his or her right to physical integrity.”³⁹⁵ It may also engage a violation of article 8.³⁹⁶ In

³⁸⁷ See, *Ibid*, para 137-140.

³⁸⁸ See, *Ibid*. On article 5(unnecessary and unlawfully subjected to involuntary placement and treatment without her consent), 6(failure to be given a fair hearing as regards to appointing a representatives during the criminal proceedings and an opportunity to examine witnesses), 8(the involuntary placement and treatment was unnecessary and interfered with her private life. The forced medication was an assault and harmed her life even after her release) and 13(she did not have an effective remedy to challenge the forced medical treatment against her).

³⁸⁹ See, *Ibid*, para 158.

³⁹⁰ See, *Ibid*, para 159-171.

³⁹¹ See, *Ibid*, para 144-151.

³⁹² See, *Ibid*, para 168.

³⁹³ See, *Ibid*, para 169 & 171.

³⁹⁴ See, *Ibid*, para 171.

³⁹⁵ See, *Ibid*, para 212.

³⁹⁶ See, *Ibid*, para 212 & 213.

this case there was no dispute that the forced medication was an interference of the applicants private life, the issue was whether such interference was justified under article 8(2).³⁹⁷ The lack of proper safeguards in the Finnish legislation in situations of forced medication led to the court finding a violation.³⁹⁸ The court held that:

Forced administration of medication represents a serious interference with a person's physical integrity, and must accordingly be based on a "law" that guarantees proper safeguards against arbitrariness. In the present case such safeguards were missing. The decision to confine the applicant for involuntary treatment included an automatic authorization to proceed to forcible administration of medication if the applicant refused the treatment. The decision-making was solely in the hands of the doctors treating the patient, who could take even quite radical measures regardless of the applicant's wishes. Moreover, their decision-making was free from any kind of immediate judicial scrutiny: the applicant did not have any remedy available whereby she could require a court to rule on the lawfulness, including proportionality, of the forced administration of medication, or to have it discontinued.³⁹⁹

The court's judgment presents interesting and authoritative viewpoints relevant to this thesis. First it strongly reiterates the thesis viewpoint that arbitrariness is an actual concern in the issue of civil commitment. In *X V Finland (2012)*, the law was present but was inadequate in terms of safeguards. The law was also clear in terms of application including consulting an external independent psychiatric but was not executed. This jurisprudence does not maintain that forced treatment is prohibited but that proper protections should be in place in order to avoid human rights violations of persons with mental disability. These protections include taking into account the wishes of individuals who are capable of making their own choices and for those that incapable all available means should initially be pursued. The second engaging issue is the fact that the court did not view forced medication as a violation of article 3 as alleged by the applicant but a matter falling under article 8 the right to private family and private life. This case represents a clear departure and perhaps a new way of deciding cases on forced medication as in the case of *Herczegfalvy v Austria (1992)*, where the court did not find a violation of article 8 on grounds of forced treatment or article 3, but

³⁹⁷ See, *Ibid*, para 214 & 215.

³⁹⁸ See, *Ibid*, para 221.

³⁹⁹ See, *Ibid*, para 220.

instead found on the lack of safeguards to ensure that the applicant's correspondences were not interfered with.⁴⁰⁰ It however cautioned that still such patients are under the protection of article 3 as illustrated below.

Hence in *Herczegfalvy v Austria*, the court considered the issue of medical necessity as applied to Herczegfalvy through force feeding in order to prevent the deterioration in his physical and mental health. The court also considered the use of used coercive measures including the intramuscular injection of sedatives and the use of handcuffs and the security bed.⁴⁰¹ The applicant a Hungarian refugee was convicted of various criminal offences in Austria and detained in prison and a mental health institution between May 1972 and November 1984.⁴⁰² During his detention, it is alleged that he became aggressive, assaultive to wardens and other inmates and was declared partly incapacitated due to mental illness as experts reports indicated.⁴⁰³ He was therefore placed in a psychiatric hospital according to the Criminal law of Austria relating to mentally ill offenders.⁴⁰⁴ After his discharge from the mental institution, he was taken back to prison where he began a hunger strike as a protest to his detention and refusal of the authorities to give him his file.⁴⁰⁵ In 1979-1980, his health was deteriorating (he collapsed) and was rushed to the hospital where he was force fed and treated.⁴⁰⁶ Due to his resistance to medical treatment, coercive measures such as the intramuscular injection of sedative, handcuffs and a security bed were used.⁴⁰⁷ The applicant due to all these alleged a violation of article 3 (inhuman and degrading treatment and torture) and article 5 among other rights.⁴⁰⁸ He contended that his forced feeding and medication amounted to a breach of article

⁴⁰⁰ See, *Herczegfalvy v Austria*, Application no. 10533/83, ECHR (1992), para 85-96.

⁴⁰¹ See, *Ibid.*

⁴⁰² See, *Ibid.*

⁴⁰³ See, *Ibid.*, para 9-22.

⁴⁰⁴ See, *Ibid.*, para 40-55.

⁴⁰⁵ See, *Ibid.*, para 24-34.

⁴⁰⁶ See, *Ibid.*

⁴⁰⁷ See, *Ibid.*, para 79.

⁴⁰⁸ See, *Ibid.*

3. In finding a no violation of article 3, the court maintained that “the established principles of medicine are admittedly in principle decisive in such cases; as a general rule, a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading.”⁴⁰⁹ However it noted that even though in this particular case the coercive measures were justified, it still was worrying enough.⁴¹⁰

Hence the court emphasized that:

The Court considers that the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with. While it is for the medical authorities to decide, on the basis of the recognised rules of medical science, on the therapeutic methods to be used, if necessary by force, to preserve the physical and mental health of patients who are entirely incapable of deciding for themselves and for whom they are therefore responsible, such patients nevertheless remain under the protection of Article 3 (art. 3), whose requirements permit of no derogation.⁴¹¹

The ECHR courts jurisprudence aligns with the position of the World Psychiatric Association and American Psychiatric Association that states that “although not sufficient by itself to justify involuntary treatment of capable persons, “medical necessity”, it is a cornerstone of ensuring that involuntary treatment is used only when appropriate and when other interventions are not likely to be successful.”⁴¹² Furthermore, as seen from the jurisprudence of the court, coercive measure used within the perimeter’s of therapeutic assistance and within established safety guidelines do not lead to a breach of the right to be free from ill-treatment and torture. It is worrying indeed as the court has established and it must therefore be used as a last resort under constant monitoring and for the limited amount of time possible. These views off course are partly in contrast with what the CRPD Committee and Special rapporteur on Torture have declared to the effect that there is no therapeutic

⁴⁰⁹ See, *Ibid*, para 82.

⁴¹⁰ See, *Ibid*, para 83.

⁴¹¹ See, *Ibid*, para 82.

⁴¹² See, American Psychiatric Association & World Psychiatric Association Joint Response Letter to the Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez, *Supra* note 129.

justification for the use of solitary confinement and restraints and any use on an individual with mental disabilities constitutes cruel, ill-treatment, torture and inhuman and degrading.⁴¹³

The above analysis presents divergent views on the application of forced interventions and use of coercive measures. However the viewpoints are not all divergent because one point that is analogous to all is the understanding that arbitrary and abusive practices occur or may occur where there are no safeguards and where they are inhumanely applied. Some of the cases provided above have instances where the law has been misapplied or where there is a lacuna in the law in regards to procedural and substantive protection. The case of *Lukas Bures V Czech Republic (2012)* emphasizes the importance of being precautionous even in situations where medical necessity is paramount.⁴¹⁴ It also indicates that certain restraining circumstances may constitute a breach of article 3 of the ECHR. In this legal case, Lukas aged 22 years old in 2007 was diagnosed as having a psycho-social disability and inadvertently overdosed on Akineton a psychiatric drug prescribed by his psychiatrist.⁴¹⁵ He was taken to a sobering-up center part of the psychiatric hospital he was being treated by the police after being found in a street in a confused state mind and the fact that he was wearing no trousers or underwear.⁴¹⁶

⁴¹³ See, Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez, *Supra* note 76, para 63 states: “The mandate has previously declared that there can be no therapeutic justification for the use of solitary confinement and prolonged restraint of persons with disabilities in psychiatric institutions: both prolonged seclusion and restraint may constitute torture and ill-treatment (A/63175, paras. 55-56). The Special Rapporteur has addresses the issue of solitary confinement and stated that its imposition of any duration on persons with mental disabilities is cruel, inhuman or degrading treatment (A/66/268, paras. 67-68, 78). Moreover, any restraint on people with mental disabilities for even a short period of time may constitute torture and ill-treatment. It is essential that an absolute ban on all coercive and non-consensual measures, including restraint and solitary confinement of people with psychological or intellectual disabilities, should apply in all places of deprivation of liberty including psychiatric and social care institutions. The environment of patient powerlessness and abusive treatment of persons with disabilities in which restraint and seclusion is used can lead to other non-consensual treatment, such as forced medication and electroshock procedures.”

⁴¹⁴ See, *Lukas Bures V The Czech Republic*, Application No. 37679/08, ECHR (2012).

⁴¹⁵ See, *Ibid*, para 6&7.

⁴¹⁶ See, *Ibid*, para 7.

The applicant relying on Article 3 alleged that he had been ill-treated at the hospital's sobering-up center, specifically by being strapped with leather restraints belts to a bed for several hours without supervision, even though he did not present a danger to anyone.⁴¹⁷ As a result of the strapping his blood and nerve vessels were compressed resulting in an impaired movement of his elbow.⁴¹⁸ Furthermore, he claimed that his complaint after release from the sobering clinic on ill-treatment to the authorities had not been effectively investigated as procedural requirement under article 3.⁴¹⁹ The Court found a violation of article 3. In its judgment the court looked at the States negative and positive obligation in protecting the rights of its citizens. It maintained that persons in sobering-up centers are essentially deprived of their liberty under article 5 and since the center was a public body, the actions of the staff were attributable to the State.⁴²⁰ In this case the Czech authorities had the negative responsibility to ensure that the rights of persons within its control are protected.⁴²¹ As regards meeting the necessary threshold to establish ill-treatment under article 3, the court rejected the government assertion that the claim does not fulfill the threshold and should have been brought under article 8.⁴²² It thus maintained that article 3 is one of the most fundamental values in a democratic society from which no negation can be justified irrespective of the victim's behavior.⁴²³ That in order for a claim to fall under article 3, a certain minim level of severity has to be indicated depending on various circumstances "such as the duration of the treatment, its physical and mental effects and, in some cases, the gender, age and state of health of the victim."⁴²⁴ Further factors include the purpose for which the treatment was inflicted together with the intention or motivation behind it, as well as its context, such as an atmosphere of heightened tension and emotions."⁴²⁵

⁴¹⁷ See, *Ibid*, para 64.

⁴¹⁸ See, *Ibid*, para 14.

⁴¹⁹ See, *Ibid*, para 27-41.

⁴²⁰ See, *Ibid*, para 73-77.

⁴²¹ See, *Ibid*, para 77- 82.

⁴²² See, *Ibid*, para 67.

⁴²³ See, *Ibid*, para 83.

⁴²⁴ See, *Ibid*, para 84.

⁴²⁵ See, *Ibid*.

This case according to the court involves the vulnerability of mentally ill persons and as shown in its jurisprudence, such vulnerability has to be taken into consideration.⁴²⁶ In addition, it is paramount to be vigilant in these cases where there is a position of inferiority and powerlessness experienced by patients in psychiatric hospitals even where medical necessity is therapeutically imperative.⁴²⁷ The court reasoned further that persons deprived of their liberty and to those that are subjected to physical restraints without their conduct being the cause, diminishes their human dignity.⁴²⁸ According to the court, the use of physical restraints as evidenced by ‘European and national practices are unanimous in declaring that they can be used only in exceptional circumstances, as a matter of last resort, under constant supervision and is used as an only means available to prevent immediate or imminent harm to the patient or others’.⁴²⁹ Therefore a violation was made on the basis that the State failed in its negative obligation, applications of the restraints were not necessary in the circumstances, the applicant was restless and restraints were unnecessary and the fact that he was restrained without supervision for a long period of time.⁴³⁰ A violation on procedural was also made for the failure of the government to prosecute after a complaint was made as required by the ECHR Convention.⁴³¹

From the aforementioned case, it is very apparent that there are other situations in which compulsory detention and treatment of persons with mental disability may engage a violation of the right to be free from ill-treatment and torture. It is also apparent that vigilance has to be maintained as the court propounds in order to prevent arbitrary abuses in mental health care settings for persons with mental disabilities. According to the examined cases, involuntary detention and treatment for per-

⁴²⁶ See, *Ibid*, para 85.

⁴²⁷ See, *Ibid*, para 86 & 87.

⁴²⁸ See, *Ibid*, para 87.

⁴²⁹ See, *Ibid*, para 95.

⁴³⁰ See, *Ibid*, para 100-106.

⁴³¹ See, *Ibid*, para 121-134.

sons with mental disability has been shown to pose significant risk for arbitrary abuse. However, it has also been shown from the ECHR jurisprudence and other regional courts that it is widely recognize and legally practiced. Additionally there is an expectation that the risk of abuse and arbitrariness is prevented by and punished by implementing proper laws and ethical guidelines. Hospitalization as presented can be a lifesaving for persons with mental disorders. While the CRPD jurisprudence supports the abolition of compulsory hospitalization and treatment legislations and enabling legislations, we have to face the realities of the day that appears different from State practice to court jurisprudences that uphold the same. The support in practice is underscored with the actuality that these measures constitute an alternative form which many individuals with mental disability may benefit from. Hence, a balancing act has to be undertaken that involves dealing with ill-treatment in mental health care settings and on the other having this option open for those that may require its services. According to this thesis, this balancing act between an individual's right to liberty, right from torture and the right to mental health can in one way be achieved through guaranteeing and keenly implementing both substantive and procedural safeguards in the authorizing legislations

1.3. Conclusion

This chapter's aim was to examine the position of civil commitment of persons with mental disability in the international and regional human rights framework. It is hoped that what was set to be achieved has been accomplished. The outcome of this examination indicates that but for the CRPD and UNWGAD Basic Principles, the limitation on the right to liberty for forced medical intervention in regards to involuntary commitment and treatment of persons with disability is an acceptable method as illustrated by various United Nations Treaties and regional human rights treaties and their interpretations.

The multifaceted reasons for divergence for and against the process were also presented with those against expounding persuasive reasoning leaning towards absolute self-determination of an individual with mental disability as espoused by the CRPD, the ills of the medical model of disability and issues on forced medications that do not work but advantageous to pharmaceutical companies. Those in favour of the process equally forwarded compelling reasons that included forced interventions to promote respect and recovery of autonomy when an individual lacks capacity to make autonomous decisions, forced interventions to preserve the right to life and to the right to physical and mental health. It also came across that some forced interventions constitute/d arbitrary deprivation of liberty, abusive, inhumane and torturous while for others it did not tantamount to as such as long as proper safeguards were/are applied appropriately. There was consensus despite the divergence to the effect that civil commitment predisposes individuals to arbitrary abuse and violation of other rights. It also became apparent that violations occur in institutions, community based facilities and homes. In view of these, there was a unified call upon State Parties to undertake legislative and other measures to guarantee the prevention of such occurrence. These measures could be in the form of comprehensive procedural and substantive safeguards, provision of community mental health services and sensitization for example that not everybody with a mental disability requires mental health treatment, but support.

Civil commitment as presented is juxtaposed within the right to liberty and as conversed throughout the chapter it is a right guaranteed to all. It is not an absolute right and may be limited only if authorized by law. These enabling laws must be compatible with international norms and standards. The limitations should moreover be lawful and without any arbitrariness. Hence, there must be protections in the prescribing legislation to ensure that lawfulness is upheld and arbitrariness prevented and punished. The protections that generally emerge from the analysis and traverse the research areas are:

- (a) Right to information concerning the limitation on the right to liberty
- (b) Right to information in a manner understood by the individual concerned
- (c) Right to challenge the limitation
- (d) Right to legal assistance
- (e) Right to review of the limitation in a timely manner
- (f) Right to discharge or release after the end of the limited duration
- (g) Right to a remedy in the event of unlawful limitation on the right to liberty
- (h) Right to humane treatment and to humane conditions of detention.
- (i) Relevant far trial rights.

These are the general safeguards that are highlighted in various international human rights documents on limitation on the right to liberty. In regards to civil commitment of persons with mental disabilities, the above protections must be applied together with the following distinct safeguards depending with the individual circumstances:

- (a) Limitation on the right to liberty for the purpose of treatment must be according to a prescribed law- many a times it's the mental health legislation.
- (b) The mental illness must be of a severity that necessitates treatment and limitation of this right.
- (a) Evidence of the severity of the illness must be demonstrated by credible independent medical evidence mostly psychiatric medical report. Individuals have the right to seek their own independent second medical opinion
- (b) Consent for treatment must be obtained before any waiver from both capacitated and incapacitated persons with mental disability.
- (c) Alternative methods of consent such as advance directives must be supported and respected. The use of substituted decision making and guardianships must be regulated and must have the right of the individuals to challenge their guardianships.
- (d) Least restrictive methods of therapeutic assistance must be sought first before resorting to involuntary commitment and treatment.
- (e) Involuntary commitment and treatment must take place in a relevant institution of therapeutic assistance such as clinic, hospital or mental health center.
- (f) Appropriate medical treatment must be administered with appropriate supervision of the individual committed for therapeutic assistance.
- (g) Mental health therapeutic assistance must be given in a humane manner. It must be in provided in hygienic environment including the use of proper medical equipment's
- (h) Other rights of the individuals not restricted must be respected at all times such as right to information, to correspondences and to visits from family and friends etc.
- (i) Timely or periodic review of the compulsory placement must be observed.
- (j) Information on the compulsory committal of the individual with mental disability must be kept in order.
- (k) Discharge of the individual must be made after a successful healing of the individual or when the individual wishes.
- (l) Access to competent judicial mechanisms must be available and unrestricted.

The list above is not exhaustive but provides a collective understanding of what is present in the international human rights scene. One other important issue is the continuous call to provide mental health services within the communities in order to enable every individual the enjoyment of their right to community living and participation. Those individuals who do not require admissions must equally be given the necessary support without discrimination and neglect. Finally, the exploration shows that civil commitment is a practice that is legitimately ongoing with States unwilling to end it and justifying with the use of comprehensive standards to counter abuse. Whether they may be persuasive enough to be situated within the CRPD jurisprudence remains a paradox. This thesis however ardently holds that tackling abuse is imperative despite the disconnect between CRPD and State Parties practices. Therefore it examines these standards being put forward as cushions against the risk of ill-treatment, torture, stigmatization, discrimination and other consequences of limiting the liberty of an individual. It considers having protective standards exceedingly prudent than not having any at all especially when the practice of civil commitment continues to be exercised.

PART TWO: COMPARATIVELY SEARCHING FOR STANDARDS IN THE CHOSEN JURISDICTIONS

CHAPTER 2: CIVIL COMMITMENT: ADMISSIONS AND TREATMENTS

2.1. Introduction

This chapter is set to comparatively analyze the approach of different mechanisms that have been or are in the course of being developed to give effect to the right to liberty and right to health of the CRPD Convention in England (United Kingdom), South Africa, Ontario (Canada) and Ghana.⁴³² It also examines how these mental health laws are reconceptualised as disability laws compliant with the CRPD social model. As noted and reiterated in chapter one, the convention does not have a provision on involuntary detention and treatment as an exception to the qualified right, the right to liberty and security of person. However, the convention requires that the limitation of the right should not be based on a disability, that persons with disability subjected to the restriction should undergo similar processes with others and that the process of limitation should be in accordance with international human rights law and objectives of the convention.⁴³³ The CRPD Committee as analysed in chapter one, provided an interpretation of the article which essentially bans the implementation of civil commitment as it considers that legislation that permit such processes “are discriminatory and in violation of the prohibition of liberty on grounds of disability”.⁴³⁴ Additionally as discoursed and opined by some scholars, the Committees generalized calls to ban the process of civil commitment and enabling legislation without more guidance especially in account of State practice, does not provide sufficient guidelines to State Parties in regards to mental health reform.

435

⁴³² Note that, England is interchanged with UK whilst Ontario Canada.

⁴³³ See, CRPD Article 14 (1&2).

⁴³⁴ See, CRPD Committee, General comment 1, Supra note 40, para 42.

⁴³⁵ See, Christopher Slobogin, Eliminating Mental Disability as a Legal Criterion in deprivation of Liberty Cases: The Impact of the Convention on the Rights of Persons with Disabilities on the Insanity Defense, Civil Commitment and Competency Law, 40 International Journal of Psychiatry 39 (2015).

Therefore, in view of the present CRPD ultimate calls to States and the State parties relenting use of civil commitment and competency legislations, there is a compliance and implementation dilemma. As reasoned, it is next to impossible to delink mental disorder when providing mental health care which also includes the use of involuntary care and treatment or dispensing of justice in criminal law where “saturated mental concepts such as intention, knowledge, foresight and the ability to process information”,⁴³⁶ are used to determine a person’s responsibility. Some scholars like the CRPD Committee have suggested that it is possible to do away with civil commitment based on a mental disability but, by only allowing general legislation that provide determination for capacity without attributing mental disability or impairment. This proposal however, has been met with a response that mental impairment or disability will still be mentioned if one is to determine the reason as to why there is a capacity or lack thereof.⁴³⁷ Moreover, compliance becomes difficult when other international instruments provide opposite views such as the ICCPR and MI Principles examined in chapter one.

Due to these dilemmas, it is relatable to enquire as to the implication of the right to liberty and connected rights like the right to health juxtaposed with the process of involuntary commitment and treatment with its authorizing legislation in the CRPD jurisprudence. The enquiry for the purpose of this thesis is centered within the chosen jurisdictions mental health legislation. This is because the thesis aim is examining protective standards in this statutes old and new being used to ensure that abuse and arbitrary detentions do not occur to those persons with mental health concerns subjected to the process of civil commitment. This is an approach that appears to be currently a matter-

⁴³⁶ See, John Dowson, A Realistic Approach to assessing Mental Health Laws Compliance with the CRPD, *Supra* note 95, p.73.

⁴³⁷ See, Christopher Slobogin, Eliminating Mental Disability as a Legal Criterion in deprivation of Liberty Cases: The Impact of the Convention on the Rights of Persons with Disabilities on the Insanity Defense, Civil Commitment and Competency Law, *Supra* note 434, p.37.

of-fact considering the impasse between State practices, conditions in civil commitment practices and standpoint of the CRPD.

The chosen jurisdictions guarantee the right to liberty and security of persons in their constitutions as a qualified right. The qualification is balanced by requiring proper adherence to safeguards in order to prevent arbitrariness and human rights violations. For example, the Canadian Charter of Rights and Freedoms in the Constitution Act of 1982 stipulates that “everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.”⁴³⁸ The UK Human Rights Act of 1998 provides similar wording on the prohibition but goes further to emphasize that the limitation can be based on the enumerated list of exceptions and importantly it must be ‘accordance with a procedure prescribed by the law’.⁴³⁹ The Ghanaian constitution of 1992 corresponds with the wording of the UK Act including the list of exceptions but differs slightly in the wording as ‘prescribed law’ [to] ‘accordance with procedure permitted by law’.⁴⁴⁰ The South African constitution Bill of Rights equally provides for

⁴³⁸ See, The Constitution Act of Canada (1982), s.7

⁴³⁹ See, The Human Rights Act (1998). Article 5 stipulates that -“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: (a)the lawful detention of a person after conviction by a competent court; (b)the lawful arrest or detention of a person for non-compliance with the lawful order of a court or in order to secure the fulfilment of any obligation prescribed by law; (c)the lawful arrest or detention of a person effected for the purpose of bringing him before the competent legal authority on reasonable suspicion of having committed an offence or when it is reasonably considered necessary to prevent his committing an offence or fleeing after having done so; (d)the detention of a minor by lawful order for the purpose of educational supervision or his lawful detention for the purpose of bringing him before the competent legal authority; (e)the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants; (f)the lawful arrest or detention of a person to prevent his effecting an unauthorized entry into the country or of a person against whom action is being taken with a view to deportation or extradition.”

⁴⁴⁰ See, The Constitution of the Republic of Ghana (1992). Article 14 stipulates as follows- “(1) Every person shall be entitled to his personal liberty and no person shall be deprived of his personal liberty except in the following cases and in accordance with procedure permitted by law- (a) in execution of a sentence or order of a court in respect of a criminal offence of which he has been convicted; or (b) in execution of an order of a court punishing him for contempt of court; or (c) for the purpose of bringing him before a court in execution of an order of a court; or (d) in the case of a person suffering from an infectious or contagious disease, a person of unsound mind, a person addicted to drugs or alcohol or a vagrant, for the purpose of his care or treatment or the protection of the community; or (e) for the purpose of the education or welfare of a person who has not attained the age of eighteen years; or (f) for the purpose of preventing the unlawful entry of that person into Ghana, or of effecting the expulsion, extradition or other lawful removal of that person from Ghana or for the purpose of restricting that person while he is being lawfully

this right however in a differently worded and enumerated qualifying exceptions. It states that “everyone has the right to freedom and security of persons and the right to bodily and psychological integrity”.⁴⁴¹ Among the four jurisdictions, it is only the constitutional legal frameworks of UK and Ghana that expressly authorize the intrusion of this right for the purposes of mental health treatment.⁴⁴² South Africa in article 12(2-c), prohibits “subjecting anyone to ‘medical or scientific experiments without informed consent’, a prohibition similar to article 25 of the CRPD and which is very relevant in cases of compulsory commitment and treatment of persons with mental disability.”⁴⁴³

As aforementioned, UK and Ghana qualify the right to liberty for the sake of civil commitment in their constitutions in addition to their mental health frameworks. Canada and South Africa do not have such constitutionally expressed provisions. However, they do have legislation that provide for civil commitment in their mental health legislation as shall be discussed in the next parts of this chapter. The existence of these legislation in all these jurisdictions indicates prima facie that the provision of mental health services is provided with due regard to a framework that promotes respect of individual rights and guards against arbitrariness. Inherently, practitioners and mental health users are therefore compelled to closely comply with the stipulated parameters when provid-

conveyed through Ghana in the course of his extradition or removal from one country to another; or (g) upon reasonable suspicion of his having committed or being about to commit a criminal offence under the laws of Ghana.”

⁴⁴¹ See, The Constitution of South Africa (1996). Article 12 states that- “(1) Everyone has the right to freedom and security of the person, which includes the right - (a) not to be deprived of freedom arbitrarily or without just cause; (b) not to be detained without trial; (c) to be free from all forms of violence from either public or private sources; (d) not to be tortured in any way; and (e) not to be treated or punished in a cruel, inhuman or degrading way. (2) Everyone has the right to bodily and psychological integrity, which includes the right - (a) to make decisions concerning reproduction; (b) to security in and control over their body; and (c) not to be subjected to medical or scientific experiments without their informed consent.”

⁴⁴² See, Article 5(1-e) of the Human Rights Act (1998). It states 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: (e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants;”

See also, Article 14 (1-d) of the Constitution of the Republic of Ghana (1992). It provides that- “Every person shall be entitled to his personal liberty and no person shall be deprived of his personal liberty except in the following cases and in accordance with procedure permitted by law- (d) in the case of a person suffering from an infectious or contagious disease, a person of unsound mind, a person addicted to drugs or alcohol or a vagrant, for the purpose of his care or treatment or the protection of the community;.”

⁴⁴³ See, The Constitution of the Republic of South Africa (1996).

ing care to persons with mental disability. In the course of the discussion, it shall be apparent that these legal frameworks closely mirror international standards particularly from the already discussed jurisprudence of the ICCPR, the Regional human rights system and MI Principles.

In line with the above and in view of the fact that civil commitment appears to be engaged even post-CRPD, it is imperative that there are applicable legal safeguards to “continuously keep pace with developments and new achievements in mental health care, and in order to balance patients’ rights and interests against their need and right for treatment, and public safety”.⁴⁴⁴ Hence, the following looks into access to mental health care in the research jurisdiction with standards being the main focus. It begins by describing the statutory background and the first steps of accessing mental health care through ‘admission and treatment’. Note here that this chapter limits itself to aspects of compulsory admission and treatment, community treatment orders and traditional and spiritual mental health care. Also note that involuntary or compulsory detention and treatment and civil commitment are used interchangeably. Community treatment orders/care or placement have the same meaning. In addition psychiatric or mental health facilities have similar meaning and Individual and patient is used interchangeably whenever in context. For emphasis, mental disorder, illness or mental disability is substitutable.

2.2. Statutory Overview of Access to Mental Health Treatment and Care.

Access to mental health treatment and care in the chosen jurisdictions are regulated in specific mental health legal frameworks that are specifically enacted to govern voluntary, informal and involuntary placement and care. They are other legislations designated to apply together with the primary statutes. This is because in the administration of such care, multiple rights and procedural require-

⁴⁴⁴ See, FRA-European Union Agency for Fundamental Rights, *Involuntary Placement and Involuntary Treatment of Persons with Mental Health Problems*, publication office of the European Union-Luxemburg (2012), p. 10.

ments interconnect and are applied in tandem for example the rights to legal capacity and right to consent to treatment. Majority of these mental health laws designate various types of institutions where mental health care services can be accessed. These institutions may for example include psychiatric institutions, hospitals with psychiatric sections that may offer inpatient and outpatient services, private mental health care facilities, community based centers and spiritual and traditional healing centers (Ghana). In order to understand the analysis of this chapter and how access to mental health treatment and care is undertaken in the chosen jurisdictions it is important to briefly provide their guiding statutes.

2.2.1. England (United Kingdom)

In the UK, mental health problems continues to be immense and one of the growing challenges, a burden affecting the populace, health, social and economic areas of life.⁴⁴⁵ It is also estimated that in “One in four people in the UK will experience a mental health problem in any given year”.⁴⁴⁶ These estimates pose concerns. Access to mental health care and treatment is regulated by a comprehensive set of legislation ranging from the Human Rights Act (Hereafter UKHRA), The Mental Health Act (2007 (hereafter UKMHA), the Mental Health Act (1983) and Code of Practice as amended to the Mental Capacity Acts (2005(Hereafter UKMCA) as shall be described below and comparatively discussed in the forthcoming thematic chapters. Mental health in England is offered in hospitals, psychiatric institutions and in the communities. The following describes the regulating statutes.

⁴⁴⁵ See, Mental Health foundation, The Fundamental Facts About Mental Health, Mental Health Foundation Publication (2015), p.7 & Isobel Booth (ed)., The Fundamental Facts: Latest facts and Figures on Mental Health, Mental Health Foundation Publication (2009), p.7. See also: Sally McManus, Howard Meltzer, Traolach Brugha, Paul Bebbington & Rachel Jenkins (ed)., Adult Psychiatry Morbidity in England, Results of a Household Survey, The NHS Information Centre for Health and Social Care (2007).

⁴⁴⁶ See, Mental Health Foundations, Fundamental Facts About Mental Health (2015), Ibid, p.7.

(a) The Human Rights Act (1998).

The Human Rights Act (herein after UKHRA), is an important document for mental health users, practitioners and legislators in England. First, as a result of incorporating those rights contained in the European Convention of Human Rights into its text, it offers extensive human rights protection standards to individuals with mental disability.⁴⁴⁷ Second, through this incorporation and specifically Article 5 that provides that “everyone has the right to liberty and security of person [and that] no one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law: the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants”, it guarantees that the UK has a legal framework that offers protection against unlawful and arbitrary detention of those subjected to civil commitment process.⁴⁴⁸ From the jurisprudence of the ECHR court presented in chapter one, it is evident that this ECHR article been effective in offering protection against abuse and arbitrariness whilst allowing for compulsory care for persons with mental illness. The third and final relevance of the UKHRA is that by requiring that any primary legislation enacted should be compatible with it, it ensures statutory review that in turn guards against overreaching or obsolete legislations.⁴⁴⁹ It in fact mandates that “a statement of incompatibility be given by a minister in charge of a crown or a bill during a second reading of the Bill”.⁴⁵⁰ The UKHRA rights have been successful in securing rights of those disabled by effecting legislation changes. For instance, the

⁴⁴⁷ See, The Human Rights Act (1998). See also, The European Convention of Human Rights (1950).

⁴⁴⁸ See, UKHRA (1998), Art 5(1-e) in Schedule 1.

⁴⁴⁹ See, UKHRA (1998). S. 4-Declaration of incompatibility. (1) Subsection (2) applies in any proceedings in which a court determines whether a provision of primary legislation is compatible with a Convention right. (2) If the court is satisfied that the provision is incompatible with a Convention right, it may make a declaration of that incompatibility. (3) Subsection (4) applies in any proceedings in which a court determines whether a provision of subordinate legislation, made in the exercise of a power conferred by primary legislation, is compatible with a Convention right. (4) If the court is satisfied— (a) that the provision is incompatible with a Convention right, and (b) that (disregarding any possibility of revocation) the primary legislation concerned prevents removal of the incompatibility, it may make a declaration of that incompatibility.”

⁴⁵⁰ See, UKHRA (1998), s. 19. It states: ““a minister of the Crown in charge of a Bill in either House of Parliament must, before Second Reading of the Bill—(a) make a statement to the effect that in his view the provisions of the Bill are compatible with the Convention rights (“a statement of compatibility”); or (b) make a statement to the effect that although he is unable to make a statement of compatibility the government nevertheless wishes the House to proceed with the Bill”.

amendment of the current Mental Capacity Act that introduced ‘deprivation of liberty safeguards’ was as a result of violations found in the case of *HL v UK ECHR (2004)* also known as the *Bournemouth case*.⁴⁵¹ Analyzed from a CRPD perspective the UKHRA may not be compatible because it expressly sanctions deprivation of liberty for the purpose of providing mental health treatment to persons with “unsound mind”. Furthermore the criterion of dangerousness established by the ECHR jurisprudence contributes to an argument of non-compliance.

(b) The Mental Health Act (2007)

This Act (hereinafter UKMHA 2007) provides amendment to the Mental Health Act 1983 which provides guidelines for voluntary and involuntary mental health care in England and Wales, and the Mental Capacity Act (herein after UKMCA 2005) which outlines the legal framework for undertaking decisions on behalf of adults who are incapable to make specific decisions for themselves.⁴⁵² It is presented as the first herein because it is recent and it introduces the following key changes to the UKMHA 1983:

(a) a Simplified Single Definition of Mental Disorder, Abolishing the ‘Treatability’ Test and introducing a new Appropriate Medical Treatment Test, (b) ensuring that Age Appropriate Services are available to any patients admitted to hospital who are aged under 18, (c) Broadening the Professional Groups that can take particular roles, (d) Introducing the right for patients to apply to court to displace their Nearest Relative, and civil partners in the list of potential nearest relatives, (e) ensuring that patients have a right to an Advocacy Service when under compulsion (implemented in 2009), (f) introducing new safeguards regarding Patients and Electro-Convulsive Therapy, (g) introducing a new provision to allow Supervised Community Treatment. This allows a patient detained on a treatment order to receive their treatment in the community rather than as an in-patient, (h) earlier automatic referral to a Mental Health Review Tribunal (Tribunal) where patients don’t apply themselves & new Tribunal system structure and (i) new ‘2nd Professional’ role for renewal of section 3.⁴⁵³

⁴⁵¹ See, *R. v Bournemouth Community and Mental Health NHS Trust Ex p. L* [1997] EWCA Civ 2879 & *HL V UK (2004)* Supra note 242.

⁴⁵² See, *The Mental Health Act (2007)*. See also, United Kingdom Department of Health, *Post- Legislative Assessment of the Mental Health Act 2007-Memorandum to the Health Committee of the House of Lord*, The Stationery Office, (July 2012), p.2. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/228522/8408.pdf.

⁴⁵³ See, Claire Barcham, *Understanding the Mental Health Act Changes- Challenges and Opportunities for Doctors*, 1 *British Journal for Medical Practitioners* 13 (2008). See also, UKMHA (2007), part 1, chapters 1-8.

After the aforementioned Bournemouth case the UKMHA 2007 introduced the ‘deprivation of liberty safeguards’ inserted into the UKMCA whose aims is to protect the liberty of the incapacitated individual by guaranteeing that proper procedures are followed before limiting the right to liberty.⁴⁵⁴ It promotes the engagement of those incapacitated in all decision making and guarantees no infringement by requiring that decisions are subject to independent scrutiny.⁴⁵⁵

(c) The Mental Health Act (1983)

The Mental Health Act (herein after UKMHA 1983) as amended by the UKMHA (2007) provides a legal framework for the admission, treatment and care and administration of properties of those individuals with mental illness in England and Wales.⁴⁵⁶ Like the Ontario, South Africa and Ghana legislation on mental health, it outlines the procedures by which individuals diagnosed with a mental disorder can compulsorily restrained in hospitals for assessment and/ or treatment and held in police custody.⁴⁵⁷ It also sanctions the use of compulsory treatment and regulates treatment of the accused and offenders. It give emphasis to patient’s rights such as the right to information, to review of detention, right to appeal and right to respect advance made wishes among others as substantiated in the Mental Health Act Code of Practice (2015) (here after UKMHA Code of Practice).⁴⁵⁸ The responsibility of overseeing the implementation of the Act is by the Care Quality Commission (CQC) as provided by the *Health and Social Care Act (2008)*.⁴⁵⁹ Previously the role was undertaken by the Mental Health Act Commission.

⁴⁵⁴ See, UKMHA (2007), part 2, Chapter 2, s. 49-51.

⁴⁵⁵ See, Ibid, part 2

⁴⁵⁶ See, UKMHA (1993) as amended.

⁴⁵⁷ See Ibid.

⁴⁵⁸ See, UK Department of Health, Mental Health Act 1983: Code of Practice, The Stationery Office (2015).

⁴⁵⁹ See, Health and Social Care Act (2008). The Preamble sets out that: “An Act to establish and make provision in connection with a Care Quality Commission; to make provision about health care (including provision about the National Health Service) and about social care; to make provision about reviews and investigations under the Mental Health Act 1983; to establish and make provision in connection with an Office of the Health Professions Adjudicator and make other provision about the regulation of the health care professions; to confer power to modify the regulation of social care workers; to amend the Public Health (Control of Disease) Act 1984; to provide for the payment of a grant

The approach of the Act to issues of mental treatment does not match with the CRPD interpretations mainly because it supports compulsory detention and treatment. Consent is not required to detain or treat an individual with a mental disorder except in a limited number of treatments such as electro convulsive treatment. In addition earlier made advance wishes may be overridden in order to provide treatment if it is in the best interest of the individual concerned. It also supports the use of guardianship system which is contrary to article 12 of the convention. However, its conformity can be seen through the many protections offered in the Act and the mere fact that the legislation and actions undertaken in its mandate must be compliant with the UKHRA.

(d) The Mental Capacity Acts (2005)

This statute (herein after UKMCA 2005) as amended by the UKMHA 2007, provides the legal framework for representing and undertaking the responsibility of making decisions in lieu of an individual who lacks the capacity to make certain decisions for him or herself in England and Wales.⁴⁶⁰ The UKMCA 2005 presents five fundamental principles (e.g. best interest, presumption of capacity and use of less restrictive measure) and procedures for undertaking decisions and executing actions in relation to personal welfare, healthcare and financial matters affecting people who may be incapable of making particular decisions about these matters for themselves.⁴⁶¹ It requires that “everyone working with and/or caring for an adult who may lack capacity to make specific

to women in connection with pregnancy; to amend the functions of the Health Protection Agency; and for connected purpose”

See also s.8 & 9 define health and social care to include services that involve mental health care.

⁴⁶⁰ See, Mental Capacity Act (2005) as amended s. 2.

⁴⁶¹ See, *Ibid*, s. 1. This section states that: “(1) the following principles apply for the purposes of this Act. (2)A person must be assumed to have capacity unless it is established that he lacks capacity. (3)A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success. (4)A person is not to be treated as unable to make a decision merely because he makes an unwise decision. (5)An act done or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests. (6)Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.”

decisions must comply with this Act when making decisions or acting for that person, when the person lacks the capacity to make a particular decision for themselves”.⁴⁶²

In addition to dealing with capacity issues, the UKMCA 2005 as amended also deals with deprivation of liberty. One of its amendments is the introduction of Deprivation of Liberty Safeguards (herein after UKMCA DOLS) that lay out criteria for information to be considered and inserted in the application forms during assessments and,⁴⁶³ criteria for the appointment of personal representatives.⁴⁶⁴ As highlighted earlier, the Bournemouth Case led to the enactment of the UKMHA 2007, which in turn amended UKMCA 2005 in respect to capacity issues involving detained mentally incapacitated individuals.⁴⁶⁵ Compulsory commitment of individuals who are mentally incapacitated in hospital or care establishment for treatment of mental or physical illness can also be exceptionally effected under the UKMCA in the best interest of the individual.⁴⁶⁶ These exceptional circumstances are three in number and are highlighted as follows in the case of *P v Cheshire West and Chester Council and another and P and Q v Surrey County Council (2014)*:

Deprivation of liberty is not permitted under the Act save in three circumstances: (i) it is authorised by the Court of Protection by an order under section 16(2)(a); (ii) it is authorised under the procedures provided for in Schedule A1, which relates only to deprivations in hospitals and in care homes falling within the meaning of the Care Standards Act 2000 (see Schedule A1, para 178); (iii) it falls within section 4B, which allows deprivation if it is nec-

⁴⁶² See, United Kingdom Department of Constitutional Affairs, Mental Capacity Act 2005: Code of Practice, The Stationery office (2007), p.15.

⁴⁶³ See, UKMCA (2005) as amended: (a) Mental Capacity (Deprivation of Liberty: Standard Authorizations, Assessments and Disputes about Ordinary Residence) Regulations 2008.

⁴⁶⁴ See, Ibid.

⁴⁶⁵ See, *GJ v The Foundation Trust & Anor* [2009] EWCOP 2972, para 4. It follows- “Section 50 of the Mental Health Act 2007 amended the MCA 2005 to add provisions for the lawful deprivation of liberty of a person with a mental disorder who lacks capacity to consent. Section 50(2) inserts two new sections, 4A and 4B, into the MCA. The effect of these is that deprivation of liberty may only take place under the MCA in one of three situations. These are where: (a) the deprivation is authorised by an order of the Court of Protection under section 16(2)(a) of the MCA; or (b) the deprivation is authorised in accordance with the deprivation of liberty procedures (DOLS) set out in Schedule A1; or (c) the deprivation is carried out because it is necessary in order to give life sustaining treatment, or to carry out a vital act to prevent serious deterioration in the person's condition, while a decision as respects any relevant issue is sought from the court.”

⁴⁶⁶ See, UKMCA (2005) as amended, s. 4A (2) & s. 4B. See also, UK Department of Health, Mental Health Act 1983: Code of Practice, *Supra* note 457, p. 101, para 13.31. It guides as follows: “The MCA can be relied upon to treat mental disorder where the patient lacks capacity to make the decision in question and such treatment is in the patient’s best interests, provided that the treatment is not regulated by Part 4 of the Act.”

essary in order to give life sustaining treatment or to prevent a serious deterioration in the person's condition while a case is pending before the court.⁴⁶⁷

These criteria's must be followed. Finally, it is important to be aware as emphasized that the UKMHA and UKMCA are legal frameworks "based on the need to impose as few restrictions on the liberty and autonomy of patients as possible" in order to effect treatment and care.⁴⁶⁸ Patients can only be admitted based on one of the two legal frameworks, depending on the circumstances of each case and significantly on the framework that offers less restrictive therapeutic benefits.⁴⁶⁹ This means that one Act can only be used at a time and that their application is specifically outlined through the various excluding provisions in certain instances.⁴⁷⁰ Decision makers are required to determine which regime is more appropriate for their user clients.⁴⁷¹ The UKMHA Code of Practice counsels professionals to be careful in the choice of legal regime in order to prevent "considerations [that are] not legally relevant and lead to arbitrary decision-making".⁴⁷² The reason for this concern is because it is believed that both legal frameworks, UKMHA and UKMCA have different but "appropriate procedural safeguards to ensure the rights of the person concerned are protected

⁴⁶⁷ See, *P v Cheshire West and Chester Council and another and P and Q v Surrey County Council* (2014) WLR 2.

⁴⁶⁸ See, UK Department of Health, Mental Health Act 1983: Code of Practice, Supra note 458, p. 107, para 13.58.

⁴⁶⁹ See, Ibid, p. 107&108, para 13.58 & 13.59.

⁴⁷⁰ See, UKMCA (2005) as amended, s. 4. See also, Ibid, p. 105 &107, para 13.49 & 13.56.

⁴⁷¹ See, *GJ v The Foundation Trust & Anor* [2009] Supra note 465, para 132. See also, para 58 -60 that explains as follows: *The relationship between the MHA 1983 and the MCA in the context of deprivation of liberty* "58. In my judgment, the MHA 1983 has primacy in the sense that the relevant decision makers under both the MHA 1983 and the MCA should approach the questions they have to answer relating to the application of the MHA 1983 on the basis of an assumption that an alternative solution is not available under the MCA. 59. As appears later, in my view this does not mean that the two regimes are necessarily always mutually exclusive. But it does mean, as mentioned earlier, that it is not lawful for the medical practitioners referred to in ss. 2 and 3 of the MHA 1983, decision makers under the MCA, treating doctors, social workers or anyone else to proceed on the basis that they can pick and choose between the two statutory regimes as they think fit having regard to general considerations (e.g. the preservation or promotion of a therapeutic relationship with P) that they consider render one regime preferable to the other in the circumstances of the given case. 60. My reasons for this conclusion are: (a) It is in line with the underlying purpose of the amendments to the MCA 2005, to fill a gap namely the "*Bournemouth Gap*". This shows that the purpose was not to provide alternative regimes but to leave the existing regime under the MHA 1983 in place with primacy and to fill a gap left by it and the common law. (b) The regime under the MHA 1983 has been in place for some time and includes a number of checks and balances suitable to its subject matter that are not replicated under the MCA. (c) The strong pointers referred to above in respect of the provisions of paragraphs 12 and 5 of Schedule 1A to the MCA and thus the two gateways or tests relating to ineligibility taken (a) alone and individually, and (b) together with the approach taken to determine the ineligibility of persons within Cases A to D, identified by the third column in the table set out in paragraph 2 of Schedule 1A. (d) This accords with s. 28 MCA, as originally enacted, and as it remains to-day."

⁴⁷² See, UK Department of Health, Mental health Act 1983: Code of Practice, Supra note 458, p. 108, para 13.59.

during their detention”⁴⁷³ and therefore has to be weighed against the benefit to each individual case. The bottom line is that both statutes are available to individuals with mental illness and they also offer compulsory detention of persons with mental disability for purposes of assessment, treatment and care. As mentioned some of these procedures in the UKMHA and UKMCA border each other and provide options for individuals as to which legal regime is suitable for their circumstances as determined by the care providers. As such, detention options from an order given by the Court of Protection, a DOLs authorization and the UKMHA are available for any person who:

- (a) is suffering from a mental disorder (within the meaning of the Act)
- (b) needs to be assessed and/or treated in a hospital setting for that disorder or for physical conditions related to that disorder (and meets the criteria for an⁴⁷⁴ application for admission under sections 2 or 3 of the Act)
- (c) has a care treatment package that may or will amount to a deprivation of liberty
- (d) lacks capacity to consent to being accommodated in the relevant hospital for the purpose of treatment, and
- (e) does not object to being admitted to hospital, or to some or all the treatment they will receive there for mental disorder.⁴⁷⁵

Similar reasoning on non-compliance to the CRPD advanced above on UKMHA equally applies to this legislation. As shown above from the statutory scheme, the use of involuntary admission and treatment to treat and care for persons with mental disability in England and Wales is constantly reviewed and reformed. The review and reforms are positive as regards ensuring protection. Yet, reforms brings changes and with these changes new challenges arise including the increase of the risk of abuse and arbitrariness in detention, treatment and care of persons due to the increase use of the UKMCA framework. The CQC (Care Quality Commission), a body charged with the responsibility of monitoring UKMHA in England in regards to patients detained in hospitals, patients subject to community treatment orders and those under guardianship reported in 2015 that “[they] know that the number of times the Act is used is increasing, with 58,399 uses this year compared to

⁴⁷³ See Ibid, p. 108, para 13.59.

⁴⁷⁴ See, Ibid, p. 107, para 13.56.

⁴⁷⁵ See, Ibid, p. 105 & 107, para 13.49.

53,176 in 2013/14, [and that] this is an increase of 10% on the previous year and the highest year-on-year increase ever”.⁴⁷⁶ As such “by the end of 2013/14, there were 23,531 people subject to the Act, either detained in hospital or under a community treatment order [that] this represents an increase of 6% from 2012/13”.⁴⁷⁷ An increase was also noted in the use of placement powers to detain individuals believed to suffer from a mental disorder and in need of immediate need of care or control from a 2012/2013 figure of 21,814 to a 24, 489 in 2013/2014.⁴⁷⁸

It would be expected that in this pro- CRPD era, pro-deinstitutionalization and of strong activism against civil commitment, compulsory measures would be in the decline contrary to its upsurge.⁴⁷⁹ The CQC observes that ‘the rise in compulsory admissions to psychiatric hospitals has been a common, but not universal, feature of European health systems since the 1990s, and drawing examples from the UK particularly the use of UKMHA, they deduce there is a possible link between the decline in numbers of available beds and the increasing use of compulsory detention [for example] between quarter 1 2010/11 and quarter 4 2013/14, the number of available mental health NHS beds decreased by almost 8%.”⁴⁸⁰ Equally, they find a growing concern as regards the incorrect misapplication of the UKMHA. The CQC 2014/2015 findings indicate that despite the good practices in provision of mental health services which has improved due to the utilization of the UKMHA Code of Practice, they still found some arbitrariness in the provision of services due to the failure to engage the safeguards put in place.⁴⁸¹ They emphasized ‘that the biggest concern for

⁴⁷⁶ See, CQC, Monitoring the Mental Health Act in 2014/2015, Williams Lee Group (2015), p.6.

⁴⁷⁷ See, CQC, Monitoring the Mental Health Act in 2013/2014, Williams Lee Group (2015), p.35.

⁴⁷⁸ See, Ibid, p.50. See also, UKMHA (1983) as amended, s. 136.

⁴⁷⁹ See, CQC, Monitoring the Mental Health Act in 2012/2013(summary), (2014), p. 10. They state that- “It should be a source of considerable concern to the health and social care system in this country that use of the MHA continues to rise – despite the objectives of the national mental health policy and the investments in community services of recent years. People should have access to the right services at the right time and for the right reasons with detention never being the consequence of local system failures in facilitation of timely and appropriate access to care. Under our new integrated approach to inspection we will place a much stronger emphasis on community services and on our understanding of people’s experiences of accessing appropriate mental health care in a crisis.”

⁴⁸⁰ See, Ibid, p. 10.

⁴⁸¹ See, CQC, Monitoring the Mental Health Act in 2014/2015, Supra note 476, p.63.

those individuals subjected to the UKMHA is a lack of support to be involved in their care and treatment beginning from the information given to them, their family and carers, lack of access to external support such as advocacy, and care planning which may result in limiting the individuals recovery, longer stays in hospital, poor discharge or an increase in the potential for readmission'.⁴⁸²

In addition to the trepidations mentioned above, the 2012-2015 reports highlighted the following cross cutting issues which are held to have had slight improvement each year. They include: ' a lack of proper assessment of individuals with mental disability by local authorities, a lack of access and use of independent mental health advocates as a safeguard for patients and "poor practice in restrictive practices particularly seclusion and long-term segregation".⁴⁸³ In addition they observed a practice of not providing legal information and human rights guarantees such as review options, treatment and discharge plans despite the fact there was no clinical reason and the Code of Practice instructs that there must be a system in place to inform individuals of their rights and that a proper record is kept.⁴⁸⁴ In relation to rights the 2015 report also noted "that in over a quarter of the records checked in 2013/14 there was still no evidence of a patient's consent to treatment on admission [and] that patients had little or no discussion about their treatment an unacceptable practice that could lead to unlawful treatment".⁴⁸⁵ All these indicate how the disregard for laws and in-application leads to unlawful practices and violation of rights.

To illustrate that these practices are entrenched, related findings of previous years (2012/2013) disclosed the absence of "recorded assessments of patients' consent or capacity at the point of admis-

⁴⁸² See, Ibid, p.8.

⁴⁸³ See, CQC, Monitoring the Mental Health Act in 2013/2014, Supra note 477, p.3. See also, CQC, Monitoring the Mental Health Act in 2014/2015, Supra note 475, p.6-9 &63- 64.

⁴⁸⁴ See, CQC, Monitoring the Mental Health Act in 2013/2014, Supra note 477, p.37. See also, CQC, Monitoring the Mental Health Act in 2012/2013, Supra note 479, p.4 & CQC, Monitoring the Mental Health Act in 2014/2015, Supra note 476, p.6-9 &63 -64.

⁴⁸⁵ See, CQC, Monitoring the Mental Health Act in 2013/2014, Supra note 477, p.6&7. See also, CQC, Monitoring the Mental Health Act in 2014/2015, Supra note 476, p.6-9 &63 -64.

sion or at the three month stage in detention,⁴⁸⁶ the non-consideration of the least restrictive principle in the care plans, lack of consultation with and taking account of patients wishes⁴⁸⁷ and inadequate discharges including evidence of discharge planning of patients contrary to the UKMHA and its Code of Practice.⁴⁸⁸ One relevant finding that illustrates what the thesis considers arbitrary is the daunting “continued widespread use of blanket rules in place in more than three quarters of the wards [they] visited” [and because of these they strongly declared] that “such practices have no basis in law or national guidance on good practice and are unacceptable”.⁴⁸⁹ Furthermore, just like the 2013/2014 report the findings showed that certain informal patients or those allegedly admitted through UKMCA got admitted using nurses holding powers for six hours as per the UKMHA, the patients detention however were as a result of falsely believing that they were going to the hospital to have a “a nice chat” or “to see a doctor” only to be detained as an inpatient and unable to leave because of the holding powers.⁴⁹⁰ Indeed, this use of subterfuge to admit patients is vicious and goes against the principles under the UKMHA and its Code of Practice and as the CQC put it “it must be open to legal challenge in any individual case as unlawful deprivation of liberty”.⁴⁹¹

Generally, this is the kind of arbitrariness that this thesis propounds to exist and is a major cause of breaches and violations of rights of persons with mental disability. The laws in England and Wales are extensive with substantive and procedural safeguards catering for different situations in the care of an individual subjected to the compulsory schemes to the point that it can be encouraged to be emulated in other jurisdiction with due consideration given to the health structures, judicial system,

⁴⁸⁶ See, CQC, Monitoring the Mental Health Act in 2012/2013, Supra note 479, p.54.

⁴⁸⁷ See, Ibid, p.7.

⁴⁸⁸ See, Ibid, p.4.

⁴⁸⁹ See, Ibid, p.6. The CQC asserted: “In 46% of cases reviewed the reason given for the blanket rules was ‘hospital policy’ [or imposed because] of a historical incident or in 13% of cases no-one seemed able to give a reason.”

⁴⁹⁰ See, Ibid, p.16.

⁴⁹¹ See, Ibid, p.16

social and economic positions of those countries. The following presents the South Africa statutory framework

2.2.2. South Africa

South Africa is a country with a population of 51.8 million inhabitants as per 2011 census and an estimated 54.8 by mid-year 2015.⁴⁹² From these numbers it is estimated that “about 1 in 5 South African suffers from a mental illness/ disorder severe enough to affect their lives.”⁴⁹³ It is also asserted that mental illness or “neuropsychiatric disorders are ranked 3rd in their contribution to the overall burden of disease in South Africa, after HIV and AIDS and other infectious diseases”.⁴⁹⁴ Yet many who suffer from mental disability would prefer to die than disclose that they are with an illness from some sort of mental illness due to stigmatization that hinders early intervention and treatment.⁴⁹⁵ This practice of non-disclosure is also compounded with the fact that “mental health care continues to be under-funded and under-resourced compared to other health priorities in the country, despite the fact that neuropsychiatric disorders are ranked third in their contribution to the burden of disease in South Africa.”⁴⁹⁶ In addition, challenges like “enormous inequity between provinces in the distribution of mental health services and resources, lack of public awareness of mental health and widespread stigma against those who suffer from mental illness; a lack of accurate routinely collected data regarding mental health service provision and mental health services that continue to

⁴⁹²See, Statistics South Africa, South African Statistics (2014), p.2.20-2.27. Available at: <http://beta2.statssa.gov.za/publications/SASStatistics/SASStatistics2014.pdf>.

⁴⁹³ See, South Africa Federation for Mental Health, Understanding Mental Illness (Presentation in the Mental Illness Awareness Month) (2011), p.1. Available at: <http://www.safmh.org.za/Images/understandingMentalIllness.pdf>. See also, Beauregard Tromp et al, One in Three South Africans Suffer from Mental Illness-Most Won't get any help, Times Live (published on 07 July 2014).

⁴⁹⁴ See, Department of Health of The Republic of South Africa, National Mental Health Policy Framework and Strategic Plan 2013-2020, (2013), p.10.

⁴⁹⁵ See, South Africa Federation for Mental Health, Understanding Mental Illness, Supra note 493.

⁴⁹⁶ See, Department of Health of The Republic of South Africa, National Mental Health Policy Framework and Strategic Plan 2013-2020, Supra note 494, p.10.

labour under the legacy of colonial mental health systems with heavy reliance on psychiatric hospitals” intensifies the protracted situation in mental health care and rehabilitation in south Africa.⁴⁹⁷

There are 22 psychiatric hospitals in South Africa and 36 psychiatric wards in general hospitals.⁴⁹⁸ In addition to these there are various private mental health facilities and Non-governmental run community based mental health centres as well as spiritual and traditional centres of healing. Some of these private and non-governmental are registered and funded by the government to provide community care, treatment and rehabilitation in order to meet the aims of the renowned progressive Mental health Care Act (herein SMHCA 2002).⁴⁹⁹ Spiritual or/and traditional mental services and centres remain unregistered and unfunded. So far South Africa has endeavoured to keep up with the CRPD by making calls for deinstitutionalization but with some challenging consequences. It is confirmed that the process of “deinstitutionalization has progressed at a rapid rate in South Africa, without the necessary development of community–based services [leading] to a high number of homeless mentally ill, people living with mental illness in prisons and revolving door patterns of care”.⁵⁰⁰ This kind of consequences is not new for many countries particularly African countries which do not have proper structures to provide community based care and inadvertently making the same psychiatric institutions as the only place where individuals with mental disability can find mental health care.⁵⁰¹ With this brief view of South Africa, the following presents the legislative scheme.

⁴⁹⁷ See, *Ibid*, p.10 & 15.

⁴⁹⁸ See, Beauregard Tromp et al, One in Three South Africans Suffer from Mental Illness-Most Won’t get any Help, *Supra* note 493.

⁴⁹⁹ See, Mental Health Care Act (2002): General Regulation Relating to the Mental Health Care Act, 2002 Amendment (2014). Regulation 6 as amended states –“Within available resources the State must provide subsidies to appropriate non-profit organizations or volunteer organizations for the provision of community care, treatment and rehabilitation to meet the objectives of the Act.”

⁵⁰⁰ See, Department of Health of The Republic of South Africa, National Mental Health Policy Framework and Strategic Plan 2013-2020, *Supra* note 494, p.16.

⁵⁰¹ See, Jonathan Kenneth Burns, The Mental Health Gap In South Africa- A Human Rights Issue, 6 *The Equal rights Review*, 104 (2011).

(a) The Constitution of the Republic of South Africa (1996)

The legal framework for the access to health care including mental health care starts from article 27 of the constitution which presents it as a right of everyone to have access to health care and to emergency care services without discrimination.⁵⁰² The South African constitutional court in one of its jurisprudence *Soobramoney v. Minister of Health [Kwazulu-Natal] (1998)* gives an interpretation on this right particularly emphasizing on States responsibility and the use of available resources where it emphasized that the right as given in the constitution is a guarantee to all and it places a qualified burden upon the State to take all "reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of this right."⁵⁰³ Corresponding values are expressed in the National Health Act which promotes equality in access to health care system, promotes informed consent for users and guidelines for incapable users, protection of information, and details on medical research including setting up the national health council to oversee health concerns and the devolution of health care from the government to the provinces.⁵⁰⁴ The constitution does not provide for or make a differentiation between voluntary or involuntary meth-

⁵⁰² See, The Constitution of the Republic of South Africa (1996), s. 27.

⁵⁰³ See, *Soobramoney vs. Minister of Health, KwaZulu-Natal 1998 (1) SA 765 (CC)*. The applicant Sobromaney Coinciding a 41 year old man without employment was suffering from a chronic renal failure due to diabetes, an irreversible condition. He sought a dialysis treatment in a state hospital in order to prolong his life, but due to a certain set policy that required that in order to access this treatment one must be eligible for a kidney transplant and must not suffer other diseases and since he did not qualify these requirements his admission was effectively denied. As a result Sobromaney made an application to the High Court to direct the hospital to administer the on-going treatment but the court dismissed his application upon which he appealed to the Constitutional court. His contention before the court was patients with terminal diseases and who needed to prolong their lives were eligible to be supported with such treatment by the State according to section 27(3), which entitles the right to access health care and prohibits denial of emergency treatment. Sobromaney relied on section 11 on the right to life to argue his position. The constitutional court dismissed the applicant's claims and held that there is no need to infer from section 11 because the right in contention is directly provided for in section 27. In addition, the nature of State obligation under section 27 (3), is positive and negative in that they are to provide emergency care and to refrain from denying anyone that care. The issue as the court interpreted is defining what emergency care meant. In this regard the court emphasized that it is that kind of care or treatment that is remedial, necessary and available to prevent detriment in situations of emergency or disasters. Hence it could not possibly be applied to situations such as the applicants that involved ongoing treatment for life prolongation and more so it "it would make it substantially more difficult for the state to fulfil its primary obligations under sections 27(1) and (2) to provide health care services to 'everyone' within its available resources". The state had the obligation under section 27 to use "reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of this right". Therefore, the hospital policy was held to be reasonable because all renal units were over-stretched that there were more people suffering from renal failure than there were dialysis machines and it could not possibly interfere with such rational decisions made in good faith by medical practitioners and the State.

⁵⁰⁴ See, The National Health Act 61 (2004).

ods of mental health care and treatment but as introduced, it guarantees access to health and protection of human rights, human dignity, equality and freedom of everybody including those with mental disability.⁵⁰⁵ It prohibits discrimination based on a disability among other grounds.⁵⁰⁶ The Constitution bill of rights “applies to all law, and binds the legislature, the executive, the judiciary and all organs of State”.⁵⁰⁷ This infers that all actions taken by the State and private entities legislatively and otherwise ought to comply with the constitution. This type of compliance is comparably mandated in the Ontario Charter of Fundamental rights and UK Human Rights Act. In any case, compliance is a must. In addition, deprivation of liberty must not be arbitrary or unjust and individual’s right to bodily and psychological integrity must be upheld.⁵⁰⁸ Every endeavour that the government takes must be reasonably executed by taking all legislative and other measures to do so.

(b) Mental Health Care Act 17 (2002) & General Regulation Relating to the Mental Health Care Act, 2002 Amendment (2014)

The statutory regulation of mental health in South Africa is provided by the SMHCA and its regulation replacing the Mental Health Act No. 18 of 1973.⁵⁰⁹ The Act has been acknowledged as “one of the most progressive piece of legislation in the world”.⁵¹⁰ At home it is considered a tool for dismantling “apartheid practices that existed within a health care system that discriminated against those with mental illness [and the] implementation of the MHCA speaks to the political as well as moral obligations of a government toward all of its citizens in creating a legislative framework for mental health services as well as ensuring the successful implementation thereof”.⁵¹¹ It directly sets

⁵⁰⁵ See, The Constitution of the Republic of South Africa (1996), s.7.

⁵⁰⁶ See, Ibid, s.9.

⁵⁰⁷ See, Ibid, s.8 (1).

⁵⁰⁸ See, Ibid, s. 12

⁵⁰⁹ See, M Y Moosa & F Y Jeena, A Review of the Applications for Involuntary Admissions made to the Mental Health Review Boards by Institutions in Gauteng in 2008, 16 South Africa Journal of Psychiatry 125 (2010).

⁵¹⁰ See, Jonathan K. Burns, The Mental Health Gap in South Africa a Human Rights Issue, Supra note 501, p. 100.

⁵¹¹ See, Ramlall. S, The Mental Health Act No 17- South Africa. Trial and Triumphs: 2002-1012, 15 African Journal of Psychiatry 407 (2012).

its own objective and purpose in the preamble declaring that it is “to provide for the care, treatment and rehabilitation(‘rehabilitation means a process that facilitates an individual attaining an optimal level of independent functioning’) of persons who are mentally ill; to set out different procedures to be followed in the admission of such persons; to establish Review Boards in respect of every health establishment; to determine their powers and functions; to provide for the care and administration of the property of mentally ill persons; to repeal certain laws; and to provide for matters connected therewith”.⁵¹² Further objectives are highlighted under section 3 that focuses in ‘affording the best possible and available mental health care, treatment and rehabilitation services to the population equitably, efficiently and in the best interest of mental health care users within the limits of the available resources’.⁵¹³

The praises bespoken of the Act comes from the fact that it commits a whole chapter to human rights and duties involving the respect of human dignity, privacy, equality, prohibition of exploitation and abuse, right to appeal, right to information, right to discharge, right to representation right to consent to care and treatment and to knowledge of rights in the endeavor of protecting rights of mentally ill individuals.⁵¹⁴ Furthermore, it addresses issues of compulsory admission, protection of patient’s properties and establishment of independent review boards with ombudsman functions, it introduces principles of the use of least restrictive measures of compulsion, rehabilitation and reintegration and decentralization of mental health care into community based services and primary health care.⁵¹⁵

Unlike the Canadian and UK, the Act does not have separate legislation such as the Health Consent Act or Substitute Decision Makers Act that contain extensive specifications, criteria and standards

⁵¹² See, SMHCA (2002), the preamble.

⁵¹³ See, Ibid.

⁵¹⁴ See, Ibid, chapter III.

⁵¹⁵ See, Jonathan K. Burns, The Mental Health Gap in South Africa a Human Rights Issue, Supra note 501.

for mental health users. Though, it is the only Act that provides for rehabilitation in care and rehabilitation centres. It comparably “promotes the provision of community-based care and treatment services”, consent before treatment and knowledge of rights upon admission similar to the Canadian and UK legislations.⁵¹⁶ However it falls short to stipulate the criteria by which this community based care is to be effected. Presently in South Africa there is the revolving door syndrome because of lack of community based facilities which results in readmission of individuals.⁵¹⁷ The Act compared to the Ghanaian, offers more guidelines in matters of assisted mental health care (those incapable of consenting). It nevertheless does not mention the use of traditional or spiritual methods for mental health purpose like the Ghanaian statute. Looked through the lenses of the CRPD, the SMHCA does not conform insofar as it does not prohibit the use of ‘involuntary treatment care and rehabilitation and the use of guardianship system of decision making. It would have been expected that undertaking an amendment in 2014 to the Act, the practice of involuntary care would have been abolished but since it did not, it goes to show the resilience in the use of compulsory measures even post CRPD. This trend is a noticeable in many jurisdictions and which supports the thesis standpoint on the need of safeguards.

(c) Allied Health Professions Act 63(1982) as amended.

Like the Ghanaian Republic, South African people have a strong following and practise of traditional and spiritual rituals of healing, physical and mental. The regulatory framework that supports this application by traditional healers is the Associated Health Service Professions Act of 1982, as amended (herein after SAHSPA).⁵¹⁸ Practitioners regulated in this statute include general traditional healers, chiropractors, herbalists, osteopaths, homeopaths and naturopaths.⁵¹⁹ The SAHSPA legally

⁵¹⁶ See, SMHCA (2002), s.4.

⁵¹⁷ See, South Africa Federation of Mental Health Annual Report: Mental Health is the Nation’s Wealth, (April 2013-March 2014), p. 18. Available at: <http://www.safmh.org.za/Images/AnnualReport2014.pdf>.

⁵¹⁸ See, SAHSPA (1982) as amended.

⁵¹⁹ See, Ibid.

allows a practitioner to: “(i) diagnose, and treat or prevent physical and mental disease, illness or deficiencies in humans; (ii) prescribe or dispense medicine; or (iii) provide or prescribe treatment for such disease, illness or deficiencies in human”.⁵²⁰ The Act essentially requires that practitioners must be registered and licensed before they execute their functions under the Act.⁵²¹ The function of registering, licensing and general administration of the statute is undertaken by the Allied Professional Council of South Africa established under section 2 with the objective of promoting and protecting the health of the inhabitants of South Africa.⁵²²

As shown, the relevant practitioners can offer therapeutic services to those with mental health problems. Despite these fact, the Act lacks regulatory grounds upon which treatment can be administered including safeguards specifically for admission, treatment and care of persons with mental disability either voluntarily or involuntarily. This Act is analogous to the Ghanaian Traditional Medicine Practising Act that has no substantive and procedural protections for users. The next statutory framework to be presented is that of Ontario.

2.2.3. Ontario (Canada)

In Canada access to mental health care is regulated by the provinces and federal legal frameworks.

⁵²³Under the constitution, health matters fall under the purview of the provinces, however there are certain instances that federal and provincial powers may overlap.⁵²⁴Such circumstances include the enforcement of involuntary commitment, treatment and release of criminal offenders under criminal law as part of access to mental health care.⁵²⁵ These aspects are regulated by the federal government and at the same time the federal government relies on the provincials mental health care

⁵²⁰ See, Ibid, s. 2 (a).

⁵²¹ See, Ibid, s. 3.

⁵²² See, Ibid, s. 2.

⁵²³ See, The Constitution Act of Canada (1982), s. 5.

⁵²⁴ See, Ibid, s. 91 & 92.

⁵²⁵ See, Ibid, s.91 (27).

systems, governed by civil law to support the needs of mentally ill persons.⁵²⁶ The key legislation that regulates access to mental health in the province of Ontario includes the following:

(a) The Constitution Act 1982 & Canadian Charter of Rights and Freedoms.

As aforementioned, the Constitution Act of Canada stipulates out the legislative powers of the federal and provincial states. In matters of health care, both the federal and province have a stake in it. Before looking at the specific Ontario legislation it is imperative to reference the significant role of the constitution in safeguarding individual's freedoms and rights of persons with disability. Thus, the Canadian Charter of Rights and Freedoms protects individual's rights through judicial review of laws as to their consistency with constitutional norms under section 1.⁵²⁷ Through this section and the process of judicial review it is ensured that legislation enacted and actions executed therein are in accordance with the norms of a free and democratic society. As such, mental health legislation must be enacted and implemented in conformity with the constitution. For Ontario, its mental health laws specifically as it relates to protective standards have effectively been revised and held to be constitutional in a number of jurisprudence.⁵²⁸ However, there have been earlier cases concerning standards as well that have led to the revisions of these laws for instance changes brought about by the *Fleming V Reid (1991)* case upon a finding that a certain section of the mental Health Act was inconsistent with the constitution principles.⁵²⁹ Here the Mental Health Act as it was then

⁵²⁶ See, Ontario Hospital Association, A Practical Guide to Mental Health and the Law in Ontario, (October 2012), p. 12.

⁵²⁷ See, Peter W. Hogg, Constitutional Law of Canada 2013 Student edition, Carswell 36.4c (2013). Section 1, provides that "the *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society".

⁵²⁸ See, *S. v. Her Majesty the Queen*, 2013 ONSC. In the presiding judge pointed out that- "In my view, Ontario courts have answered conclusively that the MHA does not offend [s. 7](#), [9](#), or [12](#) of the *Charter* and that it complies completely with the procedural component of the principles of fundamental justice: *Starnaman v. Penetanguishene Mental Health Centre*, (1995), [1995 CanLII 1518 \(ON CA\)](#), 24 O.R. (3d) 701, at [para. 10](#) (C.A.), aff'ing [1994] O.J. No. 1958 (Gen. Div.); *C.B v. Sawadsky*, [2005] O.J. No. 3682, at paras. 55-65, aff'd [2006 CanLII 34259 \(ON CA\)](#), [2006] O.J. No. 4050 at [para. 21](#) (C.A.). The MHA provides a right to a hearing before the CCB, the right to an independent and impartial magistrate, a decision by the magistrate on the facts and the law, the right to know the case against oneself, and the right to answer the case."

⁵²⁹ See, *Fleming v. Reid*, 1991 CanLII 2728 (ON CA).

legitimized the Review Board to override competent wishes of a psychiatric patient communicated to his substitute decision maker, that is not to receive neuroleptic drugs.⁵³⁰ The court in finding a violation of the applicants section 7 constitutional right maintained that “a legislative scheme that permits the competent wishes of a psychiatric patient to be overridden, and which allows a patient's right to personal autonomy and self-determination to be defeated, without affording a hearing as to why the substitute consent-giver's decision to refuse consent based on the patient's wishes should not be honoured, in my opinion, violates “the basic tenets of our legal system” and cannot be in accordance with the principles of fundamental justice”.⁵³¹

In connection to the constitutional standards, it is expected that the provision of mental health care or any health care must not violate individual life, right to liberty and security. Furthermore, the use of non-consensual treatment, the denial of care and decisions must not be procedurally or substantially defective so as not to offend principles of fundamental justice in section 7 the right to liberty and security of persons.⁵³² As observed before, the Charter accepts restricting the right to liberty provided it does not offend the principles of fundamental justice.⁵³³ The meaning of fundamental justice is not defined in the Charter, but judicial decisions have set out what it entails as in the case of *Thompson and Empowerment Council v. Ontario, (2013)* where a constitutional challenge was brought against the impugned provisions of the Mental Health Act of Ontario- psychiatric assessment, involuntary admission and treatment and Community treatment orders.⁵³⁴ The Ontario Superior court of Justice found these provisions to be constitutional, that they do not offend principles of

⁵³⁰ See, Ibid.

⁵³¹ See, Ibid, para VI. Section 7 provides that: “everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.”

⁵³² See, Martha Jackman, *The Implications of Section 7 of the Charter for Health Care Spending in Canada*, Saskatoon: Commission on the Future of Health Care in Canada, (October 1, 2002), p.16.

⁵³³ See, *The Constitution Act of Canada (1982)*, s.7.

⁵³⁴ See, *Thompson and Empowerment Council v. Ontario, (2013) ONSC 5392*.

fundamental justice,⁵³⁵ they had a legislative purpose of ensuring public safety, of improving treatment and that they had substantive and procedural safeguards.⁵³⁶ The court expressed that-

The Supreme Court has set out three principles of fundamental justice that arguably apply herein: legislation cannot be overbroad; it cannot be arbitrary and it cannot be grossly disproportionate to the state interest that the legislation seeks to protect. More specifically:

- (i) A law is overbroad if it is broader than necessary to accomplish its purpose;
- (ii) A law is arbitrary if it bears no relation to, or is inconsistent with, the objective that lies behind the legislation;
- (iii) The doctrine of disproportionality requires the court to determine whether the law pursues a legitimate state interest, and if so, whether the law is grossly disproportionate to the state interest. A law will be grossly disproportionate when its impact on the s. 7 interests is so extreme that its benefits are not worth its costs.⁵³⁷

The contended provisions of the legislation OMHA passed the above criteria; they did not offend principle of fundamental justice and therefore were found to be constitutional. In addition to section 7, section 9 of the Charter prohibits arbitrary detention or imprisonment.⁵³⁸ In the Thompson Case, it was held that according to “the Supreme Court, detention will be arbitrary where it is based on a discretionary authority that is not governed by any criteria – either express or implied. That even though ‘psychiatric assessment and involuntary detention’ in the Mental Health Act is detention under the section, it is nevertheless not arbitrary because the compulsory processes therein are structured discretionally and are the antithesis of arbitrary.”⁵³⁹ That's why this infers that safeguards are important in protecting rights of individuals with mental disability, especially where a right such as the right to liberty is justifiably encroached. Conclusively, the constitution is a safety measure in itself for persons with mental disability.

⁵³⁵ See, *Ibid.* Para 130 states that- “The most that I can do as a judge (I am not a one-man royal commission) is determine if the impugned legislation, even where there is disagreement about its effectiveness, crosses into a constitutional danger zone. I am of course concerned about the extent of the disagreement over the Box B[involuntary admission] and CTO provisions, but I am obliged to conclude as a matter of law that these impugned provisions are not unconstitutional”. See also, para 75-118.

⁵³⁶ See, *Ibid.*, paras 85, 100 & 106.

⁵³⁷ See, *Ibid.*, para 75.

⁵³⁸ See, *The Constitution Act of Canada (1982)*, s.9.

⁵³⁹ See, *Thompson and Empowerment Council v. Ontario*, para 119.

(b) Canada Health Act (1985).

The Canada Health Act (herein after CHA), is a federal statute that concerns finances and particularly specifies standards with which provincial and other Canadian territorial health insurance must conform in order to receive federal transfer payments under the Canada Health Transfer.⁵⁴⁰ These conditions involve universal coverage of all insured services that is for all “insured persons”, and “Insured health services” as provided in the provincial “health care plan”.⁵⁴¹ This Act is important because, it provides possible financial access for the realization of the right to health through insured hospital services to persons with mental disability. As discussed in chapter two, few countries allocate funds to mental health services in their budgets or mainstream mental health in their health care systems including providing universal coverage. The Act excludes from the definition of hospital, “a hospital or institution primarily for the mentally disordered, or a facility or portion thereof that provides nursing home intermediate care service or adult residential care service or comparable services for children”,⁵⁴² but it statuses other areas such as extended health care services that care for persons with mental disability.⁵⁴³ Furthermore, there are provincial insurance schemes offered as per the law.

(c) Ontario Human Rights Code (1990).

Like many other human rights legislations, the Ontario Human Rights Code (herein after OHRC), interdicts actions that discriminate against people based on protected grounds such as age, disability, nationality, citizenship, race, colour, marital status, gender, creed, place of origin and ethnicity among other grounds, in protected social areas such as accommodation, employment, contracts,

⁵⁴⁰ See, Canada Health Act (1985), s.2.

⁵⁴¹ See, Ibid, s.2.

⁵⁴² See, Ibid, s.2.

⁵⁴³ See, Ibid, s.2. It defines “extended health care services” in the province that include; “nursing home intermediate care service, adult residential care service, home care service and ambulatory health care service”.⁵⁴³

membership in unions, associations and access to goods, services and facilities.⁵⁴⁴ Disability as a protected ground provides legal protection to persons with mental disability from any form of discrimination including health care settings. The code provides avenues such as application to the Human Rights Tribunal of Ontario and as held in the case of *S. v. Her Majesty the Queen (2013)*, “a complainant patient [voluntary/involuntary] is entirely within his rights to apply to the Ontario Human Rights Tribunal or to make a complaint to the Royal College of Physicians and Surgeons”.⁵⁴⁵ Another avenue is through the office of commission of human rights which can take independent inquiries, litigate and/or be a third party intervener in a case by which injured parties can claim for justice and reparations.⁵⁴⁶

(d) Ontario Mental Health Act (1990) as amended.

The Ontario Mental Health Act (herein after OMHA) as amended regulates the standards in the access to voluntary, informal and involuntary admissions to specifically designated psychiatric facilities.⁵⁴⁷ According to regulations, these specially designated psychiatric facilities are empowered to provide psychiatric services to the extent of their mandate and to certain exemptions such as offering inpatient, outpatient, day care services, and emergency services, consultative and educational services to local agencies.⁵⁴⁸ The OMHA also sets out the criteria for the administration of psychiatric outpatient under community treatment orders (CTOs).⁵⁴⁹ It also stipulates the determination of psychiatric patient’s capacity to manage their estates immediately following their admission to a

⁵⁴⁴ See, OHRC (1990).

⁵⁴⁵ See, *Ibid*, s. 32-45.10. See also, *S. v. Her Majesty the Queen*, *Supra* note 528. The court held- “In addition to the legal framework summarized by Brown J. in *Capano*, amendments made to the MHA in 2010 now afford an involuntary patient the right to apply for a transfer to another psychiatric facility. There remains, of course, a full right to appeal a CCB decision to this court pursuant to s. 48. In addition, a complainant patient is entirely within his rights to apply to the Ontario Human Rights Tribunal or to make a complaint to the Royal College of Physicians and Surgeons.”

⁵⁴⁶ See, *Ibid*, s. 27-31.

⁵⁴⁷ See, OMHA (1990).

⁵⁴⁸ See, Ontario Ministry of Health and Long Term Care, Designated Psychiatric facilities under the Mental Health Act, available at: <http://www.health.gov.on.ca/en/common/system/services/psych/designated.aspx#one>. Note that: “The Minister of Health and Long-Term Care is responsible for designating psychiatric facilities under the *Mental Health Act* and hospitals under the Mental Disorder Part of the Criminal Code (Canada).”

⁵⁴⁹ See, OMHA (1990), s. 33.

psychiatric facility.⁵⁵⁰ Of utmost importance, it protects the rights of psychiatric patients by providing a collection of rights such as written notice stating reasons for detention, the right to retain a counsel, right to a hearing before the board, right to a rights adviser,⁵⁵¹ right to be discharged, and right to review (of involuntary admission, CTOs and capacity to manage property) before the Consent and Capacity Board (herein after CCB).⁵⁵² Patients under the Act also have the right to appeal against the ‘board’s decision to the Superior Court of Justice on a question of law or fact or both’.⁵⁵³

Besides the mentioned rights the Act refers to other interlinking legislations that outline further protection to psychiatric patients such as the ‘Personal Health Information Protection Act’ that protects the collection, use and disclosure of patient’s health information.⁵⁵⁴ This legislation when analyzed against the CRPD requirements may pass and fail the required standards. It obviously falls short for recognizing involuntary admissions for persons with disability and the possible continued detention of those who have not consented to treatment. It succeeds because persons under the OMHA cannot be treated without their consent, their substitute decision maker, guardian, or contrary to their advance decisions or that of their family. It seems compliant because capacity has to be determined and it also has a significant set of substantive and procedural protections. Other important legislation connected to the OMHA are the Health care Consent Act and Substitute Decision Makers Act discussed below.

⁵⁵⁰ See, *Ibid*, s. 54-60.

⁵⁵¹ See, *Ibid*, s. 38 (1-3). A rights adviser is a person who explains the significance of the certificate of involuntary admission)

⁵⁵² See, *Ibid*, s. 1, 38 & 39.

⁵⁵³ See, *Ibid*, s. 48.

⁵⁵⁴ See, Personal Health Information Protection Act (2004).

(e) Ontario Health Care Consent Act (1996).

This piece of legislation (hereafter OHCCA) standardizes basic rules regarding effective consent to all health care matters in Ontario. Under section one it provides its purpose which involves regulating consent in treatment decisions, in admission to health care facilities and to circumstances of where personal assistance services such as substitute decision makers are chosen to those found incapable of consenting.⁵⁵⁵ In addition it tries to foster good understanding and communication between all the user parties.⁵⁵⁶ It establishes criteria for obtaining informed and voluntary consent from the capable patient or/and the patient's relevant substitute decision maker or supportive family member.⁵⁵⁷ In this regard the OHCCA "affirms the usual presumption of capacity and sets the relevant capacity test".⁵⁵⁸ This test was powerfully emphasized by the Supreme Court of Canada in *Starson v. Swayze*, (2003) where the court provided that the capacity test has two criteria which must be fulfilled, "first, a person must be able to understand the information that is relevant to making a treatment decision [and] second, a person must be able to appreciate the reasonably foreseeable consequences of the decision or lack of one."⁵⁵⁹ As such it "requires the patient to be able to apply the relevant information to his or her circumstances and to be able to weigh the foreseeable

⁵⁵⁵ See, OHCCA (1996), s. 1. It provides as follows: "The purposes of this Act are, (a) to provide rules with respect to consent to treatment that apply consistently in all settings; (b) to facilitate treatment, admission to care facilities, and personal assistance services, for persons lacking the capacity to make decisions about such matters; (c) to enhance the autonomy of persons for whom treatment is proposed, persons for whom admission to a care facility is proposed and persons who are to receive personal assistance services by, (i) allowing those who have been found to be incapable to apply to a tribunal for a review of the finding, (ii) allowing incapable persons to request that a representative of their choice be appointed by the tribunal for the purpose of making decisions on their behalf concerning treatment, admission to a care facility or personal assistance services, and (iii) requiring that wishes with respect to treatment, admission to a care facility or personal assistance services, expressed by persons while capable and after attaining 16 years of age, be adhered to; (d) to promote communication and understanding between health practitioners and their patients or clients; (e) to ensure a significant role for supportive family members when a person lacks the capacity to make a decision about a treatment, admission to a care facility or a personal assistance service; and (f) to permit intervention by the Public Guardian and Trustee only as a last resort in decisions on behalf of incapable persons concerning treatment, admission to a care facility or personal assistance services. 1996, c. 2, Sched. A"

⁵⁵⁶ See, Ibid, s. 1(d).

⁵⁵⁷ See, Ibid, s. 20-24 & 40-46.

⁵⁵⁸ See, John Dowson, A Realistic Approach to assessing Mental Health Laws Compliance with the CRPD, *Supra* note 94, p.77. See also OHCCA (1996), s. 4.

⁵⁵⁹ See, *Starson v. Swayze*, [2003] 1 S.C.R. 722, para 78-79.

risks and benefits of a decision or lack thereof”.⁵⁶⁰ The OHCCA also establishes a guideline on who qualifies to take the position of a substitute decision maker, the parameters and functions of the substitute decision maker in his or her role in making decisions on behalf of the intended individual.⁵⁶¹ It further sets out guidelines for the review of findings of incapacity by a provincial board such as the CCB.⁵⁶²

Contrary to the principles laid down in the CRPD article 12, the OHCCA supports substitute decision making. It also supports supported decision making through supportive family member and use of advance wills.⁵⁶³ While it promotes CRPDs principle of informed consent before treatments, it also provides for waiver of consent where findings of incapacity have been established and also in emergency situations provided the established guidelines are fulfilled.⁵⁶⁴

(f) Ontario Substitute Decisions Act (1992).

The Ontario Substitute Decisions Act (hereafter OSDA), is a relevant to statute to the OMHA and OHCCA. It is relevant mainly because when an individual with or without mental disability, capable and incapable are found to lack capacity to make decision for personal care or property management, then the individual will need a substitute decision maker appointed by him or her or by the Board or court in order to make a decision whether to consent or to refuse psychiatric treatment.⁵⁶⁵ It therefor sets out a legal system for granting a power of attorney for personal care or/and property and a system that ensures the protection of the individual’s rights through review together with court procedures either to appoint an attorney, guardian or to challenge the validity of a par-

⁵⁶⁰ See, Ibid.

⁵⁶¹ See, OHCCA (1996), s. 20-24 & 40-46.

⁵⁶² See, Ibid, s. 32-37, 65-69 & 70-80.

⁵⁶³ See, Ibid, s. 1(d).

⁵⁶⁴ See, Ibid, s.25-28 & 47.

⁵⁶⁵ See, OSDA (1996).

ticular power of attorney.⁵⁶⁶This Act is very important in its essence even though it is more about substitute decision making, a subject that stands contrariwise the CRPD and may be held to promote paternalistic decision making. It can conversely be stated it is a pragmatic legislation because it does not leave to chance any arbitrariness. It supports prior wishes and wishes of individuals to choose whoever they feel can be their substitute decision maker. If not capable, then the courts are empowered to undertake the task. This gives the judicial system monitoring and enforcing capacities to ensure no arbitrariness is undertaken through accountability to the court. Many countries do not have this kind of legislation that sets out criteria and functions of a substitute decision maker. This can be said to be true of South Africa and Ghana

(g) Criminal Code of Canada (1985)

As noted earlier, matters of criminal enforcement falls under the purview of the federal government. However, in certain instances both the provinces and the federal government work together to ensure justice and provide care for its accused citizens. Provision of mental health care to the accused is an example of that area where the two levels of government meet. Part XX.I of the Criminal Code of Canada (herein after CCC) of 1992, regulates the assessment, detention and release of accused persons with mental illness, those found unfit to stand trial, or not criminally responsible because of a mental disorder.⁵⁶⁷ The Act s. 672.1 (1) provides that the mentioned accused may be placed in “*hospital*”, a place in a province that is designated by the Minister of Health for the province for the custody, treatment or assessment of an accused in respect of whom an assessment order, a disposition or a placement decision is made”.⁵⁶⁸Review of the accused detention is also undertaken by the provincial review Board.⁵⁶⁹Thus, the OMHA together with the

⁵⁶⁶ See, Ibid..

⁵⁶⁷ See, CCC (1985).

⁵⁶⁸ See, Ibid.

⁵⁶⁹ See, Ibid, s. 672.1.

CCC regulate the confinement, treatment and supervision of the criminally accused in those designated psychiatric forensic facilities in the provinces.⁵⁷⁰

These are the Ontario legislative framework, coming next is the Ghanaian framework.

2.2.4. Ghana

This African republic, is comprised of 25, 905 natives⁵⁷¹ with three million estimated to be living with mental disorders.⁵⁷² The provision of health care in Ghana is provided both by private and public sectors. The ministry of health has jurisdiction over the health sector including policy making, monitoring and evaluation. Ghana health Service, the Teaching Hospitals and Catholic Health Association of Ghana offer public health service.⁵⁷³ Private health service is mixed up with private clinics, traditional and spiritual centers of healing.⁵⁷⁴ Mental health care delivery is provided through inpatient and outpatient processes. The mental health sector is mainly financed by the government and supplemented somewhat meagrely by internally generated funds and donations.⁵⁷⁵

As of 2014, concluded research emphasized that mental health is an underfunded sector with 1.4 % which is mainly distributed to a few urban areas in the exclusion of rural areas.⁵⁷⁶ That “there were 123 mental health outpatient facilities, 3 psychiatric hospitals, 7 community based psychiatric inpatient units, 4 community residential facilities and 1 day treatment center which is well below what would be expected for Ghana’s economic status”.⁵⁷⁷ Moreover, “the majority of patients were treat-

⁵⁷⁰ See, Ontario Ministry of Health and Long Term Care, Designated Psychiatric facilities under the Mental Health Act, Supra note 548.

⁵⁷¹ See, World Health Organization Estimation. Available at: <http://www.who.int/countries/gha/en/>

⁵⁷² See, Human Rights Watch Report, Like a Death Sentence, Supra note 368.

⁵⁷³ See, Mark Roberts, Caroline Mogan & Joseph Asare, An overview of Ghana’s mental health system: Results from an Assessment using the World Health Organization’s Assessment Instrument for Mental Health Systems (WHO-AIMS), 8 International Journal of Mental Health Systems 2&3 (2014).

⁵⁷⁴ See, Ibid, p.4.

⁵⁷⁵ See, Ibid, p.2&4.

⁵⁷⁶ See, Ibid, p.1.

⁵⁷⁷ See, Ibid.

ed in outpatient facilities and psychiatric hospitals and most of the inpatient beds were provided by the latter”.⁵⁷⁸ What is more is that an “estimated 2.4 million people with mental health problems of which 67,780 (i.e. 2.8%) received treatment in 2011.” The research results also concluded that in Ghana, there were “18 psychiatrists, 1,068 Registered Mental Nurses, 19 psychologists, 72 Community Mental Health Officers and 21 social workers working in mental health which is unbalanced with an unbalanced emphasis on nurses compared to what would be expected”.⁵⁷⁹ These are concerning estimates and perhaps would improve under the purview of the new mental health legislation as discussed below. The legislative framework for mental health in the Republic of Ghana begins with the Constitution and the Mental Health Act 2012.

(a) The Constitution of the Republic of Ghana (1976)

As stated in the introduction, deprivation of liberty on grounds of mental illness and for the purpose of treatment is recognized in the constitution of Ghana. Hence it can be insisted that the legal framework providing access to mental health care starts in the constitution. Over the years mental health has been regulated statutorily by different legal frameworks described in the following discussion of the current mental health legislation.

(b) Mental Health Act of Ghana (2012)

Before the enactment of the current mental health legislation, mental health in Ghana was first regulated by the lunatic Asylum ordinance which oversaw the building of the country’s first asylum in 1906.⁵⁸⁰ This ordinance remained in force until it was repealed by the commencement of the mental health Act of 1972 decree (herein after referred as the Decree). Even though it had introduced principles such as consent of the patient, voluntary treatment, visiting committees and property rights of

⁵⁷⁸ See, Ibid.

⁵⁷⁹ See, Ibid.

⁵⁸⁰ See, Lunatic Asylum Ordinance (1906).

the patients, it lacked a human rights approach. In 2012 the Republic of Ghana passed the current statute replacing the antiquated Decree of 1972. The Mental Health Act of 2012 (herein after GMHA) which entered into force in June 2012 represents a significant improvement on its predecessor. This Act is a Post-CRPD statute that still maintains the use of involuntary treatment and care. It does not conform to the CRPD position, indicating two things - One that the CRPD position on involuntary treatment is improbable if States keep enacting legislations that the CRPD Committee is aggressively trying to get them abolished and second, that involuntary treatment and care is an acceptable method of treatment and care for those with mental disorders.

Nevertheless, this current Act introduces a number of guarantees for persons with mental disorders.⁵⁸¹ These rights include general basic rights,⁵⁸² non-discrimination,⁵⁸³ privacy and my,⁵⁸⁴ guardianship matters,⁵⁸⁵ clear complaints procedures, monitoring and evaluation requirement, reporting, financial issues regarding mental health⁵⁸⁶ and detailed rules concerning vulnerable groups.⁵⁸⁷ Noteworthy provisions to highlight are those pertaining to considering children's opinion, the elderly, care for patients found on the street, the participation of a service user and elected woman in the governing board and sub-committees respectively. The Act tries to enforce gender parity in the administration of mental health.

The Act also introduces concepts of informed consent and the use of 'least restrictive medical care' in a 'least restrictive environment'.⁵⁸⁸ It allows access to private and public mental health facilities and requires that the designated mental health authority "collaborate with the traditional and alter-

⁵⁸¹ See, GMHA (2012), s.54.

⁵⁸² See, Ibid, s.55.

⁵⁸³ See, Ibid, s.54.

⁵⁸⁴ See, Ibid, s.61.

⁵⁸⁵ See, Ibid, s.68-70.

⁵⁸⁶ See, Ibid, s.80-92.

⁵⁸⁷ See, Ibid, s.63-67.

⁵⁸⁸ See, Ibid, s.58.

native medicine council and other providers of unorthodox mental health care to ensure the best interest of persons with mental health disorder’.⁵⁸⁹ This new introduction into the Act brings the entrenched use of unregulated traditional and spiritual methods of healing under scrutiny. However, the Act sets no criteria for admission, custody, review and discharge for these methods, presenting a big lacuna in the law. It should be noted that comparatively with the Ontario legislation, the Act falls short in providing adequate procedural guidelines in involuntary placement of those incapable, or consent procedures and lacks in having extensive guidelines for substitute decision makers. It is the only Act within the research jurisdiction that contains the use unorthodox mental health practices. It is contended by the thesis that it is relevant to acknowledge the beliefs and customs of the people of Ghana, an individual’s healing can come from any place. It is even more beneficial to have these customs regulated to avoid abuse. Consequentially, providing a balanced and monitored access to mental health care that is mindful of culture and that supports the whole premise of proper services that are in conformity with human rights standards.

(c) Criminal and other Offences (Procedure) Act (1960).

This Act under section 133 concerns those accused not fit to stand trial or found not criminally liable because of a mental disorder and who are thereby placed in a mental institution compulsorily for treatment and care.⁵⁹⁰ It correlates with the GMHA which standardizes involuntary treatment of state patients.⁵⁹¹ The corporation between the GMHA and criminal law cuts similarly across the research jurisdictions. It is important because State patients with mental disability are people who need care and they are also prone to arbitrary detention and treatment.

⁵⁸⁹ See, *Ibid*, s. 3 (m).

⁵⁹⁰ See, Criminal and other Offences (Procedure) Act (1960).

⁵⁹¹ See, GMHA (2012), s. 75&76.

(d) Traditional Medicine Practice Act 575 (2000).

Under the description of the GMHA it was mentioned that traditional and spiritual mental health therapeutic services are accepted. This acceptance is due to a number of factors. First it is that constitutionally individuals have the right to enjoy, practice or profess any culture, language, tradition and /or religion as long as they are not dehumanising or injurious to physical and mental wellbeing of any individual.⁵⁹² However, this has not been the case because its rampant use has been unregulated and the healing methods have so far been abusive as evidenced from recent reports of human rights abuses. The second reason is that the Traditional Medicine Practice Act (herein after GTMPA) enables further the practise of traditional medicine and promotes ‘collaboration of practitioners with the Ministry of health to establish centres for provision of traditional medical care within the national health care delivery system’.⁵⁹³ Thus, it stipulates the establishment of a council with jurisdiction to regulate the practice of traditional medicine, register practitioners, license practitioners to practice and to control the preparation and trade of herbal medicine.⁵⁹⁴ The statute defines traditional medicine as "practice based on beliefs and ideas recognized by the community to provide health care by using herbs and other naturally occurring substances" and herbal medicines as "any finished labelled medicinal products that contain as active ingredients aerial or underground parts of plants or other plant materials or the combination of them whether in crude state or plant preparation"⁵⁹⁵ It does not include the use of chains, whipping or chants in the meaning of traditional medicine or practice thereof. Hence, the concerns that emerge with the Act however how effective has is it been in ensuring that these abusive practices are addressed and monitoring that these services are offered by qualified practitioners.

⁵⁹² See, The Constitution of the Republic of Ghana (1992). Article 26 provides that: “(1) Every person is entitled to enjoy, practice, profess, maintain and promote any culture, language, tradition or religion subject to the provisions of this Constitution.(2) All customary practices which dehumanise or are injurious to the physical and mental wellbeing of a person are prohibited.”

⁵⁹³ See, The Traditional Medicine Practice Act 575 (2000), s. 2.

⁵⁹⁴ See, GTMPA (2000).

⁵⁹⁵ See, GTMPA (2000), s. 42.

For a fact “the people of Ghana have a strong tradition of religious observance and cultural life revolves around religious and cultural rituals.”⁵⁹⁶ It is also true that if an individual becomes mentally ill they regularly consult spiritual institutions or traditional healer’s shrines as the first place of help.⁵⁹⁷ Sometimes a referral is made to psychiatric institutions and sometimes not. Thus, the importance of these legislations materializes by guaranteeing that the uses of traditional and spiritual methods of healing are safe and of proper. The hindsight to all these legislations (Constitution, GMHA and GTMPA) is that they lack the proper standards regulating voluntary and involuntary detention, treatment and care of persons with mental disabilities accessing these centers. It is correct to maintain that it is more often challenging to regulate what may be considered irrational beliefs and practices, but it is possible to have an effective standardized regulatory framework that prohibits the use of practices that may fall within the ambits of inhumane and ill treatment and torture such as the chaining, whipping and sexual assaults among others. A regulatory framework has the additional benefit of guaranteeing and ensuring access to judicial remedies to those aggrieved and a platform to conduct monitoring and evaluation of these facilities that offer traditional and spiritual mental health healing. Moreover, a framework would be strengthening the already mentioned Ghanaian constitutions protection that unmistakably declares traditional practices that dehumanizes or is injurious to physical and mental health to be prohibited.

Sum Up

The given legislation have presented similar aims and functions of guaranteeing access to mental health care and services through compulsory measures that is within a regulated framework that guarantees protection of rights and access to judicial mechanisms in the event of disputes. Yet analyzed against the CRPD position, these frameworks do not fully conform. They however indicate the resilience of governments in using them to promote mental health in their domestic jurisdic-

⁵⁹⁶ See, Richard Laugharne and Tom Bums, Mental health services in Kumasi, Ghana, 23 *The Psychiatrist* (formerly the *Psychiatric Bulletin*) 362 (1999).

⁵⁹⁷ See, *Ibid.*

tions. They contain differences that may come across as effective or ineffective and less human ‘rightsy’ in providing mental health care. Hitherto, considering them is significant because they all purport to provide ways in which to prevent abuse or arbitrariness in the provision of mental health care. Furthermore, considering that the implementation of the CRPD position on compulsory measures by State Parties currently seems improbable to be followed to the letter, finding proper substantive and procedural safeguards seems to be a pragmatic approach. Accordingly the coming up sections commences the examination of these standards by first looking at the initial processes of civil commitment that involves the criteria of admission, treatment and protections therein.

2.3. Criteria for Admission and Treatment

2.3.1. Introduction

The manifestation of abuse and arbitrariness in all stages and procedures relating to the provision of health care in health care settings is not a new phenomenon.⁵⁹⁸ As a result it is important to have legislation that promote good practices and those that protect patient’s human rights in the administration of health care from the initial stages of assessment, admission to treatment and finally discharge. Provision of medical assistance can either be voluntary or involuntary. This research deals with the latter, involuntary commitment and treatment of persons with mental illness. This method of medical assistance is non-consensual and as such exposes patients to high risks of being susceptible to human right abuses. Availability of proper legislation, effective enforcement and remedying mechanisms are quintessential tools in ensuring the prevention and reduction of the risks of abuse. In the research jurisdictions and across the globe, mental health legislation and other supporting statutes are utilized to guarantee the provision of medical care and the individual human rights protection from the initial admission processes to the treatment phase and finally the discharge stage.

⁵⁹⁸ See, Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez, *Supra* note 77, para.11 & 39.

Briefly from the international human rights conventions, it can be juxtaposed that the processes and procedures involved in civil commitment are not provided. Two instruments are considered, the CRPD and MI Principles. Beginning with the CRPD, it is evident that State Parties are not encouraged to promote legislative measures that support compulsory measures but only those that respect human rights like equality, dignity, autonomy, and freedom from torture, right to health and full participation of persons with disability in the community among other rights.⁵⁹⁹ Therefore, the CRPD does not make any mention of admission procedures, treatment and discharge as regards civil commitment in its text.⁶⁰⁰ But in the article enunciating the right to health it requires that individuals with disability have equal access to health care and health rehabilitation as others.⁶⁰¹ It additionally requires the respect of individual's autonomy and dignity as well as exercise of reasonable accommodation at all times.⁶⁰² The MI Principles equally promote the same principles like the CRPD. However, unlike the CRPD it expressly provides for these procedures. For instance it describes that involuntary admission can be effected for a short duration to an individual or a patient who is already a voluntary patient in a designated mental health facility if that patient has been examined by qualified health practitioners including an independent of the first practitioner authorised by the law to determine that the patient suffers from a mental illness.⁶⁰³ It sets out the admission criteria's involving the enforcement of compulsory measures by requiring that 'there must be a presence of mental illness, that due to the illness there is a serious likelihood of immediate or imminent harm to that person or to other persons; or that, in the case of a person whose mental illness is severe and whose judgement is impaired, failure to admit or retain that person is likely to lead to a serious deterioration in his or her condition or will prevent the giving of appropriate treatment

⁵⁹⁹ See, CRPD Article 3&4.

⁶⁰⁰ See, Ibid, Article 14.

⁶⁰¹ See, Ibid, Article 25.

⁶⁰² See, Ibid, Article 4, 12 & 25.

⁶⁰³ See, MI Principles, Supra note 272, principle 16.

that can only be given by admission to a mental health facility in accordance with the principle of the least restrictive alternative'.⁶⁰⁴

These grounds equate with the ECHR and the ICCPR Committee jurisprudence discussed in chapter one. Moreover as shall be realized shortly they are reflected in the statutes of the jurisdictions in question. What also materialize as identical are the MI Principles requirements of review of admission and the respect of individual rights such as providing information upon admission to the individual or representatives and all other rights stipulated in the Principles.⁶⁰⁵ Admission according to the Principles should be for a short duration to enable preliminary assessment and treatment pending further review of the compulsory admission and treatment by the relevant domestic review body. Many of these Principles, substantive and procedural are mirrored in the research domestic statutes.⁶⁰⁶ In all the research jurisdiction access to mental health care and the application of the legislation on every person begins with the presence of a mental disorder. It should however be noted that having a mental disorder does not mean that the legislation becomes automatically applicable. Some mental disorders do not necessarily warrant the applicability of compulsory admission, treatment and care measures. As such, application is limited within the confines of the given statute definition.

From a CRPD interpretation point of view, the detention that results based on a finding of an existence of a mental disorder and the fulfillment of the rest of the criteria contradicts the CRPD prohibition of using disability as a ground for limiting the right to liberty,⁶⁰⁷ including the calls for abol-

⁶⁰⁴ See, Ibid.

⁶⁰⁵ See, Ibid.

⁶⁰⁶ See, UKMHA (1983) as amended, s. 118 (2B), See GHMA (2012), s. 54-56, See, SMHCA (2006), s. 7-17 & See also, OMHA (1990).

⁶⁰⁷ See, CRPD (2008), Art 14.

ishing permitting legislation and deinstitutionalization.⁶⁰⁸ In this regard, the MI Principles and the legislation of the research jurisdictions when analysed against these interpretations they become practically inconsistent. Notwithstanding, it is crucial that protective standards are embedded within civil commitment enabling legislation for the purpose of addressing abuse and arbitrary detentions, beginning with the initial processes of compulsory assessment, admission and treatment. Hence, the starting point of this analysis begins with looking at the initial process of admission and/or admission for assessment and then followed by treatment and care in civil commitment. Jurisdictionally it begins with England, followed by South Africa, Ontario and Ghana respectively.

2.3.2. England (United Kingdom)

2.3.2.1. Compulsory Admission for Assessment

The legislative scheme in England & Wales as provided in the UKMHA is two tier-compulsory admissions for assessment and admission for treatment.⁶⁰⁹ Admission or compulsory detention for assessment is stipulated under section 2 of the Act and may be undertaken in respect of a patient on the justification that the individual is suffering from-

- (a) a mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and
- (b) [That the individual] ought to be so detained in the interests of his/ [her] own health or safety or with a view to the protection of other persons.⁶¹⁰

The authority for the compulsory detention of an individual for assessment is for a period not exceeding 28 days. Thereafter or before depending with the circumstances of each case, the patient or

⁶⁰⁸ See, Tina Minkowiz, “A Response to the Report by Juan E Mendez, Special Rapporteur on Torture, Dealing With Torture in the Context of Healthcare, as it Pertains to Nonconsensual Psychiatric Interventions” in Center for Human Rights & Humanitarian Law Anti-Torture Initiative, *Torture in Healthcare Settings: Reflections on the Special Rapporteur on Torture’s 2013 Thematic Report*, 227-246 (2014).

⁶⁰⁹ See, UKMHA (1983) as amended, s.2 &3.

⁶¹⁰ See, *Ibid*, s.2 (2 a&b)

individual should be discharged or be detained further depending on a new application or an order as provided in the Act⁶¹¹ and re-emphasized in *R V. Wilson, Ex.p Williamson (1995)* that-

... Under section 2 is to be of a short duration and for a limited purpose, assessment of the patient's condition with a view to ascertaining whether it is a case which would respond to treatment, and whether an order under section 3 would be appropriate...although there is nothing to suggest that section 2 is a once and for all procedure, there is nothing in the Act which justifies successive or back to back applications under this section of the kind which occurred here. The power under section 2 can only be used for the limited purpose for which they were intended, and cannot be utilized for the purpose of further detaining a patient for the purposes of assessment beyond the 28 day period, or used as a stop-gap procedure.⁶¹²

With the proceeding, individuals are entitled to apply for a review to the Mental Health Tribunal (now First Tier Tribunal (Mental Health)) to have the lawfulness of their detention reviewed within 14 day period beginning with the day the individual is detained as a patient.⁶¹³ The failure to have access to such protection would be a deliberate disregard of the law and the protection of article 5(4) of the UKHRA or ECHR as held in the case of *MH v the United Kingdom (2013)*.⁶¹⁴ This case that eventually went before the ECHR Court illustrates precisely that safeguards are important and have to be practically accessible and not theoretically placed in the law in order to prevent arbitrary detentions.⁶¹⁵ Here, MH, a woman suffering from Down's syndrome, was residing with her

⁶¹¹ See, *Ibid*, s.2 (4). Powers of discharge are vested not only in tribunal but also in Hospital managers under section 23 of the UKMHA.

⁶¹² See, *R. v Wilson, ex p. Williamson*, *The Independent*, April 19 (1995) in Jean McHale & Marie Fox Ed., *Health Care Law: Text and Materials*, 2nd Ed. Sweet & Maxwell 510 (2007).

⁶¹³ See, UKMHA (1983) as amended, s. 66 (1(a, b & h)).

⁶¹⁴ See, *MH v the United Kingdom (2013)* ECHR 1008. See also, Article 5(4) ECHR that states- "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".

⁶¹⁵ See, *Ibid*. Para 84 states that- "Be that as it may, the Court does not consider it necessary to explore the theoretical protection, for the purposes of Article 5 § 4, that the petition of *habeas corpus* might offer in the context of patients detained by virtue of section 2 of the 1983 Act. In the specific circumstances of the present case, it would be wholly unreasonable to expect the applicant, or indeed her mother acting on her behalf as her litigation friend, to have attempted during the first twenty-seven days of detention to have brought a *habeas corpus* petition. The scheme established by the 1983 Act makes an application to the Tribunal for discharge the natural and obvious way of taking Article 5 § 4-type proceedings in order to contest the justification - and "lawfulness" - of the compulsory confinement of a mental patient ordered under section 2 of the 1983 Act. An incompetent patient such as the applicant could not make a section 66(2)(a) application to the Tribunal for discharge because she lacked legal capacity, but her nearest relative could make an order for her discharge from the assessment detention under section 2 of the 1983 Act. The applicant's mother attempted to do this, but she was met with a "barring order" under section 25(1) of the 1983 Act, as a consequence of

mother who was her nearest relative.⁶¹⁶ She was detained under section 2 of the Mental Health Act whereby the mother before the expiration of the detention asked that the daughter MH be discharged.⁶¹⁷ This request was barred resulting in further detention of MH based on the opinion of her registered medical officer who claimed she was a danger to herself and others if discharged, including the displacement of her mother as a nearest initiated by the social services which made the mother's discharge request to cease to have effect.⁶¹⁸ Since she lacked capacity to instruct a solicitor she could not make an application to the tribunal to challenge her detention within the 14 day period stipulated in the law.⁶¹⁹ One of the questions before the ECHR Court was whether during this first 27 days period there was a breach of her article 5(4) right.⁶²⁰ The Court held that the right for review of lawfulness of detention is guaranteed to all including detained "persons of unsound mind" to ensure the compliance of substantive and procedural conditions of the convention and relevant domestic legislation.⁶²¹ They held that in certain circumstances "special procedural safeguards may be called for in order to protect the interests of persons who, on account of their mental disabilities,

which her order for discharge had no effect and she was prevented from making any further discharge order for a period of six months (see paragraphs 8 and 39 above)."

⁶¹⁶ See, *Ibid*, para 5.

⁶¹⁷ See, *Ibid*, para 8.

⁶¹⁸ See, *Ibid*, para 39 that provides- "Where the patient is detained under section 2 or 3, section 66 permits him or her to make an application for the discharge of the order to a Mental Health Review Tribunal within fourteen days of the start of the period of detention. Furthermore, section 23 permits either the hospital authorities or the patient's nearest relative to make an order for his or her discharge from a section 2 or 3 detention. However, where the nearest relative has made an order under section 23, section 25 provides that the patient's responsible medical officer ("RMO") may make a "barring order" preventing a discharge by the nearest relative if he or she thinks that the patient if discharged would be liable to be a danger to himself or to others. The nearest relative is then prevented from making any further such application for a period of six months (section 25 (1)(b)). If the patient was detained under section 3, section 66(1)(g), 66(h)(ii) and 66(2)(d) provides that the nearest relative may bring an application to the Mental Health Review Tribunal within twenty-eight days of the date the applicant receives the barring order. However, there is no equivalent right for the nearest relative to apply to the Mental Health Review Tribunal where the barring order is made in respect of a patient detained under section 2."

⁶¹⁹ See, *Ibid*, para 11.

⁶²⁰ See, *Ibid*, para 51-87.

⁶²¹ See, *Ibid*, para 76. It states- "Nevertheless, Article 5 § 4 guarantees a remedy that must be accessible to the person concerned and must afford the possibility of reviewing compliance with the conditions to be satisfied if the detention of a person of unsound mind is to be regarded as "lawful" for the purposes of Article 5 § 1 (e) (see *Ashingdane v. the United Kingdom*, (1985) 7 EHRR 528, 28 May 1985, § 52, Series A no. 93). The Convention requirement for an act of deprivation of liberty to be amenable to independent judicial scrutiny is of fundamental importance in the context of the underlying purpose of Article 5 of the Convention to provide safeguards against arbitrariness. What is at stake is both the protection of the physical liberty of individuals and their personal security (see *Varbanov v. Bulgaria*, no. 31365/96, BAILII: [2000] ECHR 457, § 58, ECHR 2000-X)."

are not fully capable of acting for themselves,” and in this case “there was a violation of Article 5 (4) of the Convention in relation to the applicant’s initial detention by administrative order for the purposes of medical assessment in hospital.⁶²²They emphasized that-

The Convention does not oblige applicants, after unsuccessfully attempting the obvious remedy at their disposal, to attempt all other conceivable remedies provided for under national law (see, *mutatis mutandis*, *Karakó v. Hungary*, no. 39311/05, BAILII: [2009] ECHR 712, § 14, 28 April 2009). Neither the applicant nor her mother acting as her nearest relative was able in practice to avail themselves of the normal remedy granted by the 1983 Act to patients detained under section 2 for assessment. That being so, in relation to the initial measure taken by social services depriving her of her liberty, the applicant did not, at the relevant time, before the elucidation of the legal framework by the House of Lords in her case, have the benefit of effective access to a mechanism enabling her to “take proceedings” of the kind guaranteed to her by Article 5 § 4 of the Convention. The special safeguards required under Article 5 § 4 for incompetent mental patients in a position such as hers were lacking in relation to the means available to her to challenge the lawfulness of her “assessment detention” in hospital for a period of up to twenty-eight days.⁶²³

In addition to the requirement of discharge or proper and lawful continuation of detention, lawful admission for assessment should be “founded on the written recommendations in the prescribed form of two registered medical practitioners, including in each case a statement that in the opinion of the practitioner” that the two conditions above have been fulfilled.⁶²⁴The UKMHA Code of Practice instructs that an application made under this section can be used only if-

⁶²² See, *Ibid*. In para 77 the court stipulates that- “ Among the principles which can be found in the Court’s case-law under Article 5 § 4 concerning “persons of unsound mind” are the following: (a) an initial period of detention may be authorised by an administrative authority as an emergency measure provided that it is of short duration and the individual is able to bring judicial proceedings “speedily” to challenge the lawfulness of any such detention including, where appropriate, its lawful justification as an emergency measure (*Winterwerp*, cited above, §§ 57 - 61 and *X v. the United Kingdom*, cited above, § 58);(b) following the expiry of any such initial period of emergency detention, a person thereafter detained for an indefinite or lengthy period is in principle entitled, at any rate where there is no automatic periodic review of a judicial character, to take proceedings “at reasonable intervals” before a court to put in issue the “lawfulness” - within the meaning of the Convention - of his detention (*Winterwerp*, cited above, § 55 and *Stanev v. Bulgaria* [GC], (2012) 55 EHRR 22, no. 36760/06, § 171, ECHR 2012); (c) Article 5 § 4 requires the procedure followed to have a judicial character and to afford the individual concerned guarantees appropriate to the kind of deprivation of liberty in question; in order to determine whether proceedings provide adequate guarantees, regard must be had to the particular nature of the circumstances in which they take place (*Stanev*, cited above, § 171); (d) the judicial proceedings referred to in Article 5 § 4 need not always be attended by the same guarantees as those required under Article 6 § 1 for civil or criminal litigation. Nonetheless, it is essential that the person concerned should have access to a court and the opportunity to be heard either in person or, where necessary, through some form of representation (see *Megyeri*, cited above, § 22); (e) special procedural safeguards may be called for in order to protect the interests of persons who, on account of their mental disabilities, are not fully capable of acting for themselves (see, among other authorities, *Winterwerp*, cited above, § 60).”

⁶²³ See, *Ibid*, para 78.

⁶²⁴ See, UKMHA (1983) as amended, s.2. See also, *MH, R (on the application of) v Mind (The National Association for Mental Health) & Ors* [2004] EWHC 56 (Admin), para 87 the court states that- “It has not been argued that these

- (a) the full extent of the nature and degree of a patient's condition is unclear
- (b) there is a need to carry out an initial in-patient assessment in order to formulate a treatment plan, or to reach a judgement about whether the patient will accept treatment on a voluntary basis following admission, or
- (c) there is a need to carry out a new in-patient assessment in order to re-formulate a treatment plan, or to reach a judgement about whether the patient will accept treatment on a voluntary basis.⁶²⁵

Applications under this section can be made by individual, patients, nearest relatives⁶²⁶ or an Approved Mental Health Professionals.⁶²⁷ The UKMHA Code of Practice provides that the 'next of Kin' may not be necessarily the nearest relative and because the concept of nearest relative can change overtime perhaps through marriages, civil partnership or even through court appointments.⁶²⁸ In addition, nearest relatives for children and young persons subjected to care orders under the Children's Act 1989 shall be the relevant local authority and those under guardianship orders as stipulated in sections 5 and 14A of the Children's Act 1989, including those individuals named in a child arrangement,⁶²⁹ and the nearest relative can actually appoint another person to undertake his/her functions.⁶³⁰ Nearest relatives have certain rights in relation to the treatment and care of persons with mental disability detained under this section and the rest of the UKMHA as amended. In addition to the right to apply for admission for assessment and treatment, nearest relatives have the

requirements necessitate a finding of dangerousness before the detention of a patient under section 2 can continue. A person can be detained under that section, two doctors of whom one must be an approved specialist in mental disorder have to say that the patient "ought to be detained in the interests of his own health or safety or with a view to the protection of other persons" (section 2(1)(b) of the 1983 Act)".

⁶²⁵ See, UK Department of Health, Mental health Act 1983: Code of Practice, Supra note 457, p.118, para 14.27

⁶²⁶ See, UKMHA (1983) as amended, s. 26. Subsection (1) defines 'relative or 'nearest relative' to mean any of the following persons : "(a)husband or wife [F]or civil partner] ;(b)son or daughter; (c)father or mother; (d)brother or sister; (e)grandparent; (f)grandchild; (g)uncle or aunt; (h)nephew or niece."

⁶²⁷ See, Ibid, s. 114 (10). It defines Approved Mental Health Professions as : In this Act "approved mental health professional" means— (a)in relation to acting on behalf of a local social services authority whose area is in England, a person approved under subsection (1) above by any local social services authority whose area is in England, and (b)in relation to acting on behalf of a local social services authority whose area is in Wales, a person approved under that subsection by any local social services authority whose area is in Wales."

⁶²⁸ See, UK Department of Health, Mental health Act 1983: Code of Practice, Supra note 458, p.49, para 5.2. See also, UKMHA (1983) as amended, s. 29- appointment of nearest relative by court.

⁶²⁹ See, Ibid, s.27&28.

⁶³⁰ See, Mental Health (Hospital, Guardianship and Treatment) (England) Regulations. (2008. SI 2008/1184), regulation 24.

right to impede the admissions, right to information about the patient and right discharge a patient from compulsory care.⁶³¹

According to the Act, nearest relatives have the mentioned rights and also the corresponding duties that consist of exercising due diligence with their given powers. Exercising due diligence for the best interests of the patient guarantees that they do not abuse their powers if left unchecked. Before the amendments to the section, the provision on ‘nearest relatives’, was founded upon a hierarchical list which did not provide for the patients “own wishes as to whom amongst their family might be considered for this role’ leaving a wide margin of power abuse by the nearest relative.⁶³² The changes came after a challenge was taken before the ECHR Court in the case of *JT v UK (2000)*, that concerned the applicant a detained patient at a psychiatric institution under the MHA, who had a troubled relationship with her mother and the adoptive stepfather who had sexually assaulted her were her nearest relative.⁶³³ These two had access to J.T confidential information.⁶³⁴ J.T challenged the then article 26 in the MHA which had no provision or procedure by which she or any other patient could re-designate the identification of her nearest relative.⁶³⁵ The contention before the court was that the lack of procedure to initiate changes violates the applicant’s right to privacy under article 8.⁶³⁶ The court never adjudicated over this case because there was an outside court settlement including the fact that the UK had plans to amend this provision to allow patients under UKMHA with the right to change nearest relative according to their wishes.⁶³⁷ Therefore, these procedures provided under assessment must be enforced before admission for

⁶³¹ See, UK Department of Health, Post Legislative-Legislative Assessment of the Mental Health Act 2007, Supra note 452, p.8 para 30.

⁶³² See, Ibid.

⁶³³ See, *J.T. v. United Kingdom*, [2000] 1 FLR 909.

⁶³⁴ See, Ibid.

⁶³⁵ See, Ibid.

⁶³⁶ See, Ibid.

⁶³⁷ See, Ibid.

treatment is executed. The following examines the procedures and standards for compulsory admission for treatment.

2.3.2.2. Compulsory Admission for Treatment

Compulsory admission for medical treatment is stipulated under s.3.⁶³⁸ The admission for treatment may also begin with patients under section 2 as discussed above transitioning to patients under section 3. In these circumstances the Code of Practice as well explains that section 3 should be used only if:

- (a) the patient is already detained under section 2 (detention under section 2 cannot be renewed by a new section 2 application), or
- (b) the nature and current degree of the patient's mental disorder, the essential elements of the treatment plan to be followed and the likelihood of the patient accepting treatment as an informal patient are already sufficiently established to make it unnecessary to undertake a new assessment under section 2.⁶³⁹

Consent to treatment is not required in this section but "the Code of Practice establishes a clear expectation that, from the start of any treatment, consent will be sought and the patient's capacity to give consent considered, even though the Act provides powers to treat without consent".⁶⁴⁰ This contrasts to the Ontario legislation but similar to the Ghanaian where consent is not a must. The detention duration for treatment is for an initial period of six months with possible renewals after six months then subsequently a year.⁶⁴¹ As amended by the UKMHA 2007, the criteria under this section appear alike the MI Principles and the other research jurisdictions. These criteria require that an individual can be detained if:

- (a) is suffering from [F]mental disorder] of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and

⁶³⁸ See, UKMHA (1983) as amended, s.145 (1-c & 4). Definition for medical treatment under subsection 1(c) included: nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care.

⁶³⁹ See, UK Department of Health, Mental health Act 1983: Code of Practice, Supra note 458, p.119, para 14.28.

⁶⁴⁰ See, CQC, Monitoring the Mental Health Act in 2012/2013, Supra note 479, p.54. See also, UK Department of Health, Mental health Act 1983: Code of Practice, Supra note 457.

⁶⁴¹ See, UKMHA (1983) as amended, s. 20.

- (b) it is necessary for the health or 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[F3; and
- (c) Appropriate medical treatment is available for him.⁶⁴²

The Act defines medical treatment in regards to mental disorder as that whose “purpose is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or tions”.⁶⁴³ However, medical treatment under the UKMHA is generally construed as that including “nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care”.⁶⁴⁴ Therefore, to detain an individual under this section for treatment it is imperative that the treatment is appropriate and available in the relevant hospital in which the individual is to be detained.⁶⁴⁵ Medical treatment conversely does not necessarily mean the administration of medication even though most times it does, but depending with each patient’s circumstances it might mean special day to day care “under the clinical supervision of an approved clinician in a safe and secure therapeutic environment with a structured regime”.⁶⁴⁶ An example of such a regime is the use of community treatment orders that does not require detention.

A further requirement in the section is that, that requires applicants to use registered medical personnel. Like in the making of the assessment application, application for admission and treatment can be made by the individual, parent, nearest relative or approved mental health professional. Additionally, admission for treatment can be instituted on the written recommendations of two registered medical professionals. This written recommendations are required to contain the held opinion of the practitioners as to have satisfied the criteria’s above, the reasons for the opinion and “a

⁶⁴² See, Ibid, s.3 (2)

⁶⁴³ See, Ibid, s.145 (4). It provides inter alia: “Any reference in this Act to medical treatment, in relation to mental disorder, shall be construed as a reference to medical treatment the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations.”

⁶⁴⁴ See, Ibid, s.145 (1-c). It states that; “medical treatment” includes nursing, [F30psychological intervention and specialist mental health habilitation, rehabilitation and care (but see also subsection (4) below);]”.

⁶⁴⁵ See, UK Department of Health, Mental health Act 1983: Code of Practice, Supra note 458, p.24, para 23.7 & 23.8.

⁶⁴⁶ See, Ibid, p.247, para 23.7.

statement of the reasons for that opinion so far as it relates to the conditions set out in paragraph (c) of that subsection, specifying whether other methods of dealing with the patient are available and, if so, why they are not appropriate.”⁶⁴⁷ This is a practical and informative stipulation that provides adequate substantiation for using compulsory measures and controls any uninformed decisions to use compulsory measures. This provision does not appear in the Ghanaian statute but in different wordings is present in the South African and Ontario legislation.

As noted in the beginning some patients under the Act such as those under section 2 (compulsory admission for assessment) may transition from assessment to compulsorily detained patients for treatment. Other individuals that may be subjected to section 3 (compulsory admission for treatment) involve those that are brought in through emergency admission under section 4 and those who already inpatients under section 5 for assessments that lead thereafter to compelled treatment. In the same way the provision may apply to individuals brought in by police empowered by the Act to remove a person who appears to have mental disability of nature that requires immediate need of care or control from his or her residence or public to a place of safety for a period not exceeding 72 hours.⁶⁴⁸ A person taken to a place of safety is entitled to be ‘examined by a registered medical practitioner, to be interviewed by an approved mental health professional and to have the necessary arrangements for his/ [her] treatment and care made’ or released upon the expiration of the designated time.⁶⁴⁹ These procedures must be followed to avoid arbitrary detentions by the police. The case of *R (Sessay) v South London & Maudsley NHS Foundation Trust & Anor (2011)* manifests unlawful detention practices because the police disregarded the clear letter of the law.⁶⁵⁰ The claimant in this case alleged unlawful detention at a hospital because it was contrary to the UKMHA section 135 and 136 (exclusive police powers to remove someone believed to have a mental illness

⁶⁴⁷ See, UKMHA (1983) as amended, s. 3 (3-b&a).

⁶⁴⁸ See, Ibid, s.135 & 136.

⁶⁴⁹ See, Ibid, s. 136.

⁶⁵⁰ *R (Sessay) v South London and Maudsley NHS Foundation Trust (2011) EWHC 2617 (QB).*

to a place of safety) including a violation of her article 5(right to liberty) and 8(right to respect privacy and family life) under the ECHR. The allegations were made after the second defendant a police, made an assessment of the claimants situation including taking into account the best interest of the claimant and the principle of necessity under common law to remove the claimant and her baby from their home without a warrant after complaints were made by her neighbour, whereby she was taken to Maudsley Hospital and was held for thirteen hours before being admitted lawfully under section 2 of the UKMHA.⁶⁵¹

The contention in *Sessay* is/was that arbitrary deprivation of liberty occurred when the police used the UKMCA section 5 and 6 that does not confer police officers with the authority to remove persons to the hospitals or other places of safety for the purpose of sections 135 and 136 of the UKMHA including the long detention and unlawful treatment by the first defendant before being properly admitted.⁶⁵² An additional contention argued out was that “there is no power to deprive patients, such as the claimant, of their liberty in psychiatric hospitals under the common law doctrine of necessity on which the Trust relies”.⁶⁵³ After a thorough analysis of the facts, the relevant law and reliance on ECHR jurisprudence such as *Winterwerp v. The Netherlands (1979-80)* on article 5, the English court reached a conclusion that the claimant’s right under the alleged articles were breached and made a declaration to that effect.⁶⁵⁴ The reasoning behind the court’s decision

⁶⁵¹ See, Ibid, para 1-15.

⁶⁵² See, Ibid, para 4, 5 & 31.

⁶⁵³ See, Ibid, para 31.

⁶⁵⁴ See, *ibid*, para 50-51. They state: “50. *Winterwerp v The Netherlands (1979-80)* 2 EHRR 387 at paragraph 39 the European Court made clear that the first of these conditions does not apply in emergency cases. (See also *X v United Kingdom* (decision of 5 November 1981, Series A No.46 at paras 41 and 45)). 51. In order for there to be a deprivation of liberty falling within the scope of Article 5(1) the objective element of a person's confinement must be "for a not negligible length of time" (*Stork v Germany* (2005) 43 EHRR 96 at para 74, cited in the recent case of *P and Q v Surrey County Council* [2011] EWCA Civ 190 at para 17). In *Foka v Turkey* (Application No.28940/95; decision of 26 January 2009) the European Court stated at para 75: "Even if it is not excluded that Article 5 (1) may apply to deprivations of liberty of a very short length (see *X v Germany*, No.8819/79, Commission Decision of 19 March 1981, Decisions and Reports (DR) 24, pp 158, 161), the Convention organs' case law shows that this provision was considered not applicable in cases where the applicants' stay in a police station lasted only a few hours and did not go beyond the time strictly necessary to accomplish certain formalities (see, for instance, *Guenat v Switzerland*, No.24722/94, Commission

was that hospitals under the UKMHA have enough powers to execute the detention of an individual without the reliance on the common law.⁶⁵⁵ Furthermore, the UKMHA under part II “provides a comprehensive code for compulsory admission to hospital for non-compliant incapacitated patients such as the claimant [and that] the common law principle of necessity does not apply in this context”.⁶⁵⁶ Moreover, it would be contrary to article 5 ECHR because of the lack of safeguards as held in *HL v UK (2004)*.⁶⁵⁷ Thus, police have their responsibility cut out under the UKMHA and the UKMCA does not apply as relied upon.

The above related to the procedures in the UK. The following discussion presents the South African procedures and standards on admissions and treatment.

Decision of 10 April 1995, Decisions and Reports (DR) 81, pp.130, 134 [approximately 2-3 hours]...” 52. In *Austin v Metropolitan Police Commissioner* [2009] AC 564 at paragraph 34 Lord Hope held that there is “room, even in the case of fundamental rights as to whose application no restriction or limitation is permitted by the Convention, for a pragmatic approach to be taken which takes full account of all the circumstances”. So where the police had reasonably believed that a breach of the peace was imminent the imposition of a cordon for many hours around an area enclosing thousands of demonstrators who could only leave with the permission of the police was lawful. Lord Hope added at para 34: “No reference is made in Article 5 to the interests of public safety or the protection of public order as one of the cases in which a person may be deprived of his liberty. This is in sharp contrast to Article 10(2), which expressly qualifies the right to freedom of expression in these respects. But the importance that must be attached in the context of Article 5 to measures taken in the interests of public safety is indicated by Article 2 of the Convention, as the lives of persons affected by mob violence may be at risk if measures of crowd control cannot be adopted by the police. This is a situation where a search for a fair balance is necessary if these competing fundamental rights are to be reconciled with each other.”

⁶⁵⁵ See, *B v Forsey* [1988] SLT 572 in *Ibid*, para 40.

⁶⁵⁶ See, *Ibid*, para 59.

⁶⁵⁷ See, *Ibid*, para 44 & 45. They held that- “44. L’s carers applied to the European Court of Human Rights, which held that L had been deprived of his liberty and there had been a breach of Article 5(4) of the ECHR in that the use by the doctor of the common law doctrine of necessity, instead of statutory powers to detain, did not meet the requirement in Article 5(1)(e) that such a detention must be carried out in accordance with the procedure prescribed by law: *HL v United Kingdom* [2004] 40 EHRR 761. Following that decision amendments were introduced to the Mental Capacity Act 2005 by the Mental Capacity Act 2007 (see paras 15-16 above) to bridge “the *Bournewood* gap” and provide for deprivation of liberty safeguards in relation to adults who lack capacity to decide where they should reside (see *J v The Foundation Trust* at para 6). 45. In our view a further reason supporting the Claimant’s submission that Part II MHA provides an exhaustive code for compulsory hospital admissions is that, applying the reasoning of the European Court in *HL*, if the common law doctrine applies there would not be the safeguards required by Article 5 and the system as such would not be in accordance with the law (see paras 44 above).”

2.3.3. South Africa

2.3.3.1. Compulsory admission for Assessment

Analogous to the UK and Canadian mental health legislation, the first step before accepting an individual as a mental health care user is through assessment. Even though there is a difference in terminology in reference to practitioners or persons in charge of psychiatric facilities, they are comparably similar. As such, the SMHA requires that upon an application for involuntary treatment and care and if granted by the head of health establishment,⁶⁵⁸ it must be ensured that an individual accessing mental health care and treatment must first be given an assessment in order to exclude any physical illnesses that may cause mental disorders to rule out the possibility of involuntarily admitting the individual for further psychiatric care.⁶⁵⁹ It is also presumed that in the assessment some mental health care users may recover and exclude the possibility of imposing further any unnecessary involuntary detention.⁶⁶⁰ The maximum duration for which an individual can be compulsorily admitted for assessment is 72 hours comparable to Ontario and Ghanaian legislation but contrasting the UK which stipulates 28 days.⁶⁶¹ Involuntary examination cannot exceed the given period. The individual must be discharged or once the illness is established then the mental health care user can be transferred to a designated mental health care facility for an inpatient or outpatient care.⁶⁶² The Act stipulates that the head of health establishment must give a written report to the

⁶⁵⁸ See, SMHCA (2002), s.33.

⁶⁵⁹ See, Ibid, s.34. It states- “(1) If the head of the health establishment grants the application for involuntary care, treatment and rehabilitation services, he or she must- (a) ensure that the user is given appropriate care, treatment and rehabilitation services; (b) admit the user and request a medical practitioner and another mental health care practitioner to assess the physical and mental health status of the user for a period of 72 hours in the manner prescribed; and (c) ensure that the practitioners also consider whether- (i) the involuntary care, treatment and rehabilitation services must be continued; and (ii) such care, treatment and rehabilitation services must be provided on an outpatient or inpatient basis.”

⁶⁶⁰ See, South Africa Federation for Mental Health, Guide on Admission Procedures For Mental Health Care, The SA Federation for Mental Health, p.2. Available at: <http://www.safmh.org.za/Images/AdmissionProcedures.pdf>

⁶⁶¹ See, SMHCA (2002), s.34.

⁶⁶² See, Ibid. It follows that- “(3) If the head of the health establishment following the assessment, is of the opinion that the mental health status of the mental health care user- (a) does not warrant involuntary care, treatment and rehabilitation services, the user must be discharged immediately, unless the user consents to the care, treatment and rehabilitation services; or (b) warrants further involuntary care, treatment and rehabilitation services on an outpatient basis, he or she must- (i) discharge the user subject to the prescribed conditions or procedures relating to his or her outpatient care, treatment and rehabilitation services; and (ii) in writing, inform the Review Board. (c) warrants further involuntary

user and mental health review board.⁶⁶³ Thus, if admitted and treated, the following section describes the procedures and guarantees involved.

2.3.3.2. Compulsory Admission for Care, Treatment and Rehabilitation

Consent to treatment according to the SMHCA must be sought before treatment. This requirement basically acts as a criterion and protection akin to the Ontario legislation. However, compulsory care, treatment and rehabilitation of individuals with mental illness can be provided to individuals who are incapable of making informed decisions because of the mental illness and those who need health interventions but refuse.⁶⁶⁴ This requirement appears like the UK where consent is not needed but nevertheless must be sought. The relevant application can be made by the spouse, next of kin, partner, associate, parent, guardian or a health care provider where the aforementioned are not available, unwilling or incapable.⁶⁶⁵ The applicants must have seen the individual seven days prior to the application and must state the nature of their relationship to the user.⁶⁶⁶ For the health care provider he/she must state the reasons for the application and steps taken to locate the applicant's

care, treatment and rehabilitation services on an inpatient basis, the head of the health establishment must- (i) within seven days after the expiry of the 72-hour assessment period submit a written request to the Review Board to approve further involuntary care, treatment and rehabilitation services on an inpatient basis containing- (aa) a copy of the application referred to in section 33; (bb) a copy of the notice given in terms of section 33(8); (cc) a copy of the assessment findings; and (dd) the basis for the request; and (ii) give notice to the applicant of the date on which the relevant documents were submitted to the Review Board.”

⁶⁶³ See, Ibid, s.34 (2).

⁶⁶⁴ See, Ibid, s. 1 (xiii). Defines involuntary care, treatment and rehabilitation to mean - “.the provision of health interventions to people incapable of making informed decisions due to their mental health status and who refuse health intervention but require such services for their own protection or for the protection of others and 'involuntary care, treatment and rehabilitation services' has a corresponding meaning; 'involuntary mental health care user' means a person receiving involuntary care, treatment and rehabilitation”.

⁶⁶⁵ See, Ibid, s.33 (1-(a-i&ii)). It stipulates that- “(1) (a) An application for involuntary care, treatment and rehabilitation services may only be made by the spouse, next of kin, partner, associate, parent or guardian of a mental health care user, but where the- (i) user is below the age of 18 years on the date of the application, the application must be made by the parent or guardian of the user; or (ii) spouse, next of kin, partner, associate, parent or guardian of the user is unwilling, incapable or is not available to make such application, the application may be made by a health care provider.”

⁶⁶⁶ See, Ibid, s. 33 (2-a).

relevant relations.⁶⁶⁷ The application must also state the grounds upon which the relevant care, treatment and rehabilitation is sought.⁶⁶⁸

Upon receiving the application the head of the health establishment must ensure that the individual is examined by two mental health care practitioners and at least one of them must be qualified to conduct physical examination, another criteria appearing in all the thesis jurisdictions.⁶⁶⁹ The need for this requirement as aforementioned is to rule out any physical illness that may present psychiatric symptoms. Thus, if the two reports differ the head of health establishment must ensure that the user is examined by another mental health care practitioner, a condition not specified in the Ghanaian, UK or/and Ontario statutes.⁶⁷⁰ The reports from the practitioners must affirm that circumstances required for providing care and treatment for those incapable to consent have been satisfied and that involuntary care, treatment and care must be provided.⁶⁷¹ These requirements state that-

- (b) at the time of making the application, there is reasonable belief that the mental health care user has a mental illness of such a nature that-
 - (i) the user is likely to inflict serious harm to himself or herself or others; or
 - (ii) care, treatment and rehabilitation of the user is necessary for the protection of the financial interests or reputation of the user; and
- (c) at the time of the application the mental health care user is incapable of making an informed decision on the need for the care, treatment and rehabilitation services and is unwilling to receive the care, treatment and rehabilitation required.⁶⁷²

If the above criteria's are fulfilled then the head of health establishment shall in writing approve the involuntary treatment care and rehabilitation. These criteria are related across the research jurisdiction and with the MI Principles despite minor differences. They are certainly not Pro-CRPD even if the South African legislation is considered progressive or prerequisites consent before treatment.

The subsequent analyzes Ontario.

⁶⁶⁷ See, Ibid, s. 33(2-b).

⁶⁶⁸ See, Ibid, s. 33 (2-c).

⁶⁶⁹ See, Ibid, s. 33 (4).

⁶⁷⁰ See, Ibid, s. 33 (6- a&b).

⁶⁷¹ See, Ibid, s. 33 (5).

⁶⁷² See, Ibid, s.32 (b&c).

2.3.4. Ontario (Canada)

2.3.4.1. Admission for Psychiatric Assessment

Equivalent to the other jurisdiction, in Ontario many applications for involuntary admission begins with application for psychiatric assessment. As such a physician examines an individual after an application for psychiatric assessment has been made either by a voluntary individual,⁶⁷³ informal patient,⁶⁷⁴ a substitute decision maker,⁶⁷⁵ order by court⁶⁷⁶ and those brought through police custody⁶⁷⁷ in accordance with the laid out criteria.⁶⁷⁸ The OMHA presents similar grounds for assessment like the UK legislation, particularly for first time individuals but with more different grounds and explanations for recurring patients.⁶⁷⁹ The criteria require that “where a physician examines a person and has reasonable cause to believe that the person,

- (a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself;
- (b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; or
- (c) has shown or is showing a lack of competence to care for himself or herself,

⁶⁷³ See, OMHA (1990) as amended, s. 12. It does not define “voluntary patient” but states that “Any person who is believed to be in need of the observation, care and treatment provided in a psychiatric facility may be admitted thereto as an informal or voluntary patient upon the recommendation of a physician. R.S.O. 1990, c. M.7, s. 12.” In the case of *Daugherty v. Stall*, (2002) 2657 (ON SC), the court stated that- “[21] The MHA does not define “voluntary patient.” However, s. 12 of the MHA provides that “any person who is believed to be in need of the observation, care and treatment provided in a psychiatric facility may be admitted thereto as an informal or voluntary patient upon the recommendation of a physician.” The meaning of “voluntary patient” was addressed in the Board’s decision in *Re P.A.B.*, Consent and Capacity Board Reasons for Decision TO-020721, TO-020722 dated June 25, 2002 (“*Re P.A.B.*”). In *Re P.A.B.*, the Board found it did not have jurisdiction to decide the applicant’s capacity to manage property because she was not a “patient” under the MHA. The Board stated at p. 8: In order for a person to be considered as a voluntary patient, the person must be in a position to exercise his or her own free will and must have made a capable decision to consent to voluntary status. Except in the case of a person moving from the status of involuntary patient to that of voluntary patient, this consent must be given before the person becomes a voluntary patient. [emphasis added]”.

⁶⁷⁴ See, Ibid, s. 1. It states-“informal patient” means a person who is a patient in a psychiatric facility, having been admitted with the consent of another person under section 24 of the *Health Care Consent Act, 1996*; (“malade en cure facultative”).

⁶⁷⁵ See, Ibid, s.1. It follows that- “substitute decision-maker”, in relation to a patient, means the person who would be authorized under the *Health Care Consent Act, 1996* to give or refuse consent to a treatment on behalf of the patient, if the patient were incapable with respect to the treatment under that Act, unless the context requires otherwise; (“mandataire spécial”).

⁶⁷⁶ See, Ibid, s.16.

⁶⁷⁷ See, Ibid, s. 17.

⁶⁷⁸ See, Ibid, s. 15. Section 1 defines a “physician” [to] mean a legally qualified medical practitioner and, when referring to a community treatment order, means a legally qualified medical practitioner who meets the qualifications prescribed in the regulations for the issuing or renewing of a community treatment order; (“médecin”).

⁶⁷⁹ See, Ibid, s.15.

and if in addition the physician is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,
(d) serious bodily harm to the person;
(e) serious bodily harm to another person; or
(f) serious physical impairment of the person,
the physician may make application in the prescribed form for a psychiatric assessment of the person. R.S.O. 1990, c. M.7, s. 15 (1); 2000, c. 9, s. 3 (1).⁶⁸⁰

From the excerpt, it can be deduced that these criteria in the research areas are on par in regards to the requirement on the presence of mental disorder, element of danger and harm to person and others. However, the only contrast is the similarity of South Africa and Ontario criterion that require “the shown lack of competence to care for himself or herself and violent behavior”.⁶⁸¹ Whether this is a proper or effective criterion is a question to be answered in a different analysis. But briefly it can be contended that it can and it cannot be an effective criterion. On one hand it presents the possibility for care to be administered but on the other if used as a single measuring standard, then it might provide a very large latitude which might result in unnecessary restriction on individual’s liberty. Be that as it may, the provisions must be read and executed as a whole. As previously mentioned, the Ontario legislation provides further standards involving assessment of individuals who have already received mental health treatment. In this regard it obligates that “where a physician examines a person and has reasonable cause to believe that the person:

- (a) has previously received treatment for mental disorder of an ongoing or recurring nature that, when not treated, is of a nature or quality that likely will result in serious bodily harm to the person or to another person or substantial mental or physical deterioration of the person or serious physical impairment of the person; and
- (b) has shown clinical improvement as a result of the treatment, and if in addition the physician is of the opinion that the person,
- (c) is apparently suffering from the same mental disorder as the one for which he or she previously received treatment or from a mental disorder that is similar to the previous one;
- (d) given the person’s history of mental disorder and current mental or physical condition, is likely to cause serious bodily harm to himself or herself or to another person or is likely to suffer substantial mental or physical deterioration or serious physical impairment; and
- (e) is incapable, within the meaning of the *Health Care Consent Act, 1996*, of consenting to his or her treatment in a psychiatric facility and the consent of his or her substitute decision-

⁶⁸⁰ See, *Ibid*, s. 15 (1)

⁶⁸¹ See, SMHCA (2002), s.32 (c). it states- “at the time of the application the mental health care user is incapable of making an informed decision on the need for the care, treatment and rehabilitation services and is unwilling to receive the care, treatment and rehabilitation required.”

maker has been obtained, the physician may make application in the prescribed form for a psychiatric assessment of the person. 2000, c. 9, s. 3 (2).⁶⁸²

The mentioned grounds are extensive unlike the other three research jurisdictions. Also unlike the three jurisdictions, psychiatric assessment does not involve or is not construed as compulsory admission, but it is “sufficient authority for seven days from and including the day on which it is signed by the physician to any person to take the person who is the subject of the application in custody to a psychiatric facility forthwith, and to detain the person who is the subject of the application in a psychiatric facility and to restrain, observe and examine him or her in the facility for not more than 72 hours.”⁶⁸³ It can be maintained that it is still detention because one has to comply. The 72 hours compulsory restraint on an individual’s liberty for purposes of assessment is comparable to the South African requirement. So, once the assessment is done and depending with the type of patient, admission to a psychiatric facility may follow with the attending physician taking responsibility of either discharging those that do not need admission or admitting the individuals as informal, voluntary or involuntary patients.⁶⁸⁴ For involuntary patients, a physician must complete a certificate of involuntary admission.⁶⁸⁵ This is similar to the Ghanaian standards of admitting involuntary patients. It is emphasized here that psychiatry assessment or admission does not lead to auto-

⁶⁸² See, OMHA (1990) as amended, s. 15 (1.1).

⁶⁸³ See, Ibid, s. 15 (4 & 5).

⁶⁸⁴ See, Ibid, s. 20.1. It stipulates- “The attending physician, after observing and examining a person who is the subject of an application for assessment under section 15 or who is the subject of an order under section 32, (a) shall release the person from the psychiatric facility if the attending physician is of the opinion that the person is not in need of the treatment provided in a psychiatric facility; (b) shall admit the person as an informal or voluntary patient if the attending physician is of the opinion that the person is suffering from mental disorder of such a nature or quality that the person is in need of the treatment provided in a psychiatric facility and is suitable for admission as an informal or voluntary patient; or (c) shall admit the person as an involuntary patient by completing and filing with the officer in charge a certificate of involuntary admission if the attending physician is of the opinion that the conditions set out in subsection (1.1) or (5) are met. R.S.O. 1990, c. M.7, s. 20 (1); 2000, c. 9, s. 7 (1).” Note, s.1 (1) defines “informal patient” means a person who is a patient in a psychiatric facility, having been admitted with the consent of another person under section 24 of the *Health Care Consent Act, 1996*; (“malade en cure facultative”)

⁶⁸⁵ See, OMHA (1990) as amended, s. 19. It states- “Subject to subsections 20 (1.1) and (5), the attending physician may change the status of an informal or voluntary patient to that of an involuntary patient by completing and filing with the officer in charge a certificate of involuntary admission. R.S.O. 1990, c. M.7, s. 19; 2000, c. 9, s. 6.”

matic treatment. Treatment as shall be discussed later on is through consent and where obtaining consent is impossible, then the established criteria for such situations must be observed.⁶⁸⁶

2.3.4.2. Compulsory Admission

As established, involuntary admission occurs after a psychiatric assessment has been conducted and where an attending physician “admits the person as an involuntary patient by completing and filing with the officer in charge a certificate of involuntary admission if the attending physician is of the opinion that the conditions for involuntary admissions set out in subsection (1.1) or (5) are met”.⁶⁸⁷

It is very imperative that the attending physician conducts an observation and examination of the relevant individual before admitting the individual.⁶⁸⁸ Of additional importance is that “the physician who completes a certificate of involuntary admission should not be the same physician who conducted the psychiatric assessment provided in section 15 previously discussed in the assessment section”.⁶⁸⁹ Accordingly these mentioned conditions found under section 20(1) subsection (1.1) are similar to the second additional criteria specified in the psychiatric assessment under sections 15(1) subsection (1.1).⁶⁹⁰ However an extra condition is added to section 20 (10 subsection (1.1) that requires that the individual to be admitted involuntarily “is not suitable for admission or continuation as an informal or voluntary patient”.⁶⁹¹ In addition to these criteria, subsection 5 requires that a certificate of involuntary admission or its renewal be issued after the physician has conducted an examination of the relevant patient and holds the view that “that the patient is suffering from mental disorder of a nature or quality that likely will result in, serious bodily harm to the patient, serious bodily harm to another person, or serious physical impairment of the patient unless the patient re-

⁶⁸⁶ See, OHCCA (1996) as amended.

⁶⁸⁷ See, Ibid, s. 20.1(c).

⁶⁸⁸ See, Ibid, s. 20.1.

⁶⁸⁹ See, Ibid, s. 20 (2).

⁶⁹⁰ See, Ibid & See also, ES (Re), 2014 CanLII 55695 (ON CCB), p. 6.

⁶⁹¹ See, OMHA (1990) as amended, s. 20 (1.1-f).

mains in the custody of a psychiatric facility; and that the patient is not suitable for admission or continuation as an informal or voluntary patient”.⁶⁹²

It is imperative that the physician’s opinion is substantiated because when a complaint is lodged or an application for review is made to the Board, the onus of satisfying to the Board that these conditions for involuntary status are or were met fall on the attending physician.⁶⁹³ “A patient may be certified as involuntary either under subsection 20 (5) or under subsection 20 (1.1), or both.”⁶⁹⁴ Nevertheless, it can be seen again that there is repetition of similar criteria and also the recurrence of similarities in requirements within the research jurisdictional except the requirement that involves that ‘the individual is not suitable for admission or continuation as an informal or voluntary patient’. All the mentioned criteria must be construed and applied as a whole. It should be noted that these given conditions are not the only standards that must be followed in order to warrant a proper involuntary admission. Once the certificate of involuntary admission or renewal has been filled, it must be filled and reviewed by the officer in charge of a psychiatric facility or his or her delegates in order to determine whether the required standards have been complied with.⁶⁹⁵ If they are not, then the attending physician is informed and unless a re-examination of the relevant patient or individual is done, then release of the person must be executed.⁶⁹⁶

The certificate of involuntary admission is time limited and authorizes the detention, restriction, observation and examination of the concerned individual in a psychiatric facility for duration of two weeks and/or in case of a first certificate of renewal, an additional month, for the second re-

⁶⁹² See, *Ibid*, s. 20(5).

⁶⁹³ See, ES (Re), 2014, *Supra* note 690.

⁶⁹⁴ See, *Ibid*.

⁶⁹⁵ See, OMHA (1990) as amended, s. 20 (8). See also, section 1 where it defines officer in charge to mean “the officer who is responsible for the administration and management of a psychiatric facility”.

⁶⁹⁶ See, *Ibid*.

newal, two months and if renewed a third time the duration shall be three months.⁶⁹⁷ The fourth and more renewals must be reviewed by the CCB.⁶⁹⁸ Once the authority of the certificate has been executed, concluded and the period of detention has expired, the involuntary patient ceases to be as such and is considered to be an informal or voluntary patient.⁶⁹⁹ In relation to the stated, in certain cases when the authorization has not expired, the endorsed involuntary patient's status may be discontinued to informal or voluntary upon completion of the approved form by the attending physician.⁷⁰⁰ These procedural aspects seem intricate and bureaucratic, but if effectively implemented they provide checks against unlawful detentions and treatment. Compulsory admission for treatment is discussed below.

2.3.4.3. Compulsory admission for Treatment

From the preceding discussion on Ontario legislation and the given procedures on psychiatric assessment and admission, a fundamental issue that is reiterated is that treatment shall not be provided without expressed or implied informed consent.⁷⁰¹ A patient if capable of deciding on treatment decisions including being 'able to appreciate the reasonably foreseeable consequences of a decision or lack of decision',⁷⁰² the individual has the right to do so after being provided with full information on the 'course of treatment'⁷⁰³ and 'plan of treatment'⁷⁰⁴ concerning the relevant mental

⁶⁹⁷ See, *Ibid*, s.20 (4).

⁶⁹⁸ See, *Ibid*, s. 39 (4). It states that- "On the completion of a fourth certificate of renewal and on the completion of every fourth certificate of renewal thereafter, the patient shall be deemed to have applied in the approved form under subsection (1) to the Board unless he or she has already applied under clause (2) (b). 2000, c. 9, s. 21 (3)."

⁶⁹⁹ See, *Ibid*, s. 20 (6).

⁷⁰⁰ See, *Ibid*, s. 20 (7).

⁷⁰¹ See, OHCCA (1996) as amended, s. 10 (1). It states- "A health practitioner who proposes a treatment for a person shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless, (a) he or she is of the opinion that the person is capable with respect to the treatment, and the person has given consent; or (b) he or she is of the opinion that the person is incapable with respect to the treatment, and the person's substitute decision-maker has given consent on the person's behalf in accordance with this Act. 1996, c. 2, Sched. A, s. 10 (1)".

⁷⁰² See, *Ibid*, s. 4.

⁷⁰³ See, *Ibid*, s.2 (1). "Course of treatment" means a series or sequence of similar treatments administered to a person over a period of time for a particular health problem; ("série de traitements").

⁷⁰⁴ See, *Ibid*, s. 2 (1). "plan of treatment" means a plan that- (a) is developed by one or more health practitioners, (b) deals with one or more of the health problems that a person has and may, in addition, deal with one or more of the health problems that the person is likely to have in the future given the person's current health condition, and (c) pro-

health treatment. However, it is expected that in certain instances a patient can be incapable to make such choices. In this circumstances the law provides that an individual's consent may be given by a parent, brother, guardian, attorney for personal care, spouse⁷⁰⁵ including by a substitute decision maker or by any earlier or later orally made wish, written wishes or wishes provided in a power of attorney.⁷⁰⁶ Even in situations where support for individuals is unavailable, the law articulates that publicly appointed guardian or trustee shall provide consent. In this regard, any decision made by the mentioned individuals shall take the best interest of the person concerned before granting the consent. Best interest requires the consideration of the individuals values, wishes, beliefs whether the proposed treatment is likely to improve the incapables well-being, prevent deterioration of well-being or condition, reduce the speed at which the deterioration is taking place, determine whether the treatment will improve the incapable persons condition and whether there is a less restrictive treatment that may be beneficial to the incapable individual.⁷⁰⁷ Best interest's considerations are reflected in the UK, Ghanaian and South African legislation as well. Contrasted to

vides for the administration to the person of various treatments or courses of treatment and may, in addition, provide for the withholding or withdrawal of treatment in light of the person's current health condition; ("plan de traitement").

⁷⁰⁵ See, Ibid, s.20 (1). It states- "If a person is incapable with respect to a treatment, consent may be given or refused on his or her behalf by a person described in one of the following paragraphs- 1. The incapable person's guardian of the person, if the guardian has authority to give or refuse consent to the treatment.2. The incapable person's attorney for personal care, if the power of attorney confers authority to give or refuse consent to the treatment.3. The incapable person's representative appointed by the Board under section 33, if the representative has authority to give or refuse consent to the treatment.4. The incapable person's spouse or partner.5. A child or parent of the incapable person, or a children's aid society or other person who is lawfully entitled to give or refuse consent to the treatment in the place of the parent. This paragraph does not include a parent who has only a right of access. If a children's aid society or other person is lawfully entitled to give or refuse consent to the treatment in the place of the parent, this paragraph does not include the parent.6. A parent of the incapable person who has only a right of access.7. A brother or sister of the incapable person.8. Any other relative of the incapable person. 1996, c. 2, Sched. A, s. 20 (1)."

⁷⁰⁶ See, Ibid, s. 5. It follows that- "(1) A person may, while capable, express wishes with respect to treatment, admission to a care facility or a personal assistance service. 1996, c. 2, Sched. A, s. 5 (1). (2) Wishes may be expressed in a power of attorney, in a form prescribed by the regulations, in any other written form, orally or in any other manner. 1996, c. 2, Sched. A, s. 5 (2). (3) Later wishes expressed while capable prevail over earlier wishes. 1996, c. 2, Sched. A, s. 5 (3)."

⁷⁰⁷ See, Ibid, s. 21(2). It stipulates that- "In deciding what the incapable person's best interests are, the person who gives or refuses consent on his or her behalf shall take into consideration, (a) the values and beliefs that the person knows the incapable person held when capable and believes he or she would still act on if capable;(b) any wishes expressed by the incapable person with respect to the treatment that are not required to be followed under paragraph 1 of subsection (1); and(c) the following factors: 1. Whether the treatment is likely to, (i). improve the incapable person's condition or well-being,(ii). prevent the incapable person's condition or well-being from deteriorating, or (iii). reduce the extent to which, or the rate at which, the incapable person's condition or well-being is likely to deteriorate. 2. Whether the incapable person's condition or well-being is likely to improve, remain the same or deteriorate without the treatment. 3. Whether the benefit the incapable person is expected to obtain from the treatment outweighs the risk of harm to him or her."

the CRPD, the consideration of best interests are prohibited by the CRPD Committees interpretation of article 12. However, the specifics and phrasings in the Ontario legislation resemble those that the CRPD Committee has articulated as constituting ‘wishes and preferences of the individual’ compatible with article 12.

Accordingly, from the foregoing an involuntary admission and administration of treatment of an incapable individual in a hospital, psychiatric facility or any regulated health facility must be by consent.⁷⁰⁸ When the admission and treatment is to be effected, the required legal notice of finding of incapacity and certificate of involuntary (form 33) must be given to the individual concerned and a notification to the rights adviser.⁷⁰⁹ The details of the notice must include reasons for the detention, the right to a hearing before the Capacity and Consent Board, the right to counsel without delay and also the right to apply to the Board for a transfer to another psychiatric facility.⁷¹⁰ As stated the individual has the right to retain and instruct a personal counsel and in addition the right to a rights adviser provided by the hospital in which he or she is to be detained and treated. The rights adviser is required to immediately meet up with the patient and carefully elucidate on the significance of the certificates and the patient’s rights such as a right of review by the Board.⁷¹¹ The Board has the discretionary power to review and determine whether decisions of admission and treatment meet the provided criteria in the law.⁷¹² With the same authority, it can confirm, continue, rescind

⁷⁰⁸ See, *Ibid*, s. 24(1). The section provides that-“Subject to subsection (2), a substitute decision-maker who consents to a treatment on an incapable person’s behalf may consent to the incapable person’s admission to a hospital or psychiatric facility or to another health facility prescribed by the regulations, for the purpose of the treatment. 1996, c. 2, Sched. A, s. 24 (1).”

⁷⁰⁹ See, OMHA (1990) as amended, s. 38 (1).

⁷¹⁰ See, *Ibid*, s. 38(2).

⁷¹¹ See, *Ibid*, s. 38 (3).

⁷¹² See, *Ibid*, s. 41. See also, ES (Re) (2004), *Supra* note 689 where it was held: “ In *Chokan v. Cameron* (1992) 223 Admin L.R. (2d) 23 (Ont. Gen. Div), appeal to C.A. abated [1997] O.J. No148, at paras. 45-52, the Court commented on what is now S41 of the [Mental Health Act](#). [The Board] does not have a broad jurisdictional mandate as does for example the Ontario Labour Relations Board which has exclusive jurisdiction to determine all questions of fact or law that arise in any matter before it.[...] The jurisdiction of a Board of Review constituted pursuant to the request of an involuntary patient for inquiry into his status is quite limited. Such a Board is firstly mandated to promptly review the patient’s status to determine if prerequisites set out in the Act for involuntary admission continue to be met at the hear-

and/or revoke an involuntary patient's status and certificates of involuntary admission.⁷¹³ It should be noted that there can be objections to psychiatric admission of an incapable 16 year old for treatment of a mental disorder and in this case, the only consent to be given is by a guardian with authority to consent and attorney for personal care who also has the power inscribed to do.⁷¹⁴

It goes without say that the Ontario legislation comes close to the CRPD vision because of the requirement of consent before treatment and the many protections available to individuals in its legislation. However even though this difference stands out when compared to the other jurisdictions, it still uses incapacity assessments to consent to committal in hospital and consent through substitute decision makers for informal patients. These criteria are similar to the other three research legislation. Additionally, in emergency situations, consent requirements do not apply hence comparable to the other jurisdictions. The following examines Ghana's legislative framework.

2.3.5. Ghana

2.3.5.1. Compulsory Admission and Treatment

In Ghana a person's right to liberty may be limited in order to receive medical treatment by virtue of the Constitution and the Mental Health Act (GMHA 2012). The constitution does not stipulate admission or treatment criteria. It only states that it will not be contrary to the law nor arbitrary if the right is restricted. The GMHA 2012 on the other hand provides voluntary and involuntary ad-

ing of the hearing. If the Board determines that those prerequisites were met at the time of the hearing then the Board may by order confirm the patient's status as an involuntary patient. If on the other hand the Board determines that those prerequisites were not met at the time of the hearing it shall rescind the certificate. That is the only jurisdiction a review Board has on this type of application – no more, no less.”

⁷¹³ See, Ibid, s. 41.

⁷¹⁴ See, OHCCA (1996) as amended, s. 24(2). It articulates that-“ If the incapable person is 16 years old or older and objects to being admitted to a psychiatric facility for treatment of a mental disorder, consent to his or her admission may be given only by, (a) his or her guardian of the person, if the guardian has authority to consent to the admission; or (b) his or her attorney for personal care, if the power of attorney contains a provision authorizing the attorney to use force that is necessary and reasonable in the circumstances to admit the incapable person to the psychiatric facility and the provision is effective under subsection 50 (1) of the *Substitute Decisions Act, 1992*. 1996, c. 2, Sched. A, s. 24 (2).”

mission and treatment procedures for the administration of mental health care.⁷¹⁵ Administration and treatment is for mental disorders which is defined by the Act to mean “a condition of the mind in which there is a clinically significant disturbance of mental or behavior functioning associated with distress or interference of daily life and manifesting as disturbance of speech, perception, mood, thought, volition, orientation or other cognitive functions to such degree as to be considered pathological but excludes social deviance without personal dysfunction”.⁷¹⁶

Involuntary admission and treatment is only given to involuntary patients who are treated in a mental health facility without consent under a court order or under a certificate of urgency which “means a certificate issued by a medical practitioner for involuntary admission initiated by the police or any other person for an urgent or emergency case”.⁷¹⁷ Similarly, involuntary care may be given to an individual who transitions from a voluntary to involuntary while in mental health care facility receiving mental health care.⁷¹⁸ The Ghanaian approach is comparable to the Ontario where a certificate of urgency is needed and perhaps on consent because consent must be given by the court. Unlike the UK, the Ontario and South Africa statutes that have two tier processes of compulsory admission for assessment and treatment, the GMHA legislation is one tier and speaks of involuntary admission and treatment. Conversely, they are all analogous as regards the criteria upon which a claim for involuntary treatment can be based, including the number of medical recommendation. As such the law provides that involuntary admission and treatment can only be made through an application to the court and can be granted by that court after careful evaluation of facts and the examination of witnesses on oath within 48 hours on the claim that the person is believed to be suffering from severe mental disorder and,

⁷¹⁵ See, GMHA (2012), s.39-41 & 42-53.

⁷¹⁶ See, Ibid, s. 97.

⁷¹⁷ See, Ibid, s. 97.

⁷¹⁸ See, Ibid, s. 40(5). It states that- “(5) At the time of admission, a voluntary patient shall be informed that a personal request for discharge may not be granted if the patient meets the requirements of involuntary admission at the time the request is made”.

- (a) the person named is at personal risk or a risk to other people, or
- (b) there is a substantial risk that the mental disorder will deteriorate seriously⁷¹⁹

The claim must be accompanied by two supporting medical recommendation from a registered medical practitioner and mental health practitioner given on oath before the court and should contain specifications detailing why the individual is a proper subject for the treatment, that the individual is suspected to lack capacity to make an informed treatment choices and that the treatment is necessary to restore health, prevent harm and restore capacity to make treatment decisions.⁷²⁰ The court may grant or reject the application. If it grants the application, then the duration shall be one month with the possibility of prolongation through the recommendation of a psychiatrist or head of mental health facility to the mental health tribunal that a temporary court order be made.⁷²¹ The recommendation must contain reasons as to why the prolongation is necessary as per the legislative requirements.⁷²² The duration of such a prolongation shall be twelve month at a time and reviewed every six months by the tribunal.⁷²³ This is all so far from the Ghanaian legislation. Is it pro-CRPD?

⁷¹⁹ See, Ibid, s.42& 43.

⁷²⁰ See, Ibid, s.42 (3&4). They stipulate a follows--“(3) The recommendation shall be given on oath to the court and shall be supported by two medical recommendations one from a medical practitioner and the other from a mental health practitioner. (4) The recommendation shall specify in full detail (a) the reasons why it is considered that that person is a proper subject for care, observation or treatment, (b) the facts on which the opinion has been formed, distinguishing facts observed personally from those observed by somebody else, (c) that that person is suspected to lack capacity to make informed treatment decisions, and (d) that the treatment is necessary to bring about an improvement in the person's condition, restore capacity to make treatment decisions, prevent serious deterioration or prevent injury or harm to self or others.”

⁷²¹ See, Ibid, s. 46. It states that- “(1) A psychiatrist or head of a facility may recommend the placement of a person under a temporary treatment court order for a pro-longed treatment in a psychiatric hospital if the psychiatrist or head of a facility is of the opinion that the severity of the condition warrants it. (2) This recommendation shall take into consideration the welfare of that person and the safety of the public. (3) A patient or caregiver has the right to attend and participate in appeal and complaints procedures. (4) The recommendation shall be made before the expiry of the court order for temporary treatment or its extension and shall be made on oath to the Tribunal. (5) The recommendation shall (a) specify in full detail the reasons why that person is considered a proper subject for prolonged treatment, (b) specify the nature and severity of the diagnosed mental disorder, the likelihood of complete or partial recovery, and the period which, in the opinion of the psychiatrist or head of a facility, is reasonably required to effect a complete or partial recover, and (c) specify in full detail the facts on which the opinion is based, distinguishing facts observed personally from facts communicated by others. (6) The patient shall meet the criteria stated in section 42. (7) The Tribunal shall examine the person in a place considered convenient or hold an enquiry to determine the state of mind of that person, and for that purpose, (a) the Tribunal may summon witnesses or administer oaths, and (b) the Tribunal may order the placement of that person under prolonged treatment in a psychiatric hospital if from the examination or enquiry the person meets the criteria of section 42 and prolonged treatment is the least restrictive treatment available.”

⁷²² See, Ibid, s. 46.

⁷²³ See, Ibid, s. 47.

The answer is yes because treatment comes after consent and no because the provisions on involuntary admission and treatment and dependency on capacity to grant consent for involuntary treatment by the courts goes contrary to the principles in article 12 and 14 of the CRPD. The legislation as seen is not extensive as the Ontario as it is limited in terms of standards regulating consent and capacity. It also authorizes use of spiritual and traditional methods of healing but lacks a regulatory framework.

2.3.6. Sum Up.

Despite the similarities and difference pointed out in the legislation of these research jurisdictions, one outcome that stands out is that involuntary admission and treatment is a standard method of providing mental health care. The presence of a mental disorder is a strong determinate whether limiting the right to liberty for treatment should be done but it is not the only criterion because there others such as dangerousness to self and others, possibility of physical impairment, lack of capacity and availability of proper medical treatment. These criteria including the use of two medical recommendations, powers of the court and of the nearest relative are in themselves safeguards that become effective when meticulously observed. Furthermore, from the discussion there have small extra criterions appear in some jurisdiction such as “appropriate medical treatment” UK and use of third different mental health practitioner to examine patient where two opinions differ for South Africa and so forth. Additionally, these safeguards are not exhaustive as shall be seen in the subsequent discussion and chapters. The next analysis involves community treatment orders.

2.4. Community Treatment Orders

2.4.1. Brief Introduction

The introduction to community treatment orders was discussed in chapter one. To recap briefly, the use of community treatment orders are championed as alternative to involuntary commitment because they are supposedly less restrictive and intrusive on human rights by making it possible for individuals to continue with mental health treatment within their communities. This aspect makes the use of the orders hence more complacent to the CRPD social model of disability. Interestingly, the MI Principles now considered to be superseded by the CRPD promotes the right to be provided with mental health care in the community or as close as possible to the community where applicable, provisions which are rather similar to what the CRPD commands.⁷²⁴ In spite of this positive attributes and support, studies have indicated that even though “compulsory supervision outside hospital has been developed internationally for the treatment of mentally ill people following widespread deinstitutionalization its efficacy has not yet been proven”.⁷²⁵ Proven results indicate that the use of CTOs do not reduce the rate of compulsory readmission to hospital, the number of compulsory hospital admissions and neither are there records of differences in clinical or social outcomes for those subjected to the orders.⁷²⁶ Therefore, CTOs may be branded as alternatives to involuntary commitment but in essence they enforce the same legal practice of coercion, detention and subjected individuals are not free from compulsory recall for detention and abuse whilst under the orders. In view of this, implementation of CTOs can equally be considered inconsistent with the CRPDs perspectives on forced interventions. And just like States continued practice on civil commitment in

⁷²⁴ See, MI Principle Supra note 272. Principle 7 states that- “1. Every patient shall have the right to be treated and cared for, as far as possible, in the community in which he or she lives. 2. Where treatment takes place in a mental health facility, a patient shall have the right, whenever possible, to be treated near his or her home or the home of his or her relatives or friends and shall have the right to return to the community as soon as possible. 3. Every patient shall have the right to treatment suited to his or her cultural background.” See also, CRPD (2008), article .25 (c). It states- “...Provide these health services as close as possible to people's own communities, including in rural areas;”

⁷²⁵ See, Tom Burns & Stefan Priebe et al., Community Treatment Orders for Patients with Psychosis (OCTET): A Randomised Clinical Trial, 381 *The Lancet* 1627 (2013).

⁷²⁶ See, *Ibid*, p.1631.

institutions, many jurisdictions are or have introduced CTOS, while some like the UK and province of Ontario have used it for a long time as the following discussion beginning with UK, South Africa followed by Ontario and Ghana shall indicate.

2.4.2. England (United Kingdom)

Compulsory Treatment Orders were legislatively introduced in England and Wales in 2008.⁷²⁷ However in the past patients would be permitted to leave the hospital for some designated time, hour, day or week though being subject to recall under section 17 of the UKMHA.⁷²⁸ Mental health services in “England are provided by area-based National Health Service Mental Health Trusts, each divided into catchment areas where community mental health teams (CMHTs) provide both community and inpatient care”.⁷²⁹ The UKMHA (1983) as amended by the UKMHA 2007, refers to community treatment order to mean an order made in writing by a responsible clinician discharging a detained mental health patient (community patient) who is liable to be detained in hospital pursuant to an application for admission for treatment into supervised community treatment regime, but who remains subject to a recall if the community patient does not fulfil the requirements of the CTO.⁷³⁰ The responsible clinician has to ensure that before making the order and in his opinion the ‘relevant criteria are met an approved mental health professional agrees with that opinion in writing that it is appropriate to make the order’.⁷³¹ The relevant criteria to be considered include:

- (a) the patient is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment;
- (b) it is necessary for his health or safety or for the protection of other persons that he should receive such treatment;

⁷²⁷ See, Ibid.

⁷²⁸ See, Ibid.

⁷²⁹ See, Ibid

⁷³⁰ See, UKMHA (1983) as amended, s. 17A (1, 2, 3&7), 17E (power to recall) & 145 (1).

⁷³¹ See, Ibid, s. 17A (4).

- (c) subject to his being liable to be recalled as mentioned in paragraph (d) below, such treatment can be provided without his continuing to be detained in a hospital;
- (d) it is necessary that the responsible clinician should be able to exercise the power under section 17E (1) below to recall the patient to hospital; and
- (e) appropriate medical treatment is available for him.⁷³²

These criteria correspond to those mentioned in section 3 on compulsory admission for treatment. Again the law reiterates that a CTO should only be made if there is appropriate and available medical treatment and the conditions and circumstances of the patient as they are understood at the time. Consent is not needed for a CTO to be made as the Ontario legislation requires but, the Act requires that in ascertaining the CTO the responsible clinician should take into account the patient's history of mental disorder and any other important factors and risks to the health of the individual if not detained in hospital.⁷³³ The duration of the community treatment order, known as the 'community treatment duration', is for an initial six months with the possibility of extension according to the Act or if the patient is discharged pursuant to section 23(with an order of discharge ceasing application for treatment and recall) or section 72 (1-c)- tribunals power to discharge community patient if does not satisfy detention criteria for CTO)⁷³⁴ or "the application for admission for treatment in respect of the patient otherwise ceases to have effect" or "the order is revoked under section 17F (power to recall patients back to hospital,) whichever comes first."⁷³⁵ Note that CTOs can be subjected to those under section 3 (compulsory admission for treatment) and those who have been diverted to hospital from the criminal justice system. Voluntary patients or those detained under section 2 (compulsory admission for assessment) do not qualify.

⁷³² See, *Ibid*, s. 17A (5 &6).

⁷³³ See, *Ibid*, s. 17A (6).

⁷³⁴ See, *Ibid*, s. 72 (1-c). It states "that the tribunal shall direct the discharge of a community patient if [F4it is] not satisfied—(i) he is then suffering from mental disorder or mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment; or (ii) that it is necessary for his health or safety or for the protection of other persons that he should receive such treatment; or (iii) that it is necessary that the responsible clinician should be able to exercise the power under section 17E(1) above to recall the patient to hospital; or (iv) that appropriate medical treatment is available for him; or (v) in the case of an application by virtue of paragraph (g) of section 66(1) above, that the patient, if discharged, would be likely to act in a manner dangerous to other persons or to himself."

⁷³⁵ See, *Ibid*, s. 17C.

2.4.3. South Africa

The SMHCA ‘promotes provision of community based care’ even though it does not provide expressly for community treatment orders equivalent to UK and Ontario legislation.⁷³⁶ However mental health care treatment and rehabilitation in South Africa can be provided in the community through outpatient medical services.⁷³⁷ Community based mental health services in reality are thinly stretched out and as a result it “burdens service provision within facility-based health centres, putting additional pressure on already-stretched primary health services and hospital beds, establishing a “revolving door” pattern of care, with adverse consequences for the provision of quality care”.⁷³⁸ Nevertheless, some provinces and district such as Western Cape use an assertive community treatment team which has had some progressive results such as reducing inpatient admissions and long term detentions for individuals with severe mental illness.⁷³⁹ Progressive results are important because they indicate that the SMHA good intentions and objectives of providing developed community based mental health services including support systems are not a distant hope notwithstanding the many challenges facing its development.

The SMHA position on community treatment orders requires that when a mental health user seeks mental health care and the assessment period has lapsed and that it is in the opinion of the head of health establishment that the user admitted involuntary as an inpatient can be treated as an outpatient, then the head must discharge the user according to prescribed procedures and must give a

⁷³⁶ See, D.P. Madlala & F.B. Sokudela, The Care Treatment, Rehabilitation and legal Outcomes of Referrals to a Tertiary Psychiatric Hospital According to the Mental Health Care Act No.17 of 2002, 20 *South African Journal of Psychiatry* 172 (2014).

⁷³⁷ See, Ramlall S., The Mental Health Care Act No 17 –South Africa. Trials and triumphs: 2002-2012, *Supra* note 510, p.408. See also, Department of Health of The Republic of South Africa, National Mental Health Policy Framework and Strategic Plan 2013-2020, *Supra* note 494, p.15.

⁷³⁸ See, Mental Health and Poverty Project, Policy Brief 4: Promoting Community-Based Services for Mental Health in South Africa, (November 2008), p.3.

⁷³⁹ See, Department of Health of The Republic of South Africa, National Mental Health Policy Framework and Strategic Plan 2013-2020, *Supra* note 494, p.14.

report in writing to the Review Board.⁷⁴⁰ Comparable to the UK and Ontario, the user has to be given a treatment plan and an outpatient treatment plan which he or she must follow and the failure to do so may result in a recall back as an inpatient user.⁷⁴¹ As such the law empowers the head of health establishment with the power to “cancel the discharge and request the user to return to the health establishment on an involuntary basis, if he or she has reason to believe that the user fails to comply with the conditions of such a discharge.”⁷⁴² As mentioned, the same powers exist in the UK and Ontario statutes. The following examines CTOs in Ontario.

2.4.4. Ontario (Canada)

Community treatment orders were effectively introduced in Ontario on December 2000 earlier than the UK as part of the amendments to the OMHA in order to provide least restrictive access to mental health care and treatment in the community for persons with mental illness.⁷⁴³ Equally the introduction was to address concerns brought about by the “revolving door patient”-patient with a serious mental disorder who has a history of repeated hospitalization and who satisfies the committal conditions for the completion of an application by a physician for a psychiatric assessment as stipulated in the OMHA.⁷⁴⁴ In addition, the CTOs legislative purpose targets the “involuntary psychiatric patients who agree to a treatment/supervision plan as a condition of their release from a psychiatric facility to the community” similar to the UK.⁷⁴⁵ In this regard, the OMHA provides a clear set of criteria to be enforced when making a CTO against a patient if:

(4) A physician may issue or renew a community treatment order under this section if,

⁷⁴⁰ See, SMHCA (2002), s. 34 (5).

⁷⁴¹ See, Ibid, s. 34.

⁷⁴² See, Ibid, s. 34(6).

⁷⁴³ See, OMHA (1990), as amended s. 33.1 (3). See also, Ontario Hospital Association, A Practical Guide to Mental Health and the Law in Ontario, Supra note 526, p. 45.

⁷⁴⁴ See, R.A. Malatest & Associates Ltd, Final Report on The Legislated Review of Community Treatment Orders for the Ministry of Health and Long Term Care, (May 23 2012), p.1.

⁷⁴⁵ See, OMHA (1990), as amended s. 33.1 (3). See also, R.A. Malatest & Associates Ltd, Final Report on The Legislated Review of Community Treatment Orders for the Ministry of Health and Long Term Care, Supra note 744, p.1.

(a) during the previous three-year period, the person, (i) has been a patient in a psychiatric facility on two or more separate occasions or for a cumulative period of 30 days or more during that three-year period, or (ii) has been the subject of a previous community treatment order under this section;

(b) the person or his or her substitute decision-maker, the physician who is considering issuing or renewing the community treatment order and any other health practitioner or person involved in the person's treatment or care and supervision have developed a community treatment plan for the person;

(c) within the 72-hour period before entering into the community treatment plan, the physician has examined the person and is of the opinion, based on the examination and any other relevant facts communicated to the physician, that, (i) the person is suffering from mental disorder such that he or she needs continuing treatment or care and continuing supervision while living in the community, (ii) the person meets the criteria for the completion of an application for psychiatric assessment under subsection 15 (1) or (1.1) where the person is not currently a patient in a psychiatric facility, (iii) if the person does not receive continuing treatment or care and continuing supervision while living in the community, he or she is likely, because of mental disorder, to cause serious bodily harm to himself or herself or to another person or to suffer substantial mental or physical deterioration of the person or serious physical impairment of the person, (iv) the person is able to comply with the community treatment plan contained in the community treatment order, and (v) the treatment or care and supervision required under the terms of the community treatment order are available in the community;

(d) the physician has consulted with the health practitioners or other persons proposed to be named in the community treatment plan;

(e) subject to subsection (5), the physician is satisfied that the person subject to the order and his or her substitute decision-maker, if any, have consulted with a rights adviser and have been advised of their legal rights; and

(f) the person or his or her substitute decision-maker consents to the community treatment plan in accordance with the rules for consent under the *Health Care Consent Act, 1996*, 2000, c. 9, s. 15.⁷⁴⁶

From the excerpt it can be deduced that the purpose of and criteria for CTO reecho in the research jurisdictions particularly the UK. The duration for Ontario CTO is six months but it can be renewed or terminated upon a request by the individual or a substitute decision maker at which the physician who issued or renewed the CTO reviews the individual's circumstances to determine whether the individual can be able to remain in the community without being subjected to the order.⁷⁴⁷ Renewed or new plans must follow the above prescribed criteria.⁷⁴⁸ In addition to the request for termination or renewal, the CTO can be terminated by the withdrawal of the individual consent or that

⁷⁴⁶ See, Ibid, s. 33.1 (4).

⁷⁴⁷ See, Ibid, s. 33.1 (11, 12 &13).

⁷⁴⁸ See, Ibid, s.33.1 (13).

of the substitute decision maker as provided by the Health Care Consent Act.⁷⁴⁹ Sufficient notice of the intention to withdraw has to be given to the concerned physician, who shall consider it within 72 hours upon receipt as to whether the individual is able to remain without subsection to the CTO.⁷⁵⁰ The consideration of the individual's requests involves a personal assessment and general conditions of the individual and as such if the individual fails to permit the physician to undertake the assessment, an "order for examination" valid for 30 days shall be issued for a police officer to bring the person in for the assessment.⁷⁵¹ The assessment shall be done to determine whether the individual should undergo a psychiatric assessment, or be issued another community treatment order with consent of the individual or substitute decision maker or the individual be released without being subjected to another CTO.⁷⁵²

The above list of criteria is extensive compared to the UK and expressly set out than in the South African and Ghanaian legislation where there are none. It is similar as far as the criteria on presence of a mental disorder, susceptibility to self-harm and others, possibility of providing community care, availability of care in the community and supervision, the patient's willingness to follow the plan and duration of the CTO. However it is different in the type of patient subject to the CTO, the requirement of consent and consultation with the rights adviser. These are important aspects because the legal advice on human rights that an individual receives to inform him/her and substitute decision makers when making their choices.

⁷⁴⁹ See, OHCCA (1996) as amended s. 10 & 14. S. 10 states that – "A health practitioner who proposes a treatment for a person shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless, (a) he or she is of the opinion that the person is capable with respect to the treatment, and the person has given consent; or (b) he or she is of the opinion that the person is incapable with respect to the treatment, and the person's substitute decision-maker has given consent on the person's behalf in accordance with this Act. 1996, c. 2, Sched. A, s. 10 (1)." S. 14 stipulates- "A consent that has been given by or on behalf of the person for whom the treatment was proposed may be withdrawn at any time, (a) by the person, if the person is capable with respect to the treatment at the time of the withdrawal; (b) by the person's substitute decision-maker, if the person is incapable with respect to the treatment at the time of the withdrawal. 1996, c. 2, Sched. A, s. 14."

⁷⁵⁰ See, OMHA (1990), as amended s. 33.4 (1 & 2).

⁷⁵¹ See, *Ibid*, s. 33.4 (3 & 4).

⁷⁵² See, *Ibid*, s. 33.4 (5).

2.4.5. Ghana

The Ghanaian legislation unlike the other jurisdictions does not make any reference to or provide a regulatory framework for community treatment orders, inpatient or outpatient mental health care. Even so, from a practical level, the mental health legislation is applied in inpatient and outpatient general hospital facilities within the Communities.⁷⁵³ It is held that the use of community based psychiatric inpatient facilities is largely for those with acute problems and the duration of stay may range from a week to months.⁷⁵⁴ There is no definitive time. So far there are ‘seven community based psychiatric in-patient units in the country with a total of 120 beds’ some private and some linked to the regional general hospital.⁷⁵⁵ In sum, there is a lack of set out standards like the Ontario, UK or South African. It is imperative that these guidelines are stipulated. More so, it is important for the Ghanaian people because the GMHA authorizes the use of Spiritual and traditional centers of mental healing which are closely situated within the communities. These centers have been found to infringe the rights of persons with disabilities because they offer unregulated involuntary detention and treatment.

2.4.6. Sum Up.

From the presentation it is evident that CTOs are used as alternative to involuntary admission and treatment. Even though its efficacy is not yet proven, it is still being used in certain jurisdictions like UK and Ontario where it’s been well regulated and in operation for a considerable duration. There is no jurisdiction that has completely comparable CTOs. Some may be court mandated or given by psychiatrist or approved mental health clinician. However there may be comparable requirements like the Ontario and UK legislative scheme described above. The presence of a mental disorder, applicability to individuals with revolving door syndrome, the availability of appropriate

⁷⁵³ See, Mark Roberts, Caroline Mogan & Joseph Asare, An overview of Ghana’s mental health system: Results from an Assessment using the World Health Organization’s Assessment Instrument for Mental Health Systems (WHO-AIMS), *Supra* note 573, p.5.

⁷⁵⁴ See, *Ibid.*

⁷⁵⁵ See, *Ibid.*

medicine in the community, the presence of a community treatment plan and the possibility of the person to comply with the order are some of the similarities. Differences can be seen in the use of rights adviser, the requirement for personal consent or that of a substitute decision maker, the duration in terms of renewal(UK- initial six months then a year whereas Ontario six months then six months). It can be contended that Ontario presents a more formidable regulatory structure that can stand a CRPD compliance analysis. Equally, other jurisdictions such as South Africa and Ghana among others may adopt some of its provisions in order to strengthen their own CTO legislative framework. It is important to bear in mind that the implementation of CTOs does not only depend on the law but the willingness and available resources to put structures within the community.

2.5. Substantive & Procedural Safeguards - Involuntary Admission, Treatment & CTO.

The substantive and procedural standards being provided below are a combination of all the processes analyzed- admissions, treatment and CTOs. Due to the fact that that many of the safeguards are the same and are applied equally with a few exceptions, a combined outlook is presented beginning with the England followed by South Africa, Ontario then Ghana.

2.5.1. England (United Kingdom)

(a). The respect and application of the UKMHA fundamental principles when providing mental health care to individuals under the statute is at most the basic protection. Generally, these principles include respect for individual advance wishes, dignity, diversity (cultural, religion etc.),patients wellbeing, involving users and their careers, avoidance of discrimination, promotion of public safety and minimizing restrictions on liberty among others.⁷⁵⁶

⁷⁵⁶ See, UKMHA (1983) as amended, s. 118 (2B) provides that- “In preparing the statement of principles the Secretary of State shall, in particular, ensure that each of the following matters is addressed—(a)respect for patients' past and present wishes and feelings,(b)respect for diversity generally including, in particular, diversity of religion, culture and

(b). On specifics, respect of the admission and treatment criteria under section 2 and 3 ,including other legal measures stipulated in the law. This importance was emphasized in the appeal decision in *Re S-C (Mental Patient: Habeas Corpus) (1995)* where the provisions of section 3 (compulsory admission for treatment) and section 11(4) - (approved mental health practitioner barred from proceeding to make an application recommending admission for treatment if nearest relative has not authorized it or has not been consulted.) were not complied with and resulted in a writ of habeas corpus sought and granted.⁷⁵⁷The appellant father in this case was the nearest relative authorized by the appellant to provide consent and not the mother who provided consent for the admission and treatment of the appellant.⁷⁵⁸The approved social worker on the case had full knowledge of these facts and the fact that the father had objected to consent, but nevertheless continued on the basis of the invalid consent to make the application which led to the compulsory admission for treatment of the appellant. A lower court judge even though opined this to be “disingenuous” did not find the detention of the appellant as arbitrary and unlawful.⁷⁵⁹However, the Master of Rolls, Sir Thomas Bingham (as he then was) in his opinion as to the law and its protection emphasized that-

Powers therefore exist to ensure that those who suffer from mental illness may, in appropriate circumstances, be involuntarily admitted to mental hospitals and detained. But, *and it is a very important but, the circumstances in which the mentally ill may be detained are very carefully prescribed by statute. Action may only be taken if there is clear evidence that the medical condition of a patient justifies such action, and there are detailed rules prescribing the classes of person who may apply to a hospital to admit and detain a mentally disordered person. The legislation recognises that action may be necessary at short notice and also recognises that it will be impracticable for a hospital to investigate the background facts to ensure that all the requirements of the Act are satisfied if they appear to be so. Thus we find*

sexual orientation (within the meaning of section 35 of the Equality Act 2006),(c)minimising restrictions on liberty, (d)involvement of patients in planning, developing and delivering care and treatment appropriate to them,(e)avoidance of unlawful discrimination,(f)effectiveness of treatment,(g)views of carers and other interested parties,(h)patient well-being and safety, and (i)public safety.”

⁷⁵⁷ See, *Re S-C (Mental Patient: Habeas Corpus) (1995)* EWCA Civ 60. See also, *Ibid*, s. 11(4). It states that- “An approved mental health professional may not make an application for admission for treatment or a guardianship application in respect of a patient in either of the following cases— (a)the nearest relative of the patient has notified that professional, or the local social services authority on whose behalf the professional is acting, that he objects to the application being made; or (b)that professional has not consulted the person (if any) appearing to be the nearest relative of the patient, but the requirement to consult that person does not apply if it appears to the professional that in the circumstances such consultation is not reasonably practicable or would involve unreasonable delay.]”

⁷⁵⁸ See, *Ibid*.

⁷⁵⁹ See, *Ibid*.

in the statute a panoply of powers combined with detailed safeguards for the protection of the patient. The underlying issue in the present appeal is whether those powers were properly exercised and whether the Appellant was lawfully detained. One reminds oneself that the liberty of the subject is at stake in a case of this kind, and that liberty may be violated only to the extent permitted by law and not otherwise.⁷⁶⁰

(c). The excerpt appropriately articulates that the law must be respected and powers and duties granted thereof must be properly exercised for the benefit of those receiving care under the Act. In view of this it is crucial that the reasons for making an order for detention and treatment are given by the responsible clinician with an approved opinion of an approved mental health professional. The importance is relevant for the proper diagnosis of the patient's condition and for when challenges to admissions, treatment and detention are brought.⁷⁶¹ Compulsory admission for assessment or treatment may become arbitrary and unlawful if these requirements are not met as held by Sir Bingham in *Re S-C (Mental Patient: Habeas Corpus)* in reaction to *J, Reg. v Managers of South Western Hospital, Ex parte M (1993)* a case relied upon to justify the application.⁷⁶² In this case an application for admission for treatment under section 3 was made by an approved social worker who relied on the consent of the applicant's mother and who was not the nearest relative but the uncle. The social worker did not consult the uncle on the issue of consent.⁷⁶³ The judge in this case even though stated that there was an error did not find the detention for treatment unlawful.⁷⁶⁴ In distinguishing *J, Reg case* from the *Re S-c*, Sir Bingham found it unacceptable that a finding of unlawfulness was not declared and asserted that it is a must that the letter of the law is followed to render compulsory detention for treatment lawful and in verbatim he opined as follows-

Speaking for myself, I would accept almost everything in that passage as correct with the exception of the last sentence. The learned Judge goes straight from a finding that the hospital managers were entitled to act upon an apparently valid application to the conclusion that the Applicant's detention was therefore not unlawful. That is, in my judgment, a non sequi-

⁷⁶⁰ See, Ibid.

⁷⁶¹ See, *MH, R (on the application of) v Mind (The National Association for Mental Health) & Ors (2004)*, Supra note 624.

⁷⁶² See, *J, Reg. v Managers of South Western Hospital, Ex parte M [1993] QB, 683 in Re S-C (Mental Patient: Habeas Corpus) (1995) EWCA Civ 60*

⁷⁶³ See, Ibid.

⁷⁶⁴ See, Ibid.

tur. It is perfectly possible that the hospital managers were entitled to act on an apparently valid application, but that the detention was in fact unlawful. If that were not so the implications would, in my judgment, be horrifying. It would mean that an application which appeared to be in order would render the detention of a citizen lawful even though it was shown or admitted that the approved social worker purporting to make the application was not an approved social worker, that the registered medical practitioners whose recommendations founded the application were not registered medical practitioners or had not signed the recommendations, and that the approved social worker had not consulted the patient's nearest relative or had consulted the patient's nearest relative and that relative had objected. In other words, it would mean that the detention was lawful even though every statutory safeguard built into the procedure was shown to have been ignored or violated. Bearing in mind what is at stake, I find that conclusion wholly unacceptable. I am, for my part, satisfied that on present facts an application for habeas corpus is an appropriate, and possibly even the appropriate, course to pursue. An order to the party having custody of the Appellant would ordinarily follow.⁷⁶⁵

(d). In addition to the above, it is a right for patients to be discharged upon expiration of detention time and release from CTOs or/and where the conditions of the individual necessitates further detention, the requisite procedures for renewal must be followed.⁷⁶⁶ Patients have the right to be considered for a discharge by hospital managers, responsible clinician and secretary of state for restricted patients.⁷⁶⁷ Powers of discharge are vested not only in tribunal but also in Hospital managers under section 23 of the UKMHA as amended and as explained in the UKMHA code of Practice chapter 37 and 38.⁷⁶⁸ This power to discharge is discretionary since there are no criteria in the UKMHA for which managers can follow. However, the Code of Practice reassurances that this power is checked through the requirement that managers must always keep records of patients including before reaching a decision whether to discharge, hospital managers must review the patients documentation and any other relevant information material to the circumstances of the individual. In *R v. Riverside Mental Health Trust ex parte Huzzey (1998)*, Latham J (as he then was), inferred that-

⁷⁶⁵ See, *Re S-C (Mental Patient: Habeas Corpus)*, *Supra* note 754.

⁷⁶⁶ See, UKMHA (1983) as amended, s. 17C & 17F.

⁷⁶⁷ See, UK Department of Health, *Mental health Act 1983: Code of Practice*, *Supra* note 458, p. 39 & para 4.21.

⁷⁶⁸ See, *Ibid.* Chapter 38, para 38.2 states that- "Section 23 of the Act gives hospital managers the power to discharge most detained patients and all CTO patients. They may not discharge patients who are held under the section 5 holding powers or in a place of safety under sections 135 or 136 or those remanded to hospital under sections 35 or 36 of the Act or subject to interim hospital orders under section 38, and they may not discharge restricted patients without the consent of the Secretary of State for Justice."

In my view, this argument fails to address the fact that section 23 provides, inter alia, a general discretion in the managers to discharge a patient. No criteria are set out as to what should or should not be taken into account by managers when considering a decision as to whether or not to discharge. The question of what are the relevant considerations has to be answered by looking at the general scheme of the Act. Clearly, the criteria set out in section 3 of the Act are of fundamental importance. If the criteria for admission no longer exist, I cannot see how any decision by managers not to discharge could be other than perverse hence my conclusion on Mr. Gledhill's first point. But that does not mean that the managers are restricted to considering those criteria. Section 23 implicitly recognises that managers have discretion to discharge, even if those criteria have been met. Where, as in the present case, a nearest relative has sought to obtain a discharge order but has been confronted by a barring report, those facts must equally be relevant and material considerations. In my view, the managers are not only entitled to, but must, consider whether or not they are persuaded by the barring report that the patient, if discharged, would be likely to act in a manner dangerous to other persons or to himself".(page173).⁷⁶⁹

For a fact ECHR jurisprudence provides guidance through *Winterwerp v the Netherland (1979-80)*, by emphasizing that detention ends when the detained individual mental status does not require further hospitalization and where after care is necessary.⁷⁷⁰ In situations where continued detention is necessary, then it must be short and discharge must be enforced immediately upon the conclusion of arranging the care as held in *Johnson v UK (1997)* to avoid arbitrary deprivation of liberty.⁷⁷¹

(e). Individuals have the right to review by the tribunal or appeal to higher courts. As aforementioned, Individuals, hospital managers or/and nearest relative can apply to the tribunal for review. Facilitation to access review proceedings must be carried out for detained patients. This aspect was illustrated in the case of *Modaresi, R (on the application of) v Secretary of State for Health (2013)* that involved an appeal brought as matter of public importance as to whether a public body has a public duty under the UKHRA such as the Secretary of State for Health to refer a patient to the tri-

⁷⁶⁹ See, R v. Riverside Mental Health Trust ex parte Huzzey (1998) 43 BMLR 167 in MH, R (on the application of) v Mind (The National Association for Mental Health) & Ors [2004] EWHC 56 (Admin), para 75. It states that- "Huzzey was a patient, who had been admitted for assessment before being detained under section 3 of the 1983 Act for treatment. His mother asked for his discharge under section 23 of the 1983 Act but the managers of the hospital considered that the detention of the patient should continue "for the protection of others and for his own well-being". Subsequently, a Mental Health Review Tribunal directed the claimant's discharge. The applicant obtained an order from Latham J quashing the decision of the managers authorising his continued detention."

⁷⁷⁰ See, *Winterwerp v the Netherland* Supra note 203.

⁷⁷¹ See, *Johnson v UK* Supra note 208.

bunal as provided under the UKMHA section 67 in situations where the tribunal has refused to hear a patient's application and that patient has made an application under section 67.⁷⁷² The summary of the case is that the applicant suffering from schizophrenia made an application to the tribunal for review of detention and if appropriate obtain a discharge order within the set out 14 period under section 2 of the UKMHA considering that the request submitted and denied by the tribunal was made late by the hospital authorities because of a banking holiday.⁷⁷³ An application was then made to high court where the judge did not find the hospital responsible for any arbitrary deprivation of liberty despite continued detention and later being placed under a CTO.⁷⁷⁴ Baroness Lady Hale spoke out in the following extended excerpt on the responsibility of hospitals in regards to review of patient's applications by holding that even though the appeal does not concern the hospital in her view,

.. it would be unwise for hospitals to conduct themselves on the basis that the judge was correct in his approach. These proceedings were brought by way of judicial review, but it was alleged that the patient had been unlawfully deprived of her liberty, in other words that her Convention rights had been violated. It is the hospital which deprives the patient of her liberty. It is incumbent upon the hospital to do this in accordance both with the domestic law and with the patient's Convention rights. A failure which deprives the patient of the right of access to a tribunal which the law provides may well (I put it no higher) be a breach of the patient's Convention rights. The only safe course is to have a system which ensures that this does not happen. The Mental Health Act 1983 Code of Practice (Department of Health, 2008) reminds hospitals that patients must be told, both orally and in writing, of their right to apply to the tribunal and how to do so (para 2.17). This is a statutory duty under section 132(1) of the Act. The Code also advises that hospital managers should ensure that patients are offered assistance to make an application to the tribunal (para 2.18). It would be helpful if the Code were also to advise that the hospital should ensure that tribunal applications which are given to hospital staff are transmitted to the tribunal without delay. A detained patient is in no position to ensure that her application reaches the tribunal unless the hospital affords her the facilities for it to do so.⁷⁷⁵

(f). In addition to the guarantee of review, the Act guarantees the requirement of compulsory consent to certain mental health treatments or a specified approval of treatment from a second opinion

⁷⁷² See, *Modaresi, R (on the application of) v Secretary of State for Health* [2013] UKSC 53, para 2.

⁷⁷³ See, *Ibid.*

⁷⁷⁴ See, *Ibid.*, para 5-10.

⁷⁷⁵ See, *Ibid.*, para 31 & 32.

appointed doctor (SOAD).⁷⁷⁶ A certificate of the opinion must be adduced when neurosurgery for mental disorder is to be performed, administration of electro-convulsive therapy and its medication.⁷⁷⁷ The right to give consent also encompasses the right to withdraw and therefore where consent is given and withdrawn, the treatment has to be accordingly stopped.⁷⁷⁸ It should be noted that generally consent to treatment is not required for compulsory treatment except for the aforementioned treatments.⁷⁷⁹

(g). In connection to the right to consent, patients' under UKMCA and UKMHA have a right to express their wishes including consent to treatments through advance decisions made in writing.⁷⁸⁰ "An advance decision means a decision to refuse specified medical treatment made in advance by a person who has the mental capacity to do so. They are a way in which people can refuse medical treatment at a time in the future when they may lack the capacity to consent to or refuse that treat-

⁷⁷⁶ See, UKMHA (1983) as amended, s.57, 58 & 58A.

⁷⁷⁷ See, UKMHA (1983) as amended, s. 63. It stipulates that- "The consent of a patient shall not be required for any medical treatment given to him for the mental disorder from which he is suffering not being a form of treatment to which section 57, 58 or 58A above applies if the treatment is given by or under the direction of the approved clinician in charge of the treatment".

⁷⁷⁸ See, Ibid, s. 60. It states that- "(1) Where the consent of a patient to any treatment has been given for the purposes of section 57 [F1, 58 or 58A] above, the patient may, subject to section 62 below, at any time before the completion of the treatment withdraw his consent, and those sections shall then apply as if the remainder of the treatment were a separate form of treatment. [F2(1A)Subsection (1B) below applies where—(a)the consent of a patient to any treatment has been given for the purposes of section 57, 58 or 58A above; but (b) before the completion of the treatment, the patient ceases to be capable of understanding its nature, purpose and likely effects. (1B)The patient shall, subject to section 62 below, be treated as having withdrawn his consent and those sections shall then apply as if the remainder of the treatment were a separate form of treatment. (1C)Subsection (1D) below applies where—

(a) a certificate has been given under section 58 or 58A above that a patient is not capable of understanding the nature, purpose and likely effects of the treatment to which the certificate applies; but (b)before the completion of the treatment, the patient becomes capable of understanding its nature, purpose and likely effects. (1D)The certificate shall, subject to section 62 below, cease to apply to the treatment and those sections shall then apply as if the remainder of the treatment were a separate form of treatment.] (2)Without prejudice to the application of [F3subsections (1) to (1D)] above to any treatment given under the plan of treatment to which a patient has consented, a patient who has consented to such a plan may, subject to section 62 below, at any time withdraw his consent to further treatment, or to further treatment of any description, under the plan."

⁷⁷⁹ See, Ibid, s. 63. It stipulates that- "The consent of a patient shall not be required for any medical treatment given to him for the mental disorder from which he is suffering not being a form of treatment to which section 57, 58 or 58A above applies if the treatment is given by or under the direction of the approved clinician in charge of the treatment".

⁷⁸⁰ See, UK Department of Health, Mental health Act 1983: Code of Practice, Supra note 458, p.74-76. See also, UKMCA (2005) as amended, s. 24&25 & UKMHA (1983) as amended, s.118 (2B-a).

ment”.⁷⁸¹ For patients under the UKMCA its quiet clear but for those under compulsory measures under the UKMHA a dilemma may arise where advance wishes may be taken into consideration but also may be overridden by clinicians if doing so will be in the patient’s best interest.⁷⁸² For example in *Nottinghamshire Healthcare NHS Trust v RC (2014)*, the NHS trust made an application to pursuant to section 26(4) of the UKMCA seeking a declaration that "it is lawful for those responsible for the medical care of the respondent to act in accordance with his written advance decision and withhold treatment by blood transfusion or with blood products in accordance with his expressed wishes notwithstanding the existence of powers under section 63 of the Mental Health Act 1983[powers of a clinician to offer compulsory treatment]."⁷⁸³ The court did not make a declaration but maintained that the advance decision was valid and applicable as it was made according to the law.⁷⁸⁴ The court however found this case to be ethically difficult in balancing a legal duty to do what is in the best interest for an involuntary detained patient, who had a written advance decision and with a history of compulsory detention due to “a severe personality disorder” with manifesting symptom that makes him to “engage in significant self-harm through self-laceration and blood-

⁷⁸¹ See, Ibid, p.74, para 9.4.

⁷⁸² See, Ibid, p.74, para 9.1 & 9.2. They state that- “9.1 This chapter gives guidance on statements by patients who are subject to compulsory measures under the Act about their preferences for what they would, or would not, like to happen if particular situations arise in future. Advance statements and decisions strengthen patients’ participation in their treatment and recovery and help them to feel more empowered about what may happen to them should they lack mental capacity to make decisions about their care and treatment in the future. 9.2 Advance statements do not legally compel professionals to meet patients’ stated preferences, though they should be taken into account when making decisions about care and treatment. Advance decisions to refuse treatment are legally binding. Such decisions must be recorded and documented. Advance decisions are concerned only with refusal of medical treatment and are made in advance by a person with the mental capacity to do so. The chapter details the circumstances when clinicians may lawfully treat a patient compulsorily under the Act.”

⁷⁸³ See, *Nottinghamshire Healthcare NHS Trust v RC* [2014] EWCOP 1136 (09 April 2014), para 17. See also, UKMHA (1983) as amended, s.63. It states that- “The consent of a patient shall not be required for any medical treatment given to him for the mental disorder from which he is suffering...if the treatment is given by or under the direction of the approved clinician in charge of the treatment.”

⁷⁸⁴ See, Ibid, para 10. The Justice held that- “In all other respects, it appears to me that this is clearly an advance decision which was made with capacity and is valid within the meaning of, and for the purposes of, those provisions, and is also one which is applicable to the treatment described in the advance decision, namely a treatment which is transfusions into him of blood or primary blood components (red cells, white cells, plasma or platelets). I am therefore willing to declare on an interim basis that that written advance decision is valid and is applicable to that treatment, notwithstanding that (a) his life may be at risk from the refusal of treatment, and (b) he is a patient detained under the Mental Health Acts.”

letting, most recently by opening his brachial artery".⁷⁸⁵ RCs advance decision presented two dilemmas- one being that it directed that he should not be given any blood transfusion even if his life is at risk because it is against his Jehovah witness religious beliefs,⁷⁸⁶ and the second was the reality of his thrombosis condition for which he was receiving a certain type of medication (anti-coagulant) which if he bleeds or bled would make him bleed more than usual and may lead to blood loss that hedges on life threatening treatments under the law. This case illustrates not only the protection of a right and preservation of the right to choose, but also the due diligence exercised by doctors seeking clarity in order to avoid arbitrary infringement of patients' right to life, right to privacy and bodily integrity among others.

(h). The right to make choices is connectedly to the right to information that informs the patients decisions. Thus, the right to information in accessible formats is an additional guarantee to all patients voluntary, informal and involuntary or CTO placed patients.⁷⁸⁷ The nearest relatives, guardians, careers, official solicitors and other individuals appointed by the patient must promptly as is practicable be given information as to the reasons of their detention and recall for those under CTO.⁷⁸⁸ Imperatively, information related to treatment plans, consent to treatments, duration, discharge, the changes to their status during these processes and right to apply to a tribunal for review of their detention must be given.⁷⁸⁹ The duty to guarantee this right was unmistakably elaborated by Baroness Hale of Richmond in the case of *MH v UK (2013)* where she held- -

⁷⁸⁵ See, Ibid, para 2.

⁷⁸⁶ See, Ibid, para 4, 7& 9.

⁷⁸⁷ See, UK Department of Health, Mental health Act 1983: Code of Practice, Supra note 458, p.38, para 4.10 & para 4.16. Para 4.10 stipulates that- "Information must be given to the patient [and nearest relative, guardian, carers and other people nominated by the patient] both orally and in writing, including in accessible formats as appropriate (eg Braille, Moon, easy read) and in a language the patient understands. These are not alternatives. Those providing information to patients should ensure that all relevant information is communicated in a way that the patient understands".

⁷⁸⁸ See, UKMHA (1983) as amended, s. 17E (5&6). See also, Ibid, p. 37, and para 4.9.

⁷⁸⁹ See, Ibid, s. 17E (5&6). See also, Ibid, p. 37, and para 4.9 & 4.14. Para 4.14 states that as part of the information the following should be given: (a)the reasons for their detention or CTO (b)the maximum length of the current period of detention or CTO (c)that their detention or CTO may be ended at any time if it is no longer required or the criteria for it are no longer met (d) that they will not automatically be discharged when the current period of detention or CTO ends

The managers of the hospital have a statutory duty, under section 132 of the Act, to take such steps as are practicable to ensure that the patient understands the effect of the provisions under which she is detained and the rights of applying to a mental health review tribunal which are available to her. This has to be done as soon as practicable after the patient is detained. Unless the patient wishes otherwise, this information is also to be given to the patient's nearest relative. Under the Code of Practice (published March 1999 pursuant to section 118 of the Act by the Department of Health and Welsh Office), section 14, information should be given to the patient 'in a suitable manner and at a suitable time' by a person who 'has received sufficient training and guidance'. Patients and nearest relatives have to be told how to apply to a tribunal, how to contact a suitably qualified solicitor, that free legal aid may be available, and how to contact any other organization which may be able to help them make an application. In other words, the hospital managers have to do the best they can to make the patient's rights practical and effective.⁷⁹⁰

(i). In addition to the right of information, patients under the UKMHA and UKMCA have the right to legal support. They can either solicit it privately or through other legal support systems of their choice. However, those that may not privately, the Act provides support by legislatively mandating that 'qualifying patients'⁷⁹¹ detained under the Act have the right to legal use of "independent mental health advocates (IMHA hereafter)" appointed by the relevant local authority.⁷⁹² "The IMHAs are specialist advocates who are trained specifically to work within the framework of the Act and enable patients to participate in decision-making like encouraging patients to express their views and supporting them to communicate their views."⁷⁹³ As is noted in the Code or practice, "IMHAs

(e) that their detention or CTO will not automatically be renewed or extended when the current period of detention or CTO ends (f) the reasons for being recalled, and (g) for patients subject to a CTO, the reasons for the revocation of a CTO".

⁷⁹⁰ *MH v the United Kingdom*, Supra note 614, para 32.

⁷⁹¹ See, UK Department of Health, Mental health Act 1983: Code of Practice, Supra note 458, p. 55, para 6.8. The paragraph states that- "Patients are eligible for support from an IMHA, irrespective of their age, if they are: (a) detained under the Act (b) liable to be detained under the Act, even if not actually detained, including those who are currently on leave of absence from hospital or absent without leave, or those for whom an application or court order for admission has been completed (but not those listed in paragraph 6.9 below) (c) conditionally discharged restricted patients (d) subject to guardianship, or (e) patients subject to community treatment orders (CTOs)".

⁷⁹² See, UKMHA (1983) as amended, s. 130A. See also, UKMCA (2005) as amended.

⁷⁹³ See, UK Department of Health, Mental health Act 1983: Code of Practice, Supra note 458, p. 54, para 6.3. See also, p.56 para 6.12 that outlines their role as follow- "The Act says that the support which IMHAs provide must include helping patients to obtain information about and understand the following: (a) their rights under the Act (b) the rights which other people (e.g. the nearest relative – see chapter 5) has in relation to them under the Act. (c) the particular parts of the Act which apply to them (e.g. the basis on which they are detained) and which therefore make them eligible for advocacy (d) any conditions or restrictions to which they are subject (e.g. as condition of leave of absence from hospital (see chapter 27), as a condition of a CTO (see chapter 29), or as a condition of conditional discharge) (e) any medical treatment that they are receiving or might be given (f) the reasons for that treatment (or proposed treatment), and (g) the legal authority for providing that treatment, and the safeguards and other requirements of the Act which would apply to that treatment."

should be independent of any person who has been professionally involved in the patient's medical treatment [and their] services do not replace any other advocacy and support services that are available to patients, such as independent mental capacity advocates (IMCAs) or representatives for patients who lack capacity, but are intended to operate in harmony with those services".⁷⁹⁴

(j). Finally and on top of all these specified safeguards, patients may make a complaint to the CQC (formerly the Mental Health Act Commission), and must be informed of the process during their admission as part of their right to information.⁷⁹⁵

2.5.2. South Africa

(a). Guarantees in South Africa are not very different from the UK. At the basic and significant level it begins with the respect of human dignity, freedom and equality these being the core principles and rights of the South African constitution for all individuals⁷⁹⁶This is portrayed in the case of *S v Makwanyane (1996)* dealing with the questions of death penalty versus constitutional validity.⁷⁹⁷ In this case the constitutional courts made it very clear that-

Under our constitutional order the right to human dignity is specifically guaranteed. It can only be limited by legislation which passes the stringent test of being 'necessary'. The weight given to human dignity by Justice Brennan is wholly consistent with the values of our Constitution and the new order established by it. It is also consistent with the approach to extreme punishments followed by courts in other countries.⁷⁹⁸

[It also concluded-]

the rights to life and dignity are the most important of all human rights, and the source of all other personal rights in Chapter Three. By committing ourselves to a society founded on the recognition of human rights we are required to value these two rights above all others. And this must be demonstrated by the State in everything that it does, including the way it punishes criminals.⁷⁹⁹

⁷⁹⁴ See, Ibid, p.53, para 6.3 & 6.4.

⁷⁹⁵ See, UKMHA (1983) as amended, s. 121. See also, UK Health and Social Care Act (2008) as amended, s.52 (3a).

⁷⁹⁶ See, The Constitution of the Republic of South Africa (1996), s.10.

⁷⁹⁷ See, *S v Makwanyane and Another (CCT3/94)* [1995] ZACC 3.

⁷⁹⁸ See, Ibid, para 58

⁷⁹⁹ See, Ibid, para 141.

Thus, it is expected that having a disability or the limitation of the right to liberty does not impair the enjoyment of the right to personal dignity.⁸⁰⁰ As such this principle is also reiterated in the SMHCA and laid down as one of the primary rights in the chapter that deals with rights.⁸⁰¹ Therefore persons with mental disability and involuntarily detained to receive involuntary care, treatment and rehabilitation do not lose their right to dignity in the process.

(b). In addition, individuals subjected under the SMHA have the right to equality in care, treatment and rehabilitation.⁸⁰² In view of this requirement, SMHCA declares that “a mental health care user may not be unfairly discriminated against on the grounds of his or her mental health status”.⁸⁰³ Therefore, while it is a right it is also an obligation upon the service providers and professionals to provide users with the same standards of care as that provided to other health care systems and users.⁸⁰⁴

(c). The Act also envisages that care, treatment and rehabilitation shall be provided in an ethical and just manner to avoid any actions or omissions that may violate the prohibition of torture. The Prohibition of torture is a constitutional right that guarantees that no one is arbitrarily detained

⁸⁰⁰ See, *Ibid*, para 142. It states that- “Dignity is inevitably impaired by imprisonment or any other punishment, and the undoubted power of the state to impose punishment as part of the criminal justice system, necessarily involves the power to encroach upon a prisoner's dignity. But a prisoner does not lose all his or her rights on entering prison. [Prisoners retain] those absolute natural rights relating to personality, to which every man is entitled. True [their] freedom had been greatly impaired by the legal process of imprisonment but they were entitled to demand respect for what remained. The fact that their liberty had been legally curtailed could afford no excuse for a further legal encroachment upon it. [It was] contended that the [prisoners] once in prison could claim only such rights as the Ordinance and the regulations conferred. But the directly opposite view is surely the correct one. They were entitled to all their personal rights and personal dignity not temporarily taken away by law, or necessarily inconsistent with the circumstances in which they had been placed.”

⁸⁰¹ See, SMHCA (2002) as amended, s. 8. The section provides that- “(1) The person, human dignity and privacy of every mental health care user must be respected. (2) Every mental health care user must be provided with care, treatment and rehabilitation services that improve the mental capacity of the user to develop to full potential and to facilitate his or her integration into community life. (3) The care, treatment and rehabilitation services administered to a mental health care user must be proportionate to his or her mental health status and may intrude only as little as possible to give effect to the appropriate care, treatment and rehabilitation.”

⁸⁰² See, Constitution of the Republic of South Africa (1996), s.9.

⁸⁰³ See, SMHCA (2002), s. 10 (1).

⁸⁰⁴ See, *Ibid*, s. 10 (2).

without a just cause, is not exploited, punished or treated in a way that is inhuman and degrading, including that is not detained without trial or exposed to some violence from public and private sources and importantly no one is tortured.⁸⁰⁵ These are guarantees that anyone deprived of their freedom is entitled to and it includes those persons under civil commitment in the SMHCA.⁸⁰⁶ The SMHCA guarantees the same rights to individuals subjected under its provisions and proclaims punishment to any individual who contravenes such prohibitions or guarantees of persons with mental disability. In addition to the constitutional rights the SMHCA prohibits subjecting persons under the Act to forced labour.⁸⁰⁷ Persons with mental disability under the SMHCA are only subject to those limitations prescribed by the law therein and nothing further.

(d). All patients subjected to the authority of the SMHCA have a right to be discharged upon the expiration of assessment duration and when no further assessment is required. Discharge is also guaranteed when no further treatment, care or rehabilitation is needed. Upon discharge patients have the right to a discharge report.⁸⁰⁸

(e). As a protection against unlawful detention, individuals have the right to seek review of their involuntary detention before the Review Board or to seek clarity on any matter concerning involuntary detention and treatment including seeking reparations for infringement. In addition to review before the Board, individuals have the right to make an appeal against the decision of the Head of

⁸⁰⁵ See, The Constitution of the Republic of South Africa (1996), s. 12(1).

⁸⁰⁶ See, *S v Makwanyane and Another*, Supra note 797, para 143. It says- "Imprisonment is a severe punishment; but prisoners retain all the rights to which every person is entitled under Chapter Three subject only to limitations imposed by the prison regime that are justifiable under *section* 33. Of these, none are more important than the *section* 11(2) right not to be subjected to "torture of any kind...nor to cruel, inhuman or degrading treatment or punishment." There is a difference between encroaching upon rights for the purpose of punishment and destroying them altogether. It is that difference with which we are concerned in the present case."

⁸⁰⁷ See, SMHCA (1996) as amended, s. 11. It states- "(1) Every person, body, organisation or health establishment providing care, treatment and rehabilitation services to a mental health care user must take steps to ensure that- (a) users are protected from exploitation, abuse and any degrading treatment; (b) users are not subjected to forced labour; and (c) care, treatment and rehabilitation services are not used as punishment or for the convenience of other people.

⁸⁰⁸ See, *Ibid*, s. 16.

Health establishment to the Review Board,⁸⁰⁹ and further consideration by the High court where not satisfied with the Review Boards decision.⁸¹⁰ In addition, patients under the act have a right to triple periodic review (head of health establishment, the review board and the High Court) and annual reports of involuntary care treatment and rehabilitation initially six months then yearly, with each providing information on the status of the mental health care user, the wishes if any of the user, any least restrictive means that are available than detention and recommendation about future care treatment and rehabilitation.⁸¹¹

⁸⁰⁹ See, *Ibid*, s.35. It goes as follows- “(1) (a) A mental health care user, or the spouse, next of kin, partner, associate, parent or guardian of the mental health care user may, within 30 days of the date of the written notice issued in terms of section 33 (8), appeal against the decision of head of the health establishment to the Review Board. (b) Such an appeal must contain the facts and the grounds on which the appeal is based. (2) Within 30 days after receipt of the notice of appeal, the Review Board must- (a) obtain from the head of the health establishment concerned, a copy of the application made in terms of section 33, notice given in terms of section 33 (8) and a copy of the findings of the assessment conducted in terms of section 34 (1), if applicable; (b) give the appellant, applicant, mental health practitioners referred to in section 33, an independent mental health care practitioner, if any, and the head of the health establishment concerned an opportunity to make written or oral representations on the merits of the appeal. (c) Consider the appeal in the prescribed manner; and (d) send a written notice of its decision and the reasons for such decision to the appellant, applicant, the head of the health establishment concerned and head of the relevant provincial department. (3) If the Review Board upholds the appeal- (a) all care, treatment and rehabilitation services administered to the mental health care user must be stopped according to accepted clinical practices; and (b) the user, if admitted, must be discharged by the head of the health establishment, unless the user consents to the care, treatment and rehabilitation services. (4) If the Review Board does not uphold the appeal, it must submit the documents referred to in subsection (2) (a) and (d) to the Registrar of a High Court for the review by the High Court.

⁸¹⁰ See, *Ibid*, s.36. It states that- “Within 30 days after receipt of the documents submitted by the Review Board in terms of section 34 (7) or 35 (4), the High Court- (a) must consider information submitted and any other representations made by any person referred to in section 35 (1); (b) may obtain information from any relevant person; and (c) must thereafter order- (i) further hospitalisation of the mental health care user and, if necessary, the financial affairs of the mental health care user be managed and administered according to the provisions of Chapter VIII; or (ii) immediate discharge of the mental health care user.”

⁸¹¹ See, *Ibid*, s. 37. It requires that- “(1) Six months after the commencement of care, treatment and rehabilitation services, and every 12 months thereafter, the head of the health establishment concerned must cause the mental health status of an involuntary mental health care user to be reviewed. (2) Such review must- (a) state the capacity of the mental health care user to express himself or herself on the need for care, treatment and rehabilitation services; (b) state whether the mental health care user is likely to inflict serious harm on himself or herself or other people; (c) state whether there is other care, treatment and rehabilitation services that are less restrictive or intrusive on the right of the mental health care user to movement, privacy and dignity; and (d) make recommendations regarding a plan for further care, treatment or rehabilitation service. (3) The head of the health establishment must submit a summary report of the review to the Review Board. (4) Within 30 days after receipt of the report, the Review Board must- (a) consider the report including obtaining information from any relevant person; and (b) send a written notice of its decision to the mental health care user, applicant, head of the health establishment concerned and head of the provincial department stating the reasons for the decision. (5) (a) If the Review Board decides that the involuntary mental health care user be discharged- (i) all care, treatment and rehabilitation services administered to the user must be stopped according to accepted clinical practices; and (ii) the user, if admitted, must be discharged by the health establishment concerned, unless the user consents to the care, treatment and rehabilitation services. (b) The head of the health establishment must comply with the decision of the Review Board. (6) The Registrar of the High Court must be notified in writing of a discharge made in terms of this section.”

(f). The protection against imposed decision making is impeded by the articulated right to make informed treatment decisions that equally involves the determination on whether to continue treatment upon the user's recovery of capacity to consent.⁸¹² It also involves the right to exercise the option to stop the treatment, continue as an involuntary mental health user or to get discharged according to medical clinical procedures. In order to make this right effective, the SMHA requires that to verify the presence of a mental illness, there must be the use of two recommendations one from a mental health practitioner and the other from a practitioner with knowledge of physical health. Moreover, before the Head of health establishment concurs there must be at least two concurring reports. Accordingly, to make informed decisions generally patients have the right to be informed on their rights before any treatment, care or rehabilitation takes place. As such the duty to dispense such information is on every health care provider.⁸¹³

(h). Finally, similar to the other jurisdictions the SMHCA expresses that a "mental health user is entitled to a representative, including a legal representative" when making an application to the Review Board, making an appeal or appearing before a magistrate or judge according to the relevant "laws governing rights of appearances before a court of law".⁸¹⁴ Indigent users are also guaranteed the use of Legal aid provided by the State by virtue of the Legal Aid Statute.⁸¹⁵

⁸¹² See, Ibid, s. 38. It says that- "(1) If the head of a health establishment is of the opinion from personal observation, information obtained or on receipt of representations by the user, that an involuntary mental health care user is capable of making informed decisions, he or she must enquire from the user whether the user is willing to voluntarily continue with the care, treatment and rehabilitation services. (2) If the involuntary mental health care user consents to further care, treatment and rehabilitation services, section 25 applies. (3) If the involuntary mental health care user is unwilling to continue with care, treatment and rehabilitation services and the head of the health establishment is satisfied that the user no longer has a mental illness as referred to in section 32 (b), the head of the health establishment concerned must immediately cause the user to be discharged according to accepted clinical practices."

⁸¹³ See, Ibid, s. 17. It states- "Every health care provider must, before administering any care, treatment and rehabilitation services, inform a mental health care user in an appropriate manner of his or her rights, unless the user has been admitted under circumstances referred to in section 9 (1) (c)."

⁸¹⁴ See, Ibid, s. 15 (1).

⁸¹⁵ See, Ibid, s. 15. (2).

2.5.3. Ontario (Canada)

(a). Compared to the other jurisdictions, protection against abuse equally begins from the Ontario's the constitutional principles and the mental health care legislative framework.⁸¹⁶To guarantee effective application of the framework, it was emphasized in the *Thompson case* that the admission and detaining provisions are structured in a way that "require an individualized consideration of each person's clinical history, current mental and physical status, and the likelihood of serious bodily harm to him/herself or others or substantial mental or physical deterioration of each particular patient."⁸¹⁷In this regard and as expressed further in **AG (Re) 2014**, "if [and when] the physician chooses to detain a patient in hospital against her wishes, the physician is required under the MHA to have reasons for the detention that meet the statutory criteria under ss. 20(5) or (1.1) of the MHA".⁸¹⁸ This statutory duty requires that the physician has 'cogent and compelling reasons' for the detention because "the onus at an involuntary detention hearing is on the attending physician". In the *AG (RE) case*, 'Ag was detained as an involuntary patient at Kingston General Hospital ("KGH") in Kingston Ontario' after being brought in by police for a psychiatric assessment and diagnosed by the attending physician as having delusional beliefs and exhibited hyperactive and pressured speech.⁸¹⁹ A form three was filled during her admission and also renewed (form 4 certificate of renewal) extending the applicants detention period as an involuntary patient on claims that if released to the public she will suffer serious physical impairment as provided in section 20 (1.1) of the OMHA.⁸²⁰The Board after determining the facts and the law found that the physician simply relied on suggestive and speculative evidence that if released the applicant will be hostile and provoke others thereby leading to antagonism with the police or legal system which according to the

⁸¹⁶ See, *Thompson and Empowerment Council v. Ontario*, *Supra* note 534. In para 95, the court provided that- "CTOs only apply to a class of individuals who suffer from a serious mental disorder and who, as a result of their serious mental disorder, have exhibited a pattern of recurrent hospitalizations that feature stabilization followed by discharge, discontinuation of treatment, relapse and readmission".

⁸¹⁷ See, *Ibid*, para 125.

⁸¹⁸ See, *AG (Re)*, 2014 CanLII 26425 (ON CCB), p.6.

⁸¹⁹ See, *Ibid*, p.3.

⁸²⁰ See, *Ibid*.

CCB was not enough to fulfill the requirement of likelihood of serious physical ment.⁸²¹ Hence since the applicant was not fit for voluntary status as the physician presented, she did not also meet the criteria for involuntary status and thus the Board rescinded the renewed certificate.⁸²²

(b). Together with the above, it is a procedural safeguard that relevant documentation must be signed and filed by the relevant physician or officer in charge. This was underscored in the case *TH (Re), 2011*, where the applicant diagnosed as having schizoaffective disorder was detained longer after the expiration of psychiatric assessment period of 72 hours without any proper documentation in a mental health facility.⁸²³ She sought a review before the CCB as to the lawfulness of the detention and application to rescind her involuntary status confirmation extended with the issuance of a new form.⁸²⁴ The Board after careful review of the evidence and circumstances of the applicant and using their discretionary powers under the law did not rescind the new form orders claiming the reissued forms 3 (involuntary treatment) remedied the issue.⁸²⁵ But they established that once the period for assessment had lapsed “there had been a serious violation of TH’s right of liberty when the February 26th Form 1[Application by Physician for Psychiatric Assessment] expired and she continued to be detained, physically restrained and then transferred” [and therefore the] “subse-

⁸²¹ See, *Ibid*, p.6-8.

⁸²² See, *Ibid*, p.8-9.

⁸²³ See, *TH (Re), 2011 CanLII 18236 (ON CCB)*. The applicant applied for review for her unlawful detention and transfer upon the expiry of an involuntary assessment period of 72 hours on the 26th of February. The applicant was an involuntary patient at the center for Addiction and Mental Health- Queen Division having been diagnosed as having schizoaffective disorder with previous multiple admissions to both CAMH and Trillium Health Centre beginning. The Panel of the Board after careful review of the evidence before it established that once the period for assessment had lapsed the “subsequent detention, restraint and involuntary transfer of TH to CAMH with apparently no legal documentation in place to support those actions was contrary to the stipulated criteria. However, it refused to use its discretionary power to rescind a reissuance of form 3 [certificate of involuntary treatment] given to the applicant and maintained that this was remedied by a reissue of another form on the 2nd of March as jurisprudence has shown.⁸²³ Even though the panel was not ready to rescind a form 3 [certificate of involuntary treatment], it was nevertheless “concerned that there had been a serious violation of TH’s right of liberty when the February 26th Form 1[Application by Physician for Psychiatric Assessment] expired and she continued to be detained and physically restrained and then transferred. However, we were not prepared in the circumstances here to rescind the Form 3 [certificate of involuntary treatment].

⁸²⁴ See, *Ibid*.

⁸²⁵ See, *Ibid*.

quent detention, restraint and involuntary transfer of TH to CAMH with apparently no legal documentation in place to support those actions was contrary to the stipulated criteria”.⁸²⁶

(c). It is a right and protection to be provided care and detained within the holding durations stipulated in legislation. In *P (Re), 2011* the CCB revoked a CTO issued outside the 72 hour statute required time.⁸²⁷The physician in this case failed to fulfill the prerequisite that he had examined the patient within the stated duration before issuing a CTO.⁸²⁸The evidence presented before the CCB confirmed that the physician had examined the patient 1.5 hours outside the 72 hour duration prescribed under section 33. 1(4-c) of the OMHA.⁸²⁹In a strong response to the physician’s claim that the time difference was of no consequence, the CCB held-

The *MHA* provides timelines that must be adhered to for various purposes, some being expressed in days and others in hours and the significance of expressing the requirement in hours cannot be overlooked. That the examination must take place “within 72 hours” does not mean “within 3 days”, and it does not mean “within 72 hours more or less” or “within about 72 hours”. Just as the authority under s. 15(5)(b) of the *MHA* to detain a person for psychiatric assessment “for not more than 72 hour” is strictly construed, so too is the time requirement here in question to be strictly construed.⁸³⁰

(d). Another protection against unnecessary admission, detention and treatment recurring in the entire research jurisdiction is the prerequisite to use different physicians and having second medical opinion. In Ontario the law preconditions that different physicians (assessment and admission) and officer in charge provide second medical opinion.

⁸²⁶ See, *Ibid*, p.15-16.

⁸²⁷ This case involves a review of a finding of capacity and reissuance of CTO of “Ms. P, who has been found incapable of consenting to treatment, suffers from chronic paranoid schizophrenia, symptoms of which she began to exhibit in 1996. He was hospitalized many times between 1997 and 2007 but has been subject to five previous CTOs since January of 2008.”

⁸²⁸ See, *P (Re), 2011 CanLII 4935 (ON CCB)*, p.7.

⁸²⁹ See, *Ibid*. In p. 5, the facts are presented that “The second contested criterion is the timeline requirement regarding the examination of the applicant. The community treatment plan was entered into at 3:00 p.m. on December 20, 2010, and it so happens that the date and time of the examination of the applicant (required by s.33.1(4)(c) to take place within the 72-hour period before entering into the community treatment plan) was 1:30 p.m. on December 17.”

⁸³⁰ See, *Ibid*, p.7.

(e). The right to apply for review is a safety measure in the Ontario mental health statutes as in the others. The CCB generally accepts review applications from an involuntary patient and CTO patient or their representatives inquiring whether the fundamentals of the Acts have been made.⁸³¹ The right of review applies every time when a certificate of involuntary admission or continuation of detention certificate and CTO are issued or reissued.⁸³² When a CTO beneficiary does not apply, “there is an automatic, mandatory review of the CTO by the CCB when it is renewed for the second time and upon every second renewal thereafter and an appeal to the Superior Court of Justice”.⁸³³ The right of review also includes the right to appeal to a higher court of law. This right also is present in the four jurisdictions as stated in their various sections. In Ontario the right of appeal is to the Superior Court of Justice on question of fact and law.⁸³⁴ The right also extends to those under a CTO and hence can be exercised every time a CTO is issued or renewed in order to determine whether the criteria of the CTO are met.⁸³⁵ The *P (Re), 2011* case presented above involved an inquiry as to whether or not the criteria were met for renewing a CTO.⁸³⁶ The CCB rescinded the renewing of the CTO because the statutory criterion was not met and went further to emphasize that it did not matter that in rescinding the order it will affect financially or otherwise the process of renewing a CTO as claimed by the physician. They emphasized that “the Board does not have discretion to ignore a statutory requirement for the convenience of a hospital that got it wrong.”⁸³⁷ This case is a typical example of how the law can be ignored in order to save costs at the detriment of a patient’s rights. This is an arbitrary execution of the law and the Board was right in underscoring as such.

⁸³¹ See, OMHA (1990) as amended, s. 39 (1).

⁸³² See, Ibid, s.39.

⁸³³ See, Thompson and Empowerment Council v. Ontario, Supra note, 534, para 100. See also, OMHA (1990) as amended, s.39.1 (3).

⁸³⁴ See, OMHA (1990) as amended, s. 48 (1) & OHCCA (1996) as amended, s. 80 (1).

⁸³⁵ See, OMHA (1990) as amended s. 39 & 48.

⁸³⁶ See, P (Re), 2011 Supra note, 827, p.1.

⁸³⁷ See, Ibid, p.7.

(f). In connection to the right of review, anyone can institute a violation of Charter rights as provided by the OMHA. Even though interference on the right to liberty is deemed constitutionally justifiable as in the *Thompson case*, the OMHA guarantees that interference remains within the constitutionally justifiable limits. It therefore conditions that in the event of allegations as to a breach of Charter rights, an involuntary patient can make an application to “the Ontario Superior Court of Justice [which] provides a more appropriate, efficient and timely forum for the determination of *Charter* claims. *Charter* claims may be raised on an appeal from or judicial review of the Board’s decision, or through an application for a declaration that the provisions of the enabling legislation are invalid...”⁸³⁸ Some cases have reached the Supreme Court challenging breach of fundamental principles in the Charter such as the case of *Fleming V Reid (1991)* that concerned forceful administration of neuroleptic drugs to an involuntary incompetent psychiatric patient despite his prior communicated wish to his substitute decision maker not to be treated with such drugs being overridden by the review board, found to have violated his section 7 constitutional right.⁸³⁹ In the courts reasoning, it held that “the analysis of s. 7 of the Charter involves two steps – to trigger its operation there must first be a finding that there has been a deprivation of the right to “life, liberty and security of the person” and, secondly, that that deprivation is contrary to the principles of fundamental justice”.⁸⁴⁰ In finding a violation of the applicant’s right it maintained that a patient’s advance wishes should be respected at all times whether voluntarily or involuntarily admitted in any hospital including a mental institution.⁸⁴¹

⁸³⁸ See, Ontario (Attorney General) v. Patient, 2005 CanLII 3982 (ON SCDC), para 54. This is a case a patient (Jane) who was under CTO and who brought an application for review as to whether the criteria’s were met and also challenging the constitutional validity of CTO in relation to the Charter of Fundamental freedoms. It was held that the Board has no jurisdiction to determine constitutional matters and that included Charter rights. Hence for any claims on charter rights, the OMHA and the OHCCA, have specific directions for applicants who alleged violations of charter rights. This specific expedited pathway is to the superior court of justice. Furthermore CTOs were held to be compatible with the constitution.

⁸³⁹ See, Fleming v. Reid, Supra note 529.

⁸⁴⁰ See, Ibid, para V.

⁸⁴¹ See, Ibid, para I.

(g). A patient under the Ontario legislations has the right to be discharged if that individual does not meet the required assessment or admission criteria, if necessary checks are not conducted and when duration for involuntary admission, treatment or CTO terminates. Termination can be done through withdrawal of consent and rescinding of involuntary certificates of admission or revoking of CTO due to a failure to meet statutory criteria for both involuntary and CTO processes.⁸⁴² Discharge or release can be effected by officer in charge or by the CCB after review of an individual's detention in a psychiatric facility or CTO placement if they do not comply with the legal stipulations including the fact that the patient is 'no longer in need of the observation, care and treatment provided therein'.⁸⁴³ The case of **P (Re) (2011)** illustrates that reviews are crucial in ensuring that an individual is not detained arbitrarily and can exercise the right to be discharged either from a CTO or involuntary detention where statutory stipulations are not met.⁸⁴⁴ It is important to note that like the other jurisdiction, discharge is not immediate as a discharge plan must be effected depending with each case.

(h). The right to information facilitates the right to make informed choices in Ontario and as such the legislation requires that patients voluntary, involuntary and those under a CTO have the right to a rights adviser. In *Thompson*, the Court provided a self-explanatory analysis on this right in the following excerpt:

One should also acknowledge the statutory safeguards to ensure the consent of the patient or his or her SDM [substitute decision maker]; the rights advice that is provided and the manner in which persons subject to CTOs are notified of their rights to retain and instruct coun-

⁸⁴² See, *S.E.* (2010) CanLII 41574 (ON C.C.B.). The Board maintained that—"The *MHA* states that a panel, charged with hearing the issues relating to involuntary detention, "may confirm the patient's status as an involuntary patient if the Board determines that the prerequisites set out in this *Act* for admission as an involuntary patient were met at the time of the hearing" (s.41(2) *MHA*, emphasis added). If a panel determines that the prerequisites for involuntary status are not met, it "shall rescind the certificate" (s.41(3) *MHA*, emphasis added). The permissive wording in s.41(2), particularly in contrast to the language in s.41(3), has led some panels to hold that there is discretion to refuse to confirm a certificate in certain circumstances, particularly where there are findings that actions by the hospital have the effect of depriving the applicant of legal rights. Typically, panels have only exercised the discretion where there has been "egregious" conduct on the part of the attending physician or the treatment team."

⁸⁴³ See, *OMHA* (1990) as amended, s. 20 (3, &8), s.33.2(1&2), s. 33.4(1) & s.34.1

⁸⁴⁴ See, *Ibid*, s. 33.2-33.4 & 39.1(6&7).

sel and to seek review. By providing advance notice through s. 33.1(8) and Form 49 (and confirmation of same through Form 50), not only do the CTO provisions inform individuals and their SDMs as soon as possible that they have a right (and will be given access) to rights advice and a right to retain and instruct counsel before a CTO is issued and after its issuance (Form 45), but it also allows the provision of timely rights advice about the individual's legal options. This includes advice about the potential alternatives to a CTO (e.g. involuntary admission or continuing involuntary admission) and the ability to seek review of any findings that are the prerequisites for a CTO, such as findings of incapacity to consent to treatment or involuntary admission.⁸⁴⁵

In addition to the exceeding, a CTO order or involuntary admissions validity also depends on the fact that a physician has been satisfied that the individual or his/her substitute decision maker has consulted and received advice of their legal rights. It should be noted that this right can be waived if the individual concerned waives his or her right to consult a rights adviser and the physician has been informed and if the rights adviser has tried to locate the individual subject to a CTO and cannot locate him or her.⁸⁴⁶

(i). The right to make informed decision involves making those decision through earlier made wishes, a protection promoted by the CRPD and one exercised in the UK. Thus, under the law patients earlier wishes must be respected and executed irrespective of the type of treatment regimen.⁸⁴⁷ It is important that even when it is in the best interest of the patient to override the advance wish, that there is due process is by having a hearing before the Board where all parties including the patient in question and substitute decision maker or representative is given the chance to be heard before the Board gives a direction on how to apply the wishes made or how to depart from the wishes.⁸⁴⁸ This is the message that was strongly laid out in *Fleming V Reid*.⁸⁴⁹ The court held

⁸⁴⁵ See, *Thompson and Empowerment Council v. Ontario*, Supra note 54, para 106.

⁸⁴⁶ See, OMHA (1990) as amended, s. 33.1(4-e).

⁸⁴⁷ OHCCA (1996) as amended, s. 5 & 21.

⁸⁴⁸ See, *Ibid*, s.35 & 36.

⁸⁴⁹ See, *Fleming v. Reid*, Supra note 528, para IV. The court in this paragraph emphasized that—" A patient, in anticipation of circumstances wherein he or she may be unconscious or otherwise incapacitated and thus unable to contemporaneously express his or her wishes about a particular form of medical treatment, may specify in advance his or her refusal to consent to the proposed treatment. A doctor is not free to disregard such advance instructions, even in an emergency. The patient's right to forgo treatment, in the absence of some overriding societal interest, is paramount to the doctor's obligation to provide medical care. This right must be honored, even though the treatment may be beneficial or necessary to preserve the patient's life or health, and regardless of how ill-advised the patient's decision may appear to others. These traditional common law principles extend to mentally competent patients in psychiatric facilities. They,

that “there was no hearing before the review board, nor could there be, on the question of the effect or scope of the appellants' prior competent wishes, or their substitute consent-giver's decision based on those wishes”, accordingly, the treatment orders made by the Board must be seen as arbitrary and unfair, and must be set aside.”⁸⁵⁰ Competent wishes of patients include prior and current wishes.

(j). In addition to the examined safeguards above, involuntary patients have the right to become voluntary patients once their detention period is over or have regained their capacity to make decisions and withdrawn their consent to treatment including withdrawing consent from a CTO.⁸⁵¹ In this regard and in conjunction with respecting patient's wishes, health practitioners must take into account what their patients express during their treatment discussion because decision making is a continuous process and during treatment some patients may opt to make the choice of becoming voluntary or CTO patients. As such, physicians are not only required to follow the statutory criteria but also “physicians and other health professionals are required to draw upon their professional knowledge, skill, and experience to make assessment and treatment decisions to the best of their ability.”⁸⁵² Therefore with the combination of the two, patients should not be arbitrarily and compulsorily detained just because they declare that they do not suffer from a mental illness,⁸⁵³ or they seem unkempt, dishevelled and of poor hygiene.⁸⁵⁴

like competent adults generally, are entitled to control the course of their medical treatment. Their right of self-determination is not forfeited when they enter a psychiatric facility. They may, if they wish, reject their doctor's psychiatric advice and refuse to take psychotropic drugs, just as patients suffering other forms of illness may reject their doctor's advice and refuse, for instance, to take insulin or undergo chemotherapy. The fact that these patients, whether voluntarily or involuntarily, are hospitalized in a mental institution in order to obtain care and treatment for a mental disorder does not necessarily render them incompetent to make psychiatric treatment decisions. They may be incapacitated for particular reasons but nonetheless be competent to decide upon their medical care. The Act presumes mental competency, and implicitly recognizes that a mentally ill person may retain the capacity to function competently in all or many areas of everyday life.”

⁸⁵⁰ See, *Ibid.*

⁸⁵¹ See, OMHA (1990) as amended, s. 20(6) & OHCCA (1996) as amended, s. 14 & 16.

⁸⁵² See, *S. v. Her Majesty the Queen*, *Supra* note 528, para 16.

⁸⁵³ See, *KS (Re)*, 2013 CanLII 66989 (ON CCB). The Board in this case had the task to review the involuntary status of KS allegedly suffering from Bipolar Disorder and possibly Schizophrenia and finding of incapacity by the physician after she was brought in by a police who found him in a cornfield and was muddy and a psychiatric assessment that led to his involuntary detention under the OMHA at the Civic Campus of the Ottawa Hospital. It was no issue that she had past and recurring mental disorder to the Board after evaluating the evidence and listening to Ks, but the fact that the

(h). As a final point on Ontario, patients have a right not to be treated without consent.⁸⁵⁵ It is presumed that an individual has to be mentally capable to understand the relevant information for the treatment required and make decisions thereof including understanding the reasonable foreseeable consequences.⁸⁵⁶ Accordingly, psychiatrists, physicians or any other health practitioners may not administer treatment without the consent of the individual concerned or his/her substitute decision maker.⁸⁵⁷ Finding of incapacity must be done and notice given to an individual concerned. The consent should not be obtained through any form of misrepresentation or fraud.⁸⁵⁸ Certain treatments cannot be given without consent. For example involuntary patients, a patient incapable of giving consent or refusing and who is remanded or detained pursuant to Canadian criminal code in a psychiatric facility shall not be subjected to psychosurgery.⁸⁵⁹ In addition, Unlike the UK or

physician based his judgment to issue a certificate of involuntary admission based on the fact that she was brought in from a cornfield and that in 2012 she spent hours in a bush in cold weather which presented the evidence that she is at risk of serious physical impairment and mental deterioration. In fact Ks had reasons for the two episodes which transpired accidentally and she was the one who called the police for help and she did not incur any harm. In addition the Board found issue with his evidence that “because she denied having mental disorder she therefore lacked the ability to appreciate the reasonably foreseeable consequences of a decision not to accept medication” and therefore justified a finding of incapacity. The Board in rescinding both findings, they reasoned that from the evidence, the hearing and relying in the *starson case*, that Ks history of mental disorder in the ‘the absence of clear and cogent evidence should not equate to incapacity’.

⁸⁵⁴ See, LG (Re), 2014 CanLII 32647 (ON CCB). This case involved the review of LG involuntary status before a panel of the CCB after a certificate of involuntary admission was issued to him. The certificate was issued when “On April 28, 2014 LG visited the Community High Intensity Treatment Team (CHIT Team) office and torn down several notices and signs at the entrance to the corridor, causing minor destruction of property and [allegedly] threatened to kill CHIT Team staff.” The applicant is well known to have a history of hospitalization, he had a developmental disability and autism and psychosis disorders. He however had not undergone for a long time a test to determine his intellectual status. At the time the involuntary certificate of admission was given to him and he had not exhibited any suicidal tendencies. The panel after careful review of the evidence before it unanimously rescinded to confirm involuntary status. They reasoned that, even though the applicant had a mental disorder it was not enough to warrant an involuntary confirmation because the doctor’s evidence did not substantiate such a call. In addition, there was no evidence to indicate that LG had any suicidal tendencies and that the doctors concern about LG alcoholism that might result in poor personal hygiene would only warrant consideration as to physical impairment and not sufficient evidence for serious bodily harm. As such, “the panel therefore found that the evidence did not establish that LG’s mental disorder was of a nature or quality that likely would result in serious bodily harm to him unless he remained in hospital.” Furthermore, LG had been a voluntary patient for an extended period of time that it did not seem necessary to impose unsuitability of such a status.

⁸⁵⁵ See, OHCCA (1996) as amended, s. 10.1.

⁸⁵⁶ See, *Ibid*, s. 4(1). It states that-“A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision. 1996, c. 2, Sched. A, s. 4 (1).”

⁸⁵⁷ See, *Ibid*, s. 10.

⁸⁵⁸ See, *Ibid*, s.11 (4).

⁸⁵⁹ See, OMHA (1990) as amended, s. 49 (1). Section 49 (2) defines “psychosurgery is any procedure that, by direct or indirect access to the brain, removes, destroys or interrupts the continuity of histologically normal brain tissue, or that

South Africa system, the Ontario “CTO process is consent-based and all statutory protections governing informed consent apply”.⁸⁶⁰ Even as such there is compulsory supervision of the CTO beneficiary in the community. It should be noted here that this same right does not apply to emergency admission and treatments. The above regarded Ontario. The coming up heading deals with safeguards in the Ghanaian framework.

2.5.4. Ghana

(a). Analogous UK, Ontario and South Africa, respect of constitutional rights and freedoms are promoted even by the GMHA that stipulates that all the fundamental human rights and freedoms in the constitution must be enjoyed by persons with mental disability subjected to its authority. Unfair discrimination is prohibited no matter the cause, nature and degree of the mental disorder.⁸⁶¹ According to the statute, a tenant cannot be evicted because of a mental disorder or employee dismissed because of a mental disorder.⁸⁶² This is direct prohibition that does not appear in the other research jurisdictions.

(b). Furthermore, basic human rights are an entitlement to persons with mental disability in the Act. As such the Act includes the right of all individuals to civil, political, economic, social and cultural rights such as right to education, vocational training employment, recreational activities and exercise which are essential for a enjoying a decent life.⁸⁶³ It however puts a caveat to these rights by underscoring that any “specific limitations on these rights shall be in accordance with an assess-

inserts indwelling electrodes for pulsed electrical stimulation for the purpose of altering behaviour or treating psychiatric illness, but does not include neurological procedures used to diagnose or treat organic brain conditions, intractable physical pain or epilepsy, if these conditions are clearly demonstrable.”

⁸⁶⁰ See, R.A. Malatest & Associates Ltd, Final Report on The Legislated Review of Community Treatment Orders for the Ministry of Health and Long Term Care, Supra note 744, p 2. See also, OHCCA (1996) as amended.

⁸⁶¹ See, GMHA (2012), s. 54 (1 & 2).

⁸⁶² See, Ibid, s. 54 (3).

⁸⁶³ See, Ibid, s. 55 (1) & 63.

ment of capacity.”⁸⁶⁴ Note that the Act unlike those in the other research jurisdiction has no criteria for assessment of capacity.

(c). As an additional and important protection measure, persons detained under the GMHA voluntarily or involuntarily have the right to be treated in a humane and dignified manner “at any time with respect to personal dignity and privacy”. Some ways in which humane conditions may be ensured is through allowing detained individuals to wear personal clothes, maintain personal belongings ‘subject to space limitations’ and spend their financials as far as their mental status permits them.⁸⁶⁵ These specifications do not appear in the Ontario, UK and Ontario statutes.

(d). In addition to the above, it is a guarantee under the Act to be given and have access to information pertaining the detention, treatment plan and rights upon admission as well as the right to “information provided by newspapers and other media”.⁸⁶⁶ Information may be given to the individual, caregiver, representative and relevant family member.⁸⁶⁷ This assurance is emphasized in the four jurisdictions and as such indicates its central role in the protection of rights and prevention of abuse.

(e). In conjunction to the afore, court mandated involuntary patients can be temporarily discharged by a psychiatrist or head of facility for a duration of thirty days or discharged earlier and the information communicated to the court and mental health tribunal.⁸⁶⁸ Discharge is a right when the court ordered duration lapses or by the Act.⁸⁶⁹ The tribunal has the power to effect a discharge when it is satisfied that the individual does not suffer anymore from a mental disorder, detention is no longer

⁸⁶⁴ See, Ibid, s. 55 (1).

⁸⁶⁵ See, Ibid, s. 55 (2 &3).

⁸⁶⁶ See, Ibid, s. 45, 55 (4) & 64.

⁸⁶⁷ See, Ibid, s. 55 (5).

⁸⁶⁸ See, Ibid, s. 52 & 53.

⁸⁶⁹ See, Ibid, s. 53 (1).

necessary since the individual poses no harm to self and others and the detention has ceased to be the least restrictive means.⁸⁷⁰

(f). One more important safeguard is that consent under the Act must be given in order for treatment to proceed. But this can be waived where the court grants the order for involuntary treatment. An interesting approach to receiving treatment without consent is the confluence of the right to and inability to consent and the imperative need of treatment, in that the Act guarantees “a person who by reason of a mental disorder is unable to give consent shall not be deprived by another person of medical treatment, education or any other social or economic benefit”.⁸⁷¹ Consent on the other hand must be given by the Tribunal in certain circumstances as the Act conditions that “the Tribunal shall ensure that informed consent is obtained for intrusive or irreversible procedures”.⁸⁷² Intrusive and irreversible treatments such as electroconvulsive therapy or psychosurgery shall not be used for emergency cases.⁸⁷³ Again, this criterion is present in the four jurisdictions, classified as important procedures that must be done where consent of the person, Tribunal or court has consented.

(g). The Act among the research jurisdiction is the only one that makes reference to a group of vulnerable people who may need extra care while detained. These include females, children, persons with mental retardation and the aged.⁸⁷⁴ Extra care include safety standards that may involve separate living arrangements from men and adults from children, non-admittance of persons with mental retardation to a mental facility unless that person has exhibited gross misconduct and prohibition

⁸⁷⁰ See, *Ibid*, s. 30.

⁸⁷¹ See, *Ibid*, s. 56.

⁸⁷² See, *Ibid*, s. 29.

⁸⁷³ See, *Ibid*, s. 57 (5).

⁸⁷⁴ See, *Ibid*, s. 64-67.

on administering irreversible and intrusive mental treatment on the aged, children and persons with mental retardation.⁸⁷⁵

(h). The right to respect privacy and autonomy is accentuated by the Act.⁸⁷⁶ This protection ensures that persons detained under the Act have the freedom to have private visitors such as legal representatives and family members, private observation by relevant medical practitioners during examination and that patient shall not be used for teaching or research purposes if consent is not sought from the individual or personal representative.⁸⁷⁷

(i). The right to the highest standard of health is a guarantee for all accessing mental health care.⁸⁷⁸ The law guarantees this right by claiming that persons with mental disorder have the right to the same standards of care like persons with physical health problems.⁸⁷⁹ It underscores that equality must be enforced in the use of all services, staff distribution in terms of qualification, beddings, foods, sanitation, access to essential medicine and all other medical services.⁸⁸⁰ This provision is very important because in many jurisdictions patients outweigh the number of beds and staff with the effect of some patients receiving inadequate medical attention, ending up sharing beds or lying on the floor.

(j). Previously, it was mentioned that the Act regulates the use of intrusive and irreversible treatment as a safety measure. In line with this, it prohibits any acts of torture, cruelty, forced labour and any other inhuman treatment in the administration of mental health treatment and other

⁸⁷⁵ See, Ibid.

⁸⁷⁶ See, Ibid, s. 61.

⁸⁷⁷ See, Ibid.

⁸⁷⁸ See, Ibid, s. 57.

⁸⁷⁹ See, Ibid, s. 57 (1).

⁸⁸⁰ See, Ibid, s.57 (2).

VICES.⁸⁸¹ Involuntary seclusion under the Act is permissible only in a manner that does not infringe the rights mentioned and it that it is for a short time and authorized by the relevant authority.⁸⁸²

(K). As a final point, individuals or their representatives have protection through the right to make an application for review to the tribunal and court. Review applications may be for reexamination of the tribunal's decision, discharge or any other matter concerning that person's detention and treatment.⁸⁸³ Appeals may also be lodged with the court against the decision of the tribunal or any other matter under the Act.⁸⁸⁴ In a more related issue, the Act empowers patients, their relatives, caregivers and hospital staff to report any complaints to the senior mental health personnel and expects such complaints to be addressed within 48 hours.⁸⁸⁵ If the senior mental health personnel fails to address the complaints then an appeal can be made to the tribunal which is also expected to respond within 21 days.⁸⁸⁶

2.5.5. Sum Up

The substantive and procedural provisions of the research jurisdictions have indicated a lot of similarities and a few dissimilarities. Many of the similarities have been- the proper use of admission and detention criteria (all based on a mental disability, dangerousness, availability of treatment, best interests consideration and least restrictive environment), the requirement of a treatment plan, right to discharge, right to information, to respect of dignity, equality and other freedoms, right to consent for certain mental health treatments, applications for review, and right to have rights explained to individuals at the time of admission. Differences have included the use of terminology

⁸⁸¹ See, Ibid, s. 57 (3).

⁸⁸² See, Ibid, s. 58.

⁸⁸³ See, Ibid, s. 31&32.

⁸⁸⁴ See, Ibid, s. 32 & 44.

⁸⁸⁵ See, Ibid, s. 59(1).

⁸⁸⁶ See, Ibid, s. 59 (2).

(to describe CTOs, information on rights and reviewing bodies), duration in time for certain detention periods, consent for all treatments (involuntary and CTO alike) as stipulated in the Ontario legislation and court mandated involuntary treatment in Ghana compared to the other jurisdictions where a psychiatrist or health care professional may enforce it. Particularly for Ghana there are new safeguards such as respect of civil, political, economic social rights, employment rights, housing rights, rights of specific vulnerable groups and the right to the highest standard of health with stipulations as to what it entails.

All in all, these rights including the protections are there to ensure the prevention of arbitrariness. However the case law provided indicate that even with the law, deliberate misapplication and maltreatment may occur due to attitudes of care givers or supporters. Conversely, some cases indicated that due diligence of care givers and supporters have prevented misapplication of the law or/and arbitrary admissions and treatment. The laws in other circumstances were inadequate to deal with certain situation such as in the UK and Ontario but remedied with revisions of those laws.

2.5.5. Conclusion

This chapter began with the purpose of looking at the existing mental health legislations in the research jurisdictions implemented to prevent arbitrariness against persons with mental disability in the deliverance of mental health service starting with the admission and treatment stages. The examination was conducted by comparing similarities and differences in legislation approach and application, including their coherence with the CRPD. The conclusions that can be made is that many of these legislation when analyzed against the CRPD will automatically be considered non-compliant by the mere fact that they sanction the use of involuntary detention and treatment, the use of capacity assessments, the use of guardianship systems and substitute decision makers instead

of support decision makers. In addition, countries like South Africa and Ghana their lack of regulations on the use of traditional and Spiritual mental health services would be found wanting. Ontario may be close to what the CRPD requires because of the split between detention and treatment. However it still sanctions involuntary admission, uses capacity assessment tests and substitute decision makers. The MI Principles on the other hand are much in line with many of the four jurisdiction standards on admission than the CRPD. Thus, it can be contended that the MI Principles presents more insightful and practical guidance on standards.

Be as it may, the chapters finding generally indicated a permitting culture of civil commitment with emphasis on review of detention and treatment. The cases and scholarly explored assuredly showed that there is strong judicial activism in ensuring respect of the law and prevention of arbitrariness. This was shown through findings on poor application of the law, inadequacies in the laws, and rulings on unconstitutionality of specific sections of the law that resulted in their nullifying and reading in. These actions resulted in changes in the laws that expounded and developed more protective standards. All told the following represent those protections cutting across the four jurisdictions and deemed as preventative safety measures:

- (a) Respect for human dignity, equality, privacy and autonomy
- (b) Prohibition of forced labour, torture and inhumane treatment
- (c) Respect of the criteria's for admission
- (d) The use of two or more recommendations of mental health practitioners with reasons as to why persons should be involuntarily admitted and treated. This also includes individuals using their own recommenders
- (e) The right to informed consent to be exercised even where compulsory measures are enforced. In addition persons should have the right to withdraw consent and challenge such compulsory measures. These includes the right to choose when a person regains capacity to make decisions
- (f) The requirement that detentions should be within the stipulated time. Practice shows 72 hours as maximum for compulsory admissions for assessment and six months for involuntary treatment and CTOs with in between constant review that might shorten the time if results indicate individual no longer needs compulsory admission
- (g) Right to information including to correspondences
- (h) Right to legal and rights advice upon admission and when required
- (i) Right to legal representation when making reviews or any other complaint

- (j) Right to be discharged upon expiration of treatment or court ordered admission
- (k) Right to appeal
- (l) Right not to be treated with irreversible and intrusive treatments without consent
- (m) The right to a highest standard of health which includes qualification of staff, quality of food, proper sanitation and humane living environment

CHAPTER 3: CAPACITY, CONSENT AND CIVIL COMMITMENT

3.1. Introduction

This chapter examines the process of capacity, consent within the civil commitment process. From chapter two, it was shown that compulsory measures of detention and treatment in some jurisdiction must be performed when consent is provided by a capable individual or by guardian, substitute decision maker, court, personal care attorney or by directives given through advance made wills. Therefore, this chapter explores this intricate aspect and by limiting its content to the matter of civil commitment. It begins by examining what constitutes informed consent and capacity to consent. This is then followed by looking at the right to equal recognition before the law that encompasses the right to self-determination, consent and capacity to consent as is presented by the CRPD and other international human rights treaties. The content in the chapter is also limited to a comparative discussion on consent, capacity to consent and the protections in the research jurisdictions jurisprudence. Finally a conclusion summing the findings and justifications shall be presented at the end.

What is informed consent and Capacity to consent?

Informed consent is the ability of an individual to make autonomous decision making in all aspects of life and always after thorough evaluation of the relevant Information. Capacity or “competency to consent is a status known as legal capacity generally determined by the ability to comprehend, retain, believe and weigh information provided in arriving at a decision.”⁸⁸⁷ As it is legal capacity is presumed in adult’s persons and [young adults between the age of 16 and 18 in some jurisdictions] and renders them the right to consent to, refuse or choose an alternative medical intervention, [or management of financial or properties].”⁸⁸⁸ For children under the age of 16, in many jurisdiction parents provide their consent or as in the case of other vulnerable groups such as the old, those with

⁸⁸⁷ See, Report of the then Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Anand Grover, Supra note 336, para 10.

⁸⁸⁸ See, Ibid

mental disability or incapacitated because of some reason, capacity tests are normally used to establish not only maturity as in children but competency to consent.⁸⁸⁹ When competency to capacity is not established, there are various legal and social mechanisms that are available for support in decision making such as, guardianships, attorney for personal care, personal representatives, family, substitute and support decision making. Having capacity is therefore very crucial in autonomous decision making in all aspects of an individual's life, including access to and use of health care services.

Equally, in the framework of health care access and service delivery, consent to medical treatments performs an exceedingly fundamental function. The notion of consent functions as a coalescing standard that operates throughout health care legislation and ethical standards.⁸⁹⁰ It characterizes the legitimate and moral representation of the human right to have one's autonomy and self-determination acknowledged.⁸⁹¹ These principles of medical ethics and consent applied today are recognized to have stemmed from the Hippocratic code of conduct which express forthright that 'the physician will use treatment to help the sick according to his ability and judgment, but never with the view to injury and wrongdoing',⁸⁹² The quote as read does not mention the notion of respect for patients' concerns but it can be and has been implied therein that it requires all health care personnel to exercise such competence without exceeding a given mandate, as well as refraining from infringing on the rights of the patients in their charge. The prerequisite that the patients' assent must be received, functions precisely as a restraint on the control of the health care professional.⁸⁹³ As it stands the code has evolved overtime and given various interpretations and modifications

⁸⁸⁹ See, *Ibid*, para 11.

⁸⁹⁰ See, Jean McHale & Marie Fox, *Health care law: Text and materials*, *Supra* note 612, p. 349.

⁸⁹¹ See, *Ibid*.

⁸⁹² See, W.H.S. Jones Ed., *General Introduction to Hippocrates* (1923).

⁸⁹³ See, Jean McHale & Marie Fox, *Health care law: Text and materials*, *Supra* note 612, p.349.

to its current meaning involving the protection of patients' rights, responsibility of health care providers and the obligation of the State towards the patient.⁸⁹⁴

This responsibility to ensure protection of the patient's right of self-determination is the key issue particularly for those with mental disability. It is as such because capacity to consent for medical care can be compromised by both mental and physical ailments and more recurrently evident in individuals with mental illness.⁸⁹⁵ Even though capacity to consent for medical care can be compromised by both mental and physical ailments, it is as noted nonetheless more recurrently evident in individuals with mental illness and consequently presents a lot of challenges in the provision of health care to those with mental disabilities.⁸⁹⁶ These challenges arise due to the fact that uncertainties about mental capacity evolve much more often when individuals have a mental disorder as opposed to when they have a physical ailment, making them susceptible sometimes to paternalistic actions that prevent the exercise of their autonomous being and development as individuals.⁸⁹⁷

Yet the stark reality is that even with persuasive arguments against paternalism in consent matters, for some individuals with mental disability, exercising paternalism such as use of substitute decision making methods for consenting protects the concerned individuals other rights from being encroached and at the same time facilitates the individual to exercise his or her right to health. As

⁸⁹⁴ See, Report of the then Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Anand Grover, *Supra* note 336, para 8. The rapporteur informs that "The concept of consent has evolved for centuries to arrive at its current meaning. In the aftermath of the Nuremberg Trials, increased international recognition of patients' rights developed in the twentieth century defining the responsibility of health-care providers and States responsibilities to the patient. In 1947, the Nuremberg Code asserted that the voluntary consent of the human subject to medical research is necessary under all circumstances. The Declaration of Helsinki (1964) further developed the Code principles and tied them to the ethical duties of physicians, as outlined in the Declaration of Geneva (1948). In 1994, the World Health Organization Amsterdam Declaration on Patients' Rights required informed consent as a prerequisite for any medical intervention, guaranteeing also the right to refuse or halt medical interventions."

⁸⁹⁵ See, Felicity Callard et al, *Mental Illness, Discrimination and the Law: Fighting for Social Justice*, *Supra* note 332, p. 44 & 45.

⁸⁹⁶ See, *Ibid.*

⁸⁹⁷ See, *Ibid.*, p.45.

shall be seen further in the discussion, substitute decision making mechanisms are not just exercised in a whim, but within a legislative framework with proper substantive and procedural safeguards. The bottom line according to the thesis is that be it substitute or supported decision making mechanisms, individuals with mental disability all capable and incapable to make decisions should at all times be empowered to make their own decisions and that it should be done in accordance with utmost respect of the relevant individuals rights and proper observance of substantive and procedural safeguards to avoid any arbitrary and paternalistic actions when consenting and when assessing capacity for consent.

With the above comments this chapter examines the statutory requirements and safeguards relating to consent and capacity of persons with mental disability in relation to civil commitment. Consent and capacity interlinks with civil commitment via the compulsory nature of civil treatment. The right to autonomous decision making is therefore restricted when involuntary psychiatric treatment is administered. Important notice here to keep is that not all individuals with mental illness may lack the ability to make self-decisions and/or be in need of civil commitment process for treatment due to their mental illness. However, in those circumstances when inability to consent is actual and the imperativeness to make a decision is necessary, the practice as it is or has been in many jurisdictions is that decisions are made in the best interest on behalf of the incapacitated individual either by a substitute decision maker or a guardian. In specific cases, support is given to the individual with mental illness in order to facilitate that individual to make a decision. Intrinsically, the right to autonomous decision making becomes restricted when involuntary psychiatric treatment is administered. Hence, it becomes clear that on account of this limitation the following is brought about; the criticism and denunciations of mental health legislations that provide for involuntary commitment and treatment, criticisms of competency laws used to assess the capacity of those with

mental illness and their ability to make decisions and criticisms against criminal laws with mental disability as a defense.

The following explores the notion of capacity, consent and civil commitment from an international human rights framework perspective.

3.2. International Perspectives & National Standpoints

This right to consent and autonomous decision making as regards individual with mental illness has been discussed extensively in other researches. As such this presentation is limited to the jurisprudence presented in the selected key instruments and as it relates to the right to be equal recognition before the law and the thesis viewpoint on civil commitment. The right to “equality before the law is a basic general principle of human rights protection and is indispensable for the exercise of other human rights” recognized in various international and regional human rights treaties.⁸⁹⁸ It is also recognized in many national constitutional documents. The issue of capacity, consent and civil commitment are not directly provided in some of these conventions but can be inferred from this right. Hence, the following key convention (ICCPR, ICESCR & CRPD) and guiding instrument (MI Principles) are examined below.

3.2.1. The ICCPR

The right to liberty as already established in chapter one and two is a right guaranteed to all by the ICCPR article 9 and other human rights instruments even though it is not absolute. The right can therefore be restrained for the purposes of involuntary hospitalization where deprivation is under-

⁸⁹⁸ See, CRPD Committee, General Comment No 1, Supra note 40, para 1. See also, Article 6 UDHR, Article 16 ICCPR, CEDAW, CRC, Article 3 ACHPR & Article 3 ACHR.

taken without consent.⁸⁹⁹ Even though it is not an absolute right, according to the covenant and its interpretation, the exercise of this right must be regulated by law to prevent any arbitrary abuse. Concerning consent, capacity and civil commitment the covenant does not expressly tackle them, but it can be summed up that it does under its article 7 which prohibits administration of ‘medical or scientific experimentation without the free consent of the person concerned’.⁹⁰⁰ Conversely, according to the explanation given by Human Rights Committee in General Comment No. 20, it recognizes that there are certain individuals that may not be capable to give consent and “observes that special protection in regard to such experiments is necessary in the case of persons not capable of giving valid consent, and in particular those under any form of detention or imprisonment [and that] such persons should not be subjected to any medical or scientific experimentation that may be detrimental to their health”.⁹⁰¹ It therefore qualifies the absolute nature of the right to consent in particular situations but with appropriate safeguards.

In view of the fact that General Comment 20 is an established document, concerns may arise as to whether the Committee’s opinion has changed with the recent developments brought about by the CRPD’s interpretation given in General Comment No.1 on equal recognition before the law requiring respect of autonomous decision making. The answer to this question is provided in the Human Rights Committee 2014 General Comment 35 on Article 9 (the right to liberty and security of persons).⁹⁰² This Comment recognizes that involuntary hospitalization or civil commitment falls under circumstances of deprivation of liberty under article 9 and it does not qualify it as arbitrary or con-

⁸⁹⁹ See, Human Rights Committee, General Comment 36, *Supra* note 162, para 5 & 6.

⁹⁰⁰ See, ICCPR Article 7.

⁹⁰¹ See, Human Rights Committee, General Comment No. 20: Article 7 (Prohibition of Torture, or Other Cruel, Inhuman or Degrading Treatment or Punishment), (1992), para 7.

⁹⁰² See, ICCPR, Article 9.

trary to the convention.⁹⁰³ Despite the fact that the Committee has not excluded it like the CRPD, it strongly cautions that there is:

Harm inherent in any deprivation of liberty and also the particular harms that may result in situations of involuntary hospitalization. States parties should make available adequate community-based or alternative social-care services for persons with psychosocial disabilities, in order to provide less restrictive alternatives to confinement. 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.⁹⁰⁴

From the excerpt, the Committee does not call for abolition of compulsory measures but encourages State Parties to make available other less restrictive alternatives. In fact, as part of its monitoring mandate to ensure lawful detentions it calls upon “States parties [to] explain in their reports what they have done to revise outdated laws and practices in the field of mental health in order to avoid arbitrary detention.”⁹⁰⁵ Moreover in the implementation of their responsibilities, the Committee writes on the use of safeguards and verbatim conditions that “any deprivation of liberty must be necessary and proportionate, for the purpose of protecting the person in question or preventing injury to others, must take into consideration less restrictive alternatives, and must be accompanied by adequate procedural and substantive safeguards established by law.”⁹⁰⁶ These substantive and procedural safeguards equally apply in those circumstances where an individual with mental illness is subjected to treatment without consent. The Human Rights Committee advocates that in those situations when the views of the patient cannot be articulated, there should be proper safeguards to ensure that the relevant patient guardian or representative “genuinely represents and defends the wishes and interests of the patient”.⁹⁰⁷ It goes without say that this interpretation infers that in certain circumstances treatment can be given without consent and it is in these situations that those

⁹⁰³ See, Human Rights Committee, General Comment 36, *Supra* note 162, para 5 & 19.

⁹⁰⁴ See, *Ibid*, para 19.

⁹⁰⁵ See, *Ibid*.

⁹⁰⁶ See, *Ibid*.

⁹⁰⁷ See, *Ibid*. (Note: These are similar wordings from the CRPD interpretation and are also found in the Ontario legislation)

decision making mechanisms discussed previously come into focus. Guardianship systems are recognized by the Human Rights Committee a contrasting position from that held by the CRPD Committee. This is the position, the following looks at the ICESCR.

3.2.2. The ICESCR

The Covenant on Economic Social and Cultural Rights promotes the right to the highest standard of health under article 12 as discussed in chapter two.⁹⁰⁸ According to the Committee on Economic Social Cultural rights, the “notion of “the highest attainable standard of health” in article 12.1 takes into account both the individual’s biological and socio-economic preconditions and a State’s available resources. The right to health is of the essence in our daily lives because “health is a fundamental human right indispensable for the exercise of other human rights [and] every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity.”⁹⁰⁹ It therefore applies on an equal basis to every individual regardless of status, gender, age or disability.⁹¹⁰ It follows then that this right as provided in General Comment 14 is also reiterated in General Comment 5 which is specific on persons with disabilities.⁹¹¹ General Comment 5 recognizes individuals with physical and mental disabilities and the Committee therein emphasize that that there is a “need to ensure that not only the public health sector but also private providers of health services and facilities comply with the principle of non-discrimination in relation to persons with disabilities.”⁹¹²

In essence the Committee emphasizes that persons with disabilities have equal rights and should be equally recognized before the law in all matters relating to the enjoyment of the right to health. In

⁹⁰⁸ See, ICESCR (1976).

⁹⁰⁹ See, ICESCR Committee, General Comment No. 14, Supra note 315, para 1.

⁹¹⁰ See, ICESCR, Art.2 (2). See also, ICESCR Committee, General Comment No. 20, Supra note 901, para 28 & 33.

⁹¹¹ See, ICESCR Committee, General Comment No. 14, Supra note 315, para 26.

⁹¹² See, ICESCR Committee, General comment No. 5, Supra note 913, para 17.

this regard the ICESCR Committee emphasizes that the Convention requires that “anti-discrimination measures should be based on the principle of equal rights for persons with disabilities and the non-disabled, which, in the words of the World Programme of Action concerning Disabled Persons, implies that the needs of each and every individual are of equal importance, that these needs must be made the basis for the planning of societies, and that all resources must be employed in such a way as to ensure, for every individual, equal opportunity for participation. Disability policies should ensure the access of [persons with disabilities] to all community services”.⁹¹³In addition to the right to equal recognition before the law, emphasis is made to the effect that “the right to health contains both freedoms and entitlements [which] include the right to control one’s health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation.”⁹¹⁴This is as far as the Committee has gone to construe the exercise of consent and its limitation. It does not make any comments on capacity or civil commitment.

However, explanations on the issue is available in the report of the then Special rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover, concerning the issue of informed consent as it relates to the realization of the right to health.⁹¹⁵In the report the rapporteur among other issues highlights that “guaranteeing informed consent is a fundamental feature of respecting an individual’s autonomy, self-determination and human dignity in an appropriate continuum of voluntary health-care services”.⁹¹⁶That “informed consent in health, including (but not limited to) clinical practice, public health and medical research, is an integral part of respecting, protecting and fulfilling the enjoyment of the right to health

⁹¹³ See, *Ibid.*

⁹¹⁴ See, ICESCR General Comment No. 14, *Supra* note 315, para 8.

⁹¹⁵ See, Report of the then Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Anand Grover, *Supra* note 336.

⁹¹⁶ See, *Ibid.*, para 18.

as elaborated in article 12 of the International Covenant on Economic, Social and Cultural Rights and enshrined in numerous international and regional human rights treaties and national constitutions.”⁹¹⁷The rapporteur in the same vain recognizes that the right to consent is not absolute, that the lack of competency to consent in specific circumstances may occur and that this may prevent the exercise of autonomy, and in this situations “supportive measures (such as alternative and augmentative communication) may be required to assist the exercise of legal capacity and respect the wishes of persons who, temporarily (owing to transitory states such as loss of consciousness, panic, fear or confusion) or permanently, are not able to exercise legal capacity.”⁹¹⁸ For instance to indicate where autonomy to consent may not apply he states that “only in a life-threatening emergency in which there is no disagreement regarding absence of legal capacity may a health-care provider proceed without informed consent to perform a life-saving procedure.”⁹¹⁹This typical case points to the reality that in certain circumstances the right to consent is and should be justifiably qualified

The Special rapporteurs report like the Human Rights Committee general comments qualifies the right to autonomous decision making and places emphasis on protections as counter-alternative solution. Reference to protections is reflected in his discussion on groups of individuals considered as vulnerable persons susceptible to having their right to consent abused for example women and girls sterilized without their consent.⁹²⁰To emphasize on this vulnerability and prohibition on non-consensual interventions, he referenced the CRPD that “reaffirms that the existence of a disability is not a lawful justification for any deprivation of liberty, including denial of informed consent [and

⁹¹⁷ See, Ibid.

⁹¹⁸ See, Ibid, para 12.

⁹¹⁹ See, Ibid.

⁹²⁰ See, Ibid, para 69, 70 & 71. They provide: “69. Persons with disabilities often suffer from unjustified perception of being incompetent or dangerous to themselves or others. Such prejudices, coupled with existing laws and practices limiting legal capacity, often compromise their informed consent. 70. Many States, with or without a legal basis, continue to allow for the prolonged detention of persons with mental disabilities in institutions without their free and informed consent. 71. Forced sterilization of girls and women with disabilities has been documented internationally and is even being currently proposed in Rwanda. Persons with disabilities, including children, continue to be exposed to non-consensual medical experimentation.”

therefore] States must provide persons with disabilities equal recognition of legal capacity, care on the basis of informed consent, and protection against non-consensual experimentation; as well as prohibit exploitation and respect physical and mental integrity.”⁹²¹ He further underscored that the as per the CRPD “States have the obligation to provide (on a permanent basis if necessary) any appropriate supports, including total support, for persons with disabilities to exercise their legal capacity to the greatest possible extent [.] This is particularly relevant in the provision and comprehension of information, as underlined by ICESCR General Comment 20, which emphasizes the importance of implementing supportive measures for persons with sensory impairments.”⁹²²

Like the CRPD Committee the rapporteur fell short recommending those types of support. Although, he sets himself apart from the CRPD Committee distinct opinion on prohibition on any forms of non-consensual treatment by not opposing policies that sanction non-consensual treatments, that are of therapeutic nature or/and are lifesaving.⁹²³ He actually proposes that “persons with disabilities who are not able to exercise their legal capacity must be treated according to the standards acceptable for those with disabilities in equal circumstances, [and that] “mechanisms for total support for decision-making and consent (as in all other cases) should come into effect only when a person is authoritatively determined to require it in order to exercise legal capacity.”⁹²⁴ Hence it can be summed up that the exercise of autonomy is not absolute, substitute or support decision making can be engaged and the use of legal protections is central in guaranteeing prevention of and remedying of any rights violations.

⁹²¹ See, Ibid, para 72.

⁹²² See, Ibid.

⁹²³ See, Ibid, para 73.

⁹²⁴ See, Ibid, para 74.

3.2.3. The MI Principles

From the proceeding chapters it has been established that unlike the CRPD, the MI Principles sanctions administration of mental health care through involuntary treatment. Moreover it comprehensively provides protections for individuals with mental disability and articulates the responsibilities of both patients and carers. The MI Principles proscribes discrimination on grounds of disability and contrary to the CRPD it does not consider discrimination “to include any distinction, exclusion or preference undertaken in accordance with the provisions of the present Principles and necessary to protect the human rights of a person with a mental illness or of other individuals.”⁹²⁵ For this reason it can be interpreted that mental health legislation are not discriminatory because they provide for mental health care, an interpretation that aligns with many State Parties and various scholars.

It follows therefore that the MI Principles acknowledges that individuals with mental illness should not be treated without consent except in specific situations when treatment and care can be administered without consent.⁹²⁶ For example, in civil commitment consent can be dispensed with but with strict adherence to available safeguards for protection against arbitrariness. These safeguards include but not limited to personal representatives providing consent, authorized personnel by the court, the court itself and the use of all possible means to inform the patient on the relevant care, the possibility of review of decision to treat without consent and provision of appropriate care.⁹²⁷ Other protections in the MI Principles include prohibition of certain treatment without con-

⁹²⁵ See, MI Principles, principle 1(4).

⁹²⁶ See, MI Principles.

⁹²⁷ See, Ibid, principle 11- Consent to treatment “**1.** No treatment shall be given to a patient without his or her informed consent, except as provided for in paragraphs 6, 7, 8, 13 and 15 of the present principle. **2.** Informed consent is consent obtained freely, without threats or improper inducements, after appropriate disclosure to the patient of adequate and understandable information in a form and language understood by the patient on: (a) The diagnostic assessment; (b) The purpose, method, likely duration and expected benefit of the proposed treatment; (c) Alternative modes of treatment, including those less intrusive (d) Possible pain or discomfort, risks and side-effects of the proposed treatment. **3.** A patient may request the presence of a person or persons of the patient's choosing during the procedure for granting consent. **4.** A patient has the right to refuse or stop treatment, except as provided for in paragraphs 6, 7, 8, 13 and 15 of the present principle. The consequences of refusing or stopping treatment must be explained to the patient. **5.** A patient shall never be invited or induced to waive the right to informed consent. If the patient should seek to do so, it shall be

sent of the individual or independent review of procedure where the individual is incapable to consent and consent of personal representatives such as sterilization (absolute ban as treatment for mental illness), major medical or surgical procedures, psychosurgery and other intrusive and irreversible treatments for mental health and clinical trials.⁹²⁸ The right to appeal against these decisions is guaranteed as the MI principle expresses that in “the patient or his or her personal representative, or any interested person, shall have the right to appeal to a judicial or other independent authority concerning any treatment given to him or her.”⁹²⁹

In connection to the aforementioned and since the MI Principles does not oppose limiting the right to consent. The thesis regards that for this reason and at the very minimum, it accordingly predicts the determination of capacity and requires that the determination is conducted within the bounds of the law, medical ethics and that such persons found incapable to consent must be protected with relevant protections. In this regard it emphasizes that the person whose capacity is in issue must have representation, personal or court appointed who shall ensure that the individual gets to have a fair and impartial hearing before a relevant authority that determines capacity or has jurisdictions to

explained to the patient that the treatment cannot be given without informed consent. **6.** Except as provided in paragraphs 7, 8, 12, 13, 14 and 15 of the present principle, a proposed plan of treatment may be given to a patient without a patient's informed consent if the following conditions are satisfied: (a) The patient is, at the relevant time, held as an involuntary patient; (b) An independent authority, having in its possession all relevant information, including the information specified in paragraph 2 of the present principle, is satisfied that, at the relevant time, the patient lacks the capacity to give or withhold informed consent to the proposed plan of treatment or, if domestic legislation so provides, that, having regard to the patient's own safety or the safety of others, the patient unreasonably withholds such consent (c) The independent authority is satisfied that the proposed plan of treatment is in the best interest of the patient's health needs. **7.** Paragraph 6 above does not apply to a patient with a personal representative empowered by law to consent to treatment for the patient; but, except as provided in paragraphs 12, 13, 14 and 15 of the present principle, treatment may be given to such a patient without his or her informed consent if the personal representative, having been given the information described in paragraph 2 of the present principle, consents on the patient's behalf. **8.** Except as provided in paragraphs 12, 13, 14 and 15 of the present principle, treatment may also be given to any patient without the patient's informed consent if a qualified mental health practitioner authorized by law determines that it is urgently necessary in order to prevent immediate or imminent harm to the patient or to other persons. Such treatment shall not be prolonged beyond the period that is strictly necessary for this purpose. **9.** Where any treatment is authorized without the patient's informed consent, every effort shall nevertheless be made to inform the patient about the nature of the treatment and any possible alternatives and to involve the patient as far as practicable in the development of the treatment plan. **10.** All treatment shall be immediately recorded in the patient's medical records, with an indication of whether involuntary or voluntary.”

⁹²⁸ See, Ibid, principles 11,12,13,14 &15

⁹²⁹ See, Ibid, principle 16.

hear capacity challenges.⁹³⁰ Generally, the MI Principles tries to ensure that “every patient [with mental illness] shall have the right to receive such health and social care as is appropriate to his or her health needs, and is entitled to care and treatment in accordance with the same standards as other ill persons.”⁹³¹ What is even of utmost significance is that it demands that “every patient shall be protected from harm, including unjustified medication, abuse by other patients, staff or others or other acts causing mental distress or physical discomfort.”⁹³² Taking all into account, the MI Principles should actually be given more importance than it is now because it has more guidelines than the CRPD is discussed below. It is more pragmatic in terms of emphasizing on the use of compulsory and least restrictive measures in the realization of highest standard of mental health, in essence considering diversity in individual circumstances.

3.2.4. The CRPD

The CRPD is a specific treaty providing for individuals with disability. For this reason it is the appropriate convention to take an in-depth look on how it is guaranteeing the right to equal recognition, capacity, consent and civil commitment. Besides article 14 that provides for deprivation of liberty, the exercise of the other rights stem from article 12 of the CRPD. However unlike the other conventions that provide a one line sentence on the right to equal recognition, the CRPD extrapolates extensively by including issues of capacity and consent by setting out those “specific elements

⁹³⁰ See, *Ibid*, principle 1(6) which stipulates that: “Any decision that, by reason of his or her mental illness, a person lacks legal capacity, and any decision that, in consequence of such incapacity, a personal representative shall be appointed, shall be made only after a fair hearing by an independent and impartial tribunal established by domestic law. The person whose capacity is at issue shall be entitled to be represented by a counsel. If the person whose capacity is at issue does not himself or herself secure such representation, it shall be made available without payment by that person to the extent that he or she does not have sufficient means to pay for it. The counsel shall not in the same proceedings represent a mental health facility or its personnel and shall not also represent a member of the family of the person whose capacity is at issue unless the tribunal is satisfied that there is no conflict of interest. Decisions regarding capacity and the need for a personal representative shall be reviewed at reasonable intervals prescribed by domestic law. The person whose capacity is at issue, his or her personal representative, if any, and any other interested person shall have the right to appeal to a higher court against any such decision. 7. Where a court or other competent tribunal finds that a person with mental illness is unable to manage his or her own affairs, measures shall be taken, so far as is necessary and appropriate to that person's condition, to ensure the protection of his or her interests.”

⁹³¹ See, *Ibid*, principle 8 (1).

⁹³² See, *Ibid*, principle 8 (2).

that States parties are required to take into account to ensure the right to equality before the law for people with disabilities, on an equal basis with others.”⁹³³ The article provides that:

1. States Parties reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law.
2. States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.
3. States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.
4. States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person’s circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person’s rights and interests.
5. Subject to the provisions of this article, States Parties shall take all appropriate and effective measures to ensure the equal right of persons with disabilities to own or inherit property, to control their own financial affairs and to have equal access to bank loans, mortgages and other forms of financial credit, and shall ensure that persons with disabilities are not arbitrarily deprived of their property.⁹³⁴

The thesis maintains that the CRPD provision by recognizing persons with disabilities as persons before the law and in equal basis with others is spot on because all persons regardless of their status should be recognized as such. It is also important because unlike the other conventions the CRPD expands on the requirements upon which State parties can implement this right as regards to persons with physical and mental disability. Emphasizing on this right is of great significance specifically to persons with mental disabilities based on the fact that they have long been unjustly discounted as individuals with legal capacity putting them at an unequal basis with others. Due to their disability, many have been unjustly denied the ability to enjoy this right. The CRPD Committee fittingly emphasizes that:

The right to equal recognition before the law implies that legal capacity is a universal attribute inherent in all persons by virtue of their humanity and must be upheld for persons with disabilities on an equal basis with others. Legal capacity is indispensable for the exer-

⁹³³ See, CRPD Committee, General Comment No 1, Supra note 40, para 1.

⁹³⁴ See, CRPD Article. 12.

cise of civil, political, economic, social and cultural rights. It acquires a special significance for persons with disabilities when they have to make fundamental decisions regarding their health, education and work. The denial of legal capacity to persons with disabilities has, in many cases, led to their being deprived of many fundamental rights, including the right to vote, the right to marry and found a family, reproductive rights, parental rights, the right to give consent for intimate relationships and medical treatment, and the right to liberty.⁹³⁵

The thesis considers that the CRPD Committees observations in addition to being pertinently precise and self-explanatory in highlighting the dangers of denying anyone the right to equal recognition before the law, brings two contentious issues into focus. One is that of consent for medical treatment for those deemed incapable and two, detention and compulsory mental health care without consent for persons with mental disability. The contention is established by the nature and the process of limiting the right to liberty for purposes of compulsory treatment when it excludes an individual from exercising the right to autonomy and right to make consent in regard to their mental health care. It also arises in the use of capacity assessments and the consequent use of substituted decision making mechanisms for those found incapable. As illustrated in chapter one, disability activism particularly for those with mental disability has so far been focused on eradicating this type of rights intrusion and substituted decision making that is asserted to deprive many of their voice in matters involving their own treatment including the determination of their capacity or incapacity which has a direct and inordinate after affect in their lives.⁹³⁶

To address this contention, the best place to start is examining the CRPD and the CRPD Committees interpretations on the right to equal recognition of persons and its interconnectedness to the right to liberty as it involves civil commitment, capacity and consent. Respectively, the CRPD requires that “States Parties shall take appropriate measures to provide access by persons with disa-

⁹³⁵ See, CRPD Committee, General Comment No 1, Supra note 40, para 8.

⁹³⁶ See, Amita Dhanda Legal Capacity in the Disability Rights Convention: Stranglehold of the Past or Lodestar for the Future, 34 Syracuse Journal of International Law and Commerce 433 (2007).

bilities to the support they may require in exercising their legal capacity.”⁹³⁷ In addition they should ensure that “all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law [and that] such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person’s circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body.”⁹³⁸

It can be reasoned and the thesis reasons that from the above CRPD requirements that it is perceptibly acceptable to include legislative measures currently in practice in many State Parties jurisdiction such as substituted decision making, guardianships form of decision making, advance decision making and supported decision making mechanisms. Moreover, this interpretation can be reinforced reasoning that in certain instances exercise of consent is not arbitrarily denied, but due to the limitation caused by the severe nature of mental illness treatment may be given without consent or substituted. Furthermore, even though substituted or forced intervention limits the exercise of person autonomy, there is an envisaged positive outcome that it eventually aids recovery of mental health and restores an individual’s capacity to make individual decisions. Thus, these decision making mechanisms can be applied according to an individual relevant circumstances. After all the CRPD mentions that these measures should take into account “will and preferences of the person, are free of conflict and undue influence, are proportional and tailored to the persons circumstances.”⁹³⁹

⁹³⁷ See, CRPD Article 12 (3).

⁹³⁸ See, Ibid, Article 12 (4).

⁹³⁹ See, Ibid.

However, the reasoning afforded above do not match wholly with the general interpretation of the CRPD Committee on article 12 and other observations given in its concluding observations on the same article.⁹⁴⁰ As shall be shown below, the CRPD Committee makes an interpretation that consent is absolute. It requires State Parties to abolish all forms of substitute decision making, rejects parallel implementation of substitute and supported decision making and calls for total repeal of legislations that allow treatment without consent with the its position that is radically plain and simple as follows:

Substitute decision-making regimes can take many different forms, including plenary guardianship, judicial interdiction and partial guardianship. However, these regimes have certain common characteristics: they can be defined as systems where (i) legal capacity is removed from a person, even if this is in respect of a single decision; (ii) a substitute decision-maker can be appointed by someone other than the person concerned, and this can be done against his or her will; and (iii) any decision made by a substitute decision-maker is based on what is believed to be in the objective “best interests” of the person concerned, as opposed to being based on the person’s own will and preferences. States parties’ obligation to replace substitute decision-making regimes by supported decision-making requires both the abolition of substitute decision-making regimes and the development of supported decision-making alternatives. The development of supported decision-making systems in parallel with the maintenance of substitute decision-making regimes is not sufficient to comply with article 12 of the Convention.⁹⁴¹

Similar interpretation is provided in connection between article 12 and 14 by referring to those legislations and practices that deprive persons of their liberty for compulsory care as arbitrary in nature and demands that they should be abolished including any form of substitute decision making that is used to provide consent for the treatment as it directs that:

Respecting the right to legal capacity of persons with disabilities on an equal basis with others includes respecting the right of persons with disabilities to liberty and security of the person. 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 constitutes arbitrary deprivation of liberty and violates articles 12 and 14 of the Convention. States parties must refrain from such practices and establish a mechanism to review cases whereby persons with disabilities have been placed in a residential setting without their specific consent.⁹⁴²

⁹⁴⁰ See, CRPD Committee, General Comment No 1, Supra note 40.

⁹⁴¹ See, Ibid, para 27 & 28.

⁹⁴² See, Ibid, para 40.

Well, the Committee has not offered alternative mechanisms save for pronouncing supported decision making as preferable for the social model of disability in the CRPD. It is within reasonable limits to call out on some of these mechanisms since in many countries individuals are completely stripped out of their right to exercise their autonomy without protections. On the other hand, there is the concern of resilient use by carers and State Parties continuous implementation of these so labelled ‘insufficient substitute decision making regimes’. The CRPD interpretation conversely has been met with criticisms by various scholars such as John Dawson who points out that though the CRPD “affirms certain central values that must be guaranteed to all persons with ties,”⁹⁴³ one of the CRPDs “problem concerns internal inconsistency between various rights, particularly between (what are usually called) negative and positive rights, supported by the convention [that] the text leaves considerable uncertainty as to the circumstances in which the negative and positive rights of a person should prevail.”⁹⁴⁴ For instance he claims that “involuntary psychiatric treatment could both limit a person’s autonomy and promote social inclusion, health, and standard of living, would it therefore violate or promote the persons rights under the convention?”⁹⁴⁵ He further adds that in many jurisdictions in order to balance these rights, one of the key concepts used is capacity, assessment of capacity which is done to only intervene when necessary to make the relevant decision.⁹⁴⁶ According to him, it seems that “intentionally, the Convention does not mention this central balancing concept in its text, despite the key role played by the concept of capacity in most jurisdictions healthcare law [and as a result] this produces a quandary for the conventions interpretation.”⁹⁴⁷

⁹⁴³ See, John Dawson, A Realistic Approach to assessing Mental Health Laws Compliance with the CRPD, *Supra* note 95, p. 71.

⁹⁴⁴ See, *Ibid.*

⁹⁴⁵ See, *Ibid.*

⁹⁴⁶ See, *Ibid.*

⁹⁴⁷ See, *Ibid.*

Indeed it is a quandary not only in the interpretation but also in the implementation. Melvyn Freeman and Grahama Thornicroft et al also point out this dilemma by claiming that because of poor consultation of all relevant stakeholders in the drafting of article 12 and general comment, the CRPDs Committees' interpretation of article 12, reverses the impact of the CRPD in the promotion of the rights of persons with disabilities.⁹⁴⁸ On the matter at hand, they persuasively analyze that “excluding any exemption to the presumption of legal capacity due to mental impairment, and as a result not allowing a person with severe mental illness or other impairment to have their circumstance treated as exceptional, might in fact violate his or her rights, and in some circumstances could result in harm to self or to others.”⁹⁴⁹ Incidentally they challenge the Committee's interpretation on consent by questioning whether the Committee would still hold the same standpoint on consent if it concerned treatment of physical illness and in circumstances where an individual is delirious. Melvyn's question is reasonable if considered from the perspective of our daily lives. That is, when we are sick many of us are treated without being asked for our informed consent and when we are very sick or are in emergency situations the idea never crops up. We hardly call this stigmatization or discrimination or abuse as it is being stated by the CRPD and other proponents in the case of disability.⁹⁵⁰ Melvyn Freeman and Grahama Thornicroft et al reiterates on this by adding that “consent obtained when a person does not have such decision-making capacity is not informed and therefore not valid [that] critically, the capacity to give informed consent can be hampered by many different conditions, including both physical and mental conditions.”⁹⁵¹ Therefore, they “are unclear as to whether the Committee would accept exceptions to the informed consent principle as

⁹⁴⁸ See, Melvyn Freeman & Graham Thornicroft 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*, *Supra* note 107, p. 844.

⁹⁴⁹ See, *Ibid*, p.845.

⁹⁵⁰ See, CRPD Committee, *General Comment No 1*, *Supra* note 40, para 15, 22, 32 & 33. See, also Fiona Morrissey, *The United Nations Convention on the Rights of Persons with Disabilities: A New Approach to Decision-Making in Mental Health Law*, 19 *European Journal of Human Rights* 428 & 429 (2012).

⁹⁵¹ See, Melvyn Freeman & Graham Thornicroft 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*, *Supra* note 107, p.845.

long as the reasons for the exception were not disability[and thus], we might imagine that if a person carries a diagnosis of mental illness, but independently has an infection that causes a delirium and is refusing life-saving treatment, he or she can be treated without consent only if his or her refusal to have treatment was because of delirium and not their mental illness.”⁹⁵²

John Dawson, on a similar supporting note vents out his concern by first maintaining that “the first problem with the convention –that of ambiguity- is particularly significant when it affects the meaning of its central concept, that of discrimination on the basis of disability, [and its opposite,] on an equal basis with others [and concludes that] the convention in any case does not resolve the ambiguity in this central concept of discrimination on the ground of disability [and consequently] this poses a serious barrier to satisfactory interpretation of the text”.⁹⁵³ Second, he provocatively questions whether:

It is discrimination to take into account, or not to take into account the effects of a person’s condition on their mental functioning when making legal decisions? It might be thought that the answer is that discrimination involves taking the matter into account when it would have adverse consequences for the person, and not taking into account when it would deprive the person of some advantages otherwise due. Unfortunately, that approach begs the question of what accounts as an advantage for a person – whether for instance, providing treatment without consent that improves health is an advantage or not-the very nub of the controversy.⁹⁵⁴

Like Dawson, Melvyn Freeman and Grahama Thornicroft et al, position highlighted before all concur that consent can be waived and substituted when it is imperatively necessary. In this regard, it can be maintained that they also agree with the thesis belief that substituted decision making and supported should be available as options for different individuals and their circumstances and as long as protective standards are in place and implemented effectively. Moreover, the thesis theorizes that the will and preference of an individual can be the use of substituted decision making for

⁹⁵² See, Ibid, p. 845 & 846.

⁹⁵³ See, John Dowson, A Realistic Approach to assessing Mental Health Laws Compliance with the CRPD, Supra note 95, p.71.

⁹⁵⁴ See, Ibid.

example given in form of a directive power of attorney or a written advance will empowering another to make decisions on behalf when situations arise such as enforcing compulsory care decisions. Nevertheless, these scholars sentiment on the matter is as follows:

However, there are times when informed consent is not possible because of the condition of the person and must be superseded, particularly where life is at risk. With respect to life-saving treatment, a person in a coma or a person with severe infectious or neurological disease, for example, might need treatment without his or her informed consent. A universal presumption of legal capacity and the primacy of supported decision-making therefore cannot be absolute and exceptions have to be considered. This must apply to both physical and mental health.⁹⁵⁵

One of the most relevant statements above is that “a universal presumption of legal capacity and the primacy of supported decision making cannot be absolute and exceptions have to be considered”, as it relates to State practice in implementing article 12 CRPD, something the CRPD Committee seems to not take into account. From the very beginning during the ratification of the Convention State parties indicated their strong positions as regards the exercise of right to autonomy and treatment of mental illness. During this period as shall be shown below some made general declarations to apply article 12 subject to international human rights laws and their domestic legislations whereas others took stronger declaratory positions. For example Australia made the reservation that it shall limit the right and use substitute decision making with safeguards as follows:

Australia recognizes that persons with disability enjoy legal capacity on an equal basis with others in all aspects of life. Australia declares its understanding that the Convention allows for fully supported or substituted decision-making arrangements, which provide for decisions to be made on behalf of a person, only where such arrangements are necessary, as a last resort and subject to safeguards; Australia recognizes that every person with disability has a right to respect for his or her physical and mental integrity on an equal basis with others. Australia further declares its understanding that the Convention allows for compulsory assistance or treatment of persons, including measures taken for the treatment of mental disability, where such treatment is necessary, as a last resort and subject to safeguards.⁹⁵⁶

Canada also made parallel declarations and reservation as follows:

⁹⁵⁵ See, Melvyn Freeman & Graham Thornicroft 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*, *Supra* note 106, p. 845.

⁹⁵⁶ See, United Nations Treaty Collection Database, *Convention on the Rights of Persons With Disabilities* (2008). Available at: https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=iv-15&chapter=4&lang=en.

Canada recognises that persons with disabilities are presumed to have legal capacity on an equal basis with others in all aspects of their lives. Canada declares its understanding that Article 12 permits supported and substitute decision-making arrangements in appropriate circumstances and in accordance with the law. To the extent Article 12 may be interpreted as requiring the elimination of all substitute decision-making arrangements, Canada reserves the right to continue their use in appropriate circumstances and subject to appropriate and effective safeguards. With respect to Article 12 (4), Canada reserves the right not to subject all such measures to regular review by an independent authority, where such measures are already subject to review or appeal.⁹⁵⁷

While Estonia and Poland provided short declaration to the effect that:

The Republic of Estonia interprets article 12 of the Convention as it does not forbid restricting a person's active legal capacity, when such need arises from the person's ability to understand and direct his or her actions. In restricting the rights of the persons with restricted active legal capacity the Republic of Estonia acts according to its domestic laws.⁹⁵⁸

And that,

The Republic of Poland declares that it will interpret Article 12 of the Convention in a way allowing the application of the incapacitation, in the circumstances and in the manner set forth in the domestic law, as a measure indicated in Article 12.4, when a person suffering from a mental illness, mental disability or other mental disorder is unable to control his or her conduct.⁹⁵⁹

Comparable to the aforementioned States, Norway provided analogous declarations and even went forth to comment on article 14 the right to liberty and 25 right to health as they relate to compulsory treatment maintaining their position as follows:

Article 12- Norway recognizes that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life. Norway also recognizes its obligations to take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity. Furthermore, Norway declares its understanding that the Convention allows for the withdrawal of legal capacity or support in exercising legal capacity, and/or compulsory guardianship, in cases where such measures are necessary, as a last resort and subject to safeguards.

Articles 14 and 25- Norway recognises that all persons with disabilities enjoy the right to liberty and security of person, and a right to respect for physical and mental integrity on an equal basis with others. Furthermore, Norway declares its understanding that the Convention allows for compulsory care or treatment of persons, including measures to treat mental illnesses, when circumstances render treatment of this kind necessary as a last resort, and the treatment is subject to legal safeguards.⁹⁶⁰

⁹⁵⁷ See, Ibid.

⁹⁵⁸ See, Ibid.

⁹⁵⁹ See, Ibid.

⁹⁶⁰ See, Ibid.

These declarations need no further explanation or analysis as they are very self-explanatory as far as State Parties' position and their implementation of the CRPD is concerned. In addition to the declarations, some State Parties contributed comments to the formulation of General Comment 1 and from their comments they never dithered from their initially made declaratory and reserved positions. Comparable to the scholars previously discussed, States strongly expressed their concern on Committees formulation of the General Comment which was in essence in disregard of their policies and practice. For instance Norway points out to the impractical nature of the CRPD interpretation by claiming that:

The Committee does not mention or discuss the situation where an individual is unable to express his or her wishes or preferences at all, regardless of the level of assistance given. In such cases, the support needed will necessarily imply making decisions on behalf of the person concerned. In our opinion, in such cases it is preferable that the legislation acknowledges that decisions are made on behalf of the person concerned, and provides legal safeguards to ensure that this competence is not abused. When it would necessarily be a fiction to maintain that the disabled person is the one making decisions, not acknowledging this would entail the obvious risk that the person who is "assisting" in the decision-making process is in reality expressing his or her own will and preferences, and not those of the disabled person.⁹⁶¹

The interesting issue emerging from the States viewpoints is that they are aware of the risks and vulnerability of compulsory treatment and as described are taking responsibility to ensure that further rights are not abused through advocating for safeguards. They acknowledge that "mental health services should as far as possible be based on voluntary consent and that it should be a goal for the national health care services to minimize the use of compulsory care and treatment to the extent which is absolutely necessary."⁹⁶² At the same time they are candid that "compulsory care and treatment may be appropriate when this is necessary in the individual case, for instance when persons are incapable of making decisions about their treatment and/or present a serious risk of harm

⁹⁶¹ See, Norwegian Government, Draft General Comment No. 1 on Article 12 of the Convention on the Rights of Persons with Disabilities. Available at: <http://www.ohchr.org/EN/HRBodies/CRPD/Pages/DGCArticles12And9.aspx>.

⁹⁶² See, Ibid.

to themselves or other people, and when no less intrusive means are likely to be effective.”⁹⁶³ Furthermore, they agreeably emphasize that “the decision to submit a person to compulsory care or treatment should be subject to strict legal safeguards, and the patient should have access to review of the decision by an impartial body. Compulsory care and treatment which meets these criteria cannot be considered unlawful or arbitrary deprivation of liberty under Article 14 of the Convention.”⁹⁶⁴ In essence they are stating the thesis objective of combating arbitrariness.

In continuance to the above, Denmark in its response to the General Comment looked at other international human rights instruments such as the MI Principles and interpretations of the ICCPR and found that it is permissible to limit the right to autonomy when imperatively necessary. They therefore urged the Committee to consider certain aspects of the then draft before issuing the current definitive General Comment on article 12 by postulating that:

Above all, the general comment should take into account that there will be individuals, such as those who are unconscious, who are living in a persistent vegetative state, have very advanced dementia, or have the most profound intellectual disabilities, who will not be in a position to understand that there is a decision to be made, the nature of that decision, or the consequence of any apparently expressed will or preference. If substitute care and treatment decisions are not made for these individuals, they will run the risk of being exploited, neglected, or even left to die. To assume that no one would ever require someone else to make a decision on their behalf would against this background not only be flagrantly wrong but ultimately irresponsible.⁹⁶⁵

New Zealand held the same concerns and even implored the Committee to diligently look into the issue of substitute decision making by claiming that they:

Consider the draft comment requires more clarification regarding when substitute decision making should be used where a person is unable to demonstrate any clear will or preference (most clearly when a person is unable to use any form of verbal or non-verbal communication). Without diminishing the intent of Article 12, it is conceivable that effective supports in this context will be indistinguishable from substitute decision making. We encourage the Committee to consider how the autonomy and dignity interests of any person in such a cir-

⁹⁶³ See, *Ibid.*

⁹⁶⁴ See, *Ibid.*

⁹⁶⁵ See, Danish Government, Draft General Comment No. 1 on Article 12 of the Convention on the Rights of Persons with Disabilities. Available at: <http://www.ohchr.org/EN/HRBodies/CRPD/Pages/DGCArticles12And9.aspx>.

cumstance may best be safeguarded in those exceptional circumstances where substitute decision making is unavoidable.⁹⁶⁶

As it is New Zealand in seeking more clarification did not oppose the CRPD approach on support decision making mechanisms because they expressed the need of “maintaining a supported decision making system that comprises various support options which gives primacy to a person’s will and preferences and respect for human rights norms.”⁹⁶⁷ However, the clarifications were important to gauge their policies because they still acquiesced to the use of substituted decision making in certain respects by claiming that they “viewed supported decision making as encompassing a diversity of approaches, including informal natural supports used by anyone in everyday decisions (such as family and friends) to more formalized supports for significant decisions.”⁹⁶⁸ For protection purposes, they equally accentuated on the role of safeguards claiming that it is vital that safeguards are included in substituted making based mechanisms to ensure protection. Furthermore, they noted that they encourage support decision making advocated by the CRPD committee, but there lacked safeguards “to ensure that the voice of the person using supports to express their will and preference is not distorted, neglected or abused by others in the person’s life.”⁹⁶⁹ In this regard “New Zealand acknowledged that such safeguards are not inherently present in its systems and must be developed.”⁹⁷⁰

Germany as well contributed to the drafting of the general comment and was candid enough to point out that they “do not share the Committees basic assumption of Art. 12 of the Convention affords unlimited capacity to exercise legal rights and duties to all persons with disabilities”, and “do not find it appropriate to label national legislation designed for the protection of such persons

⁹⁶⁶ See, New Zealand Submission on Draft General Comment on Article 12: Equal Recognition Before the Law (11 March 2014). p. 2. Available at: <http://www.ohchr.org/EN/HRBodies/CRPD/Pages/DGCArticles12And9.aspx>.

⁹⁶⁷ See, Ibid.

⁹⁶⁸ See, Ibid.

⁹⁶⁹ See, Ibid, p.2&3.

⁹⁷⁰ See, Ibid.

as “discriminatory” as put forth by the CRPD committee in the Draft general comment and current general comment.⁹⁷¹ Alike the other jurisdictions they shared the view of having both systems of decision making by postulating in the following excerpt that:

While sharing the view that the provision of support for persons with disabilities is the best possible way to help them exercise their rights, Germany remains convinced that there are situations in which persons with disabilities simply are not able to make decisions even with the best support available. Therefore, while representing a shift in focus from substitute decision making to supported decision-making, the Convention could not and in Germany’s view does not rule out the possibility of substitute decision-making in some cases. Most State Parties acknowledge in their legal systems the right of parents or legal guardians to represent children without distinction as to the existence of a disability. Where adults are in need of support, such support may be given by ordering legal representation or guardianship, also without distinction regarding the existence of a disability. All forms of representation or guardianship exist for the benefit of the supported person and may only be used according to the will and preferences or the best interests of the persons concerned.⁹⁷²

It is apparent from above that there are divergent understanding on the application of the principle of consent and capacity and mechanisms of implementation. But what is distinct is that State Parties legal practice indicates the right to informed consent is not absolute and can be limited when practically necessary. It is also ostensible that State Parties are not differential to the notion of implementing support decision making mechanisms, but support a mixture of both. Correspondingly, they all emphasize on the availability and use of safeguards in both supported and substituted decision making to ensure the protection of rights and curb abuse when consent is limited and when these mechanisms of support are being implemented.

The thesis in retrospect extends that the CRPD Committee should have at least deliberated more on the opinions of the State parties and provided a reasonable implementable article 12 interpretation rather than the current one which State Parties seem to naturally ignore. Germany response general-

⁹⁷¹ See, Federal Republic of Germany, German Statement on the Draft General Comment on Article 12 CRPD (20th February 2014).p. 1& 2.

Available at: <http://www.ohchr.org/Documents/HRBodies/CRPD/GC/FederalRepublicOfGermanyArt12.pdf>.

⁹⁷² See, Ibid, p. 2.

ly sums it up that “it seems therefore that the Committee’s interpretation is not shared by the State Parties in general; not even by a substantial minority. Germany doubts that it is appropriate to call an understanding of Article 12 common to the States Parties a “misunderstanding”.⁹⁷³ In hindsight too, the thesis contemplates that the Committee should have stressed more on issues of abuse and arbitrariness and provided more guidelines as it relates to individuals with mental disability and the connecting rights article 12, 14 and 25 respectively. It however did not and fortuitously giving this thesis a chance to explore the issue. Accordingly, it is within these circumstances that this chapter and in the following part discusses various approaches being used in the relevant research jurisdictions to promote the rights of autonomy and protect the right to autonomy when restrained in regards to individuals receiving mental health care and treatment.

3.3. Jurisdictional Perspective: (UK, Canada-Ontario, South Africa & Ghana)

3.3.1. England & Wales (UK)

3.3.1.1. Introduction: Statutory Background

The legislative scheme regulating consent, capacity and civil commitment in the UK include the UKMCA and UKMHA as amended as introduced in the second chapter under the UK discussion.⁹⁷⁴ The UKMHA regulates compulsory admission for treatment for mental disorder under section 3 which may also encompass patients who may transition from compulsory admission from assessment to treatment. As such consent to treatment is not required in this section but “the Code of Practice establishes a clear expectation that, from the start of any treatment, consent will be sought and the patient’s capacity to give consent considered, even though the Act provides powers to treat without consent”.⁹⁷⁵ Furthermore, even though the UKMHA regulates detention and com-

⁹⁷³ See, Ibid, p.1.

⁹⁷⁴ See, UKMHA (1993) as amended.

⁹⁷⁵ See, Care Quality Commission, Monitoring the Mental Health Act in 2012/2013, Supra note, 478, p.54. See also, UK Department of Health, Mental health Act 1983: Code of Practice, Supra note 457.

pulsory treatment, there are some cases under the Act where consent from the individual or prescribed certified form from SOAD or representative is a requirement.⁹⁷⁶ For example, “any surgical operation for destroying brain tissue or for destroying the functioning of brain tissue”, the administration of electro-convulsive therapy and others as shall be regulated by the Secretary of State.⁹⁷⁷

The UKMCA 2005 as amended by the UKMCA 2007 also mentioned covers “England and Wales, provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they may lack capacity in the future.”⁹⁷⁸ As it is the Act applies to every individual at any one time and “places a strong emphasis on the need to support individuals to make their own decisions.”⁹⁷⁹ It facilitates the exercise of this support through demanding that relevant “information [for example on treatments] is explained in a manner best suited to the individual to aid the individual’s understanding, [together with] all individuals [being] encouraged to participate in decision making and professionals carefully consider[ing] the individual’s wishes at all times.”⁹⁸⁰

This Act lays down key principles that must be respected in the operationalization of the Act that include that:

- (a) A person must be assumed to have capacity unless it is established that he lacks capacity
- (b) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
- (c) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
- (d) An act done or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.

⁹⁷⁶ See, UKMHA (1983) as amended, s. 56

⁹⁷⁷ See, Ibid, s. 56, 57, 58 & 58A.

⁹⁷⁸ See, UK Department for Constitutional Affairs, Mental Capacity Act 2005: Code of Practice, Supra note 461, p. 1.

⁹⁷⁹ See, UK Department of Health, Mental health Act 1983: Code of Practice, Supra note 457, p. 98, para 13.10.

⁹⁸⁰ See, Ibid. See also, UK Department for Constitutional Affairs, Mental Capacity Act 2005: Code of Practice, Supra note 461, p. 1.

(e)Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.⁹⁸¹

These principles apply even to those subjected to the UKMHA. The relevant question then is how do these two Acts merge to afford protection to persons with mental disability? The connection between these two legislations is situated in the issues relating to capacity, consent and deprivation of liberty. The amended UKMCA 2007 introduced Deprivation of Liberty Safeguards (also Known as DoLs) and codified rules of common law on consent that “are essential to enable decision-makers to fulfil their legal responsibilities and to safeguard their patients’ rights under the European Convention on Human Rights (ECHR)” [refer to the Bournemouth case in chapter two].⁹⁸² It is also situated in the purpose of the UKMCA “to empowers individuals to make their own decisions where possible and protects the rights of those who lack capacity” through set out standards and safeguards in situations “when carers, healthcare and social care staff will need to make decisions on behalf of individuals who lack capacity to make particular decisions themselves (including decisions that relate to care and/or treatment for mental and/or physical conditions).”⁹⁸³ This legislation compares to the Ontario Health Care and Consent Act that regulates capacity and consent issues relating to treatment and care in long term facilities. It is also comparable because they all have codified the common law principles of consent to treatment either individually or through substitute decision makers.

For the reasons above, the UKMCA can be engaged to administer mental health care for mental disorder where the relevant individual lacks the competence to make the decision in question and that such care or treatment is in that individuals best interest provided that it is not treatment regu-

⁹⁸¹ See, UKMCA (2005) as amended.

⁹⁸² See, UK Department of Health, Mental health Act 1983: Code of Practice, Supra note 457, p. 96, para 13.1. See also, UK Department for Constitutional Affairs, Mental Capacity Act 2005: Code of Practice, Supra note 461, p. 16, para 1.6.

⁹⁸³ See, Ibid, p. 97 &101, para 13.9 & 13.30(UKMHA Code). See also, Ibid, p. 15, para 1.1-1.5 (UKMCA Code).

lated under part 4 of the Act (consent on special treatments such as electro convulsive therapy).⁹⁸⁴

In this regard, practitioners and professionals in psychiatric facilities and hospitals are required according to the codes of practice to be able to use the UKMCA as a preliminary starting point for individuals who lack capacity and also be able to properly ascertain “whether they could achieve their aims safely and effectively by using the MCA [DoLs] instead of [MHA]”⁹⁸⁵

DOLS “deprivation of liberty safeguards were introduced as part of Mental Health Act 2007 and amendments to the UKMCA to provide a legal framework when the deprivation of liberty involved adults lacking capacity in hospitals, care homes, and other settings”.⁹⁸⁶ The DoLs mandates that the right to liberty for the individuals lacking capacity can only be limited other than in care homes or hospitals pursuant to a court order- ‘standard authorization’.⁹⁸⁷ The UKMHA Code of practice guides that when determining “whether to apply for a DoLS authorization, decision-makers should first assess the capacity of the person to consent to the arrangements for their care or treatment, in accordance with the MCA”.⁹⁸⁸ In addition they should try and find a least restrictive and intrusive method and in this case, the Code advises that the next step after assessment of capacity is to evaluate “whether the circumstances of the proposed accommodation and treatment amount (or are likely to amount) to a deprivation of liberty [emphasis] at this stage [being] whether the patient’s care plan can be amended to avoid any potential deprivation of liberty.”⁹⁸⁹ Nevertheless, written time specified DoLs may be given by a supervisory body such as a local authority following a request

⁹⁸⁴ See, Ibid.

⁹⁸⁵ See, Ibid, p. 96 &98, para 13.2 &13.11(UKMHA Code). See also, Ibid, p. 226 (UKMCA Code).

⁹⁸⁶ See, UKMCA as amended Schedule A1, part 1 (1). See also, Peter Bartlet, Reforming the Deprivation of Liberty Safeguards (DOLS): What Is It Exactly that We Want? 20 European Journal of Current Legal Issues, Open Journal Systems 1 (2014).

⁹⁸⁷ See, Ibid, schedule A1, part 1.

⁹⁸⁸ See, UK Department of Health, Mental health Act 1983: Code of Practice, Supra note 457, p. 103, para 13.42.

⁹⁸⁹ See, Ibid, p. 103, para 13.43.

from a managing authority which includes hospital or care home at which the relevant individual is placed or likely to be placed,⁹⁹⁰ if the following set qualifying criteria's are met:

- (a) the age requirement- [individual must be 18 years of age and above]⁹⁹¹
- (b) the mental health requirement- [whether the individual has a mental disorder defined by the UKMHA]⁹⁹²
- (c) the mental capacity requirement- [whether the relevant individual lacks capacity to determine whether or not to be assisted in the care home or hospital specified at the relevant time].⁹⁹³
- (d) the best interests requirement- [whether it is in the best interest to restrict the relevant individuals right to liberty?, or necessary to restrain in order to prevent harm to themselves? Or/ and whether deprivation of liberty is a proportionate consequence to the likelihood of the relevant Individual suffering harm and the seriousness of that harm].⁹⁹⁴
- (e) the eligibility requirement- [whether relevant individual meets the qualifying requirements under the UKMCA) Schedule 1A.]⁹⁹⁵
- (f) the no refusals requirement- [whether the relevant individual has made a legally binding advance decision to refuse partial or full treatment in question or a binding and conflicting decision by donee or deputy? If there is then the qualifying criteria for DoLs may not be met.]⁹⁹⁶

It is important to note that detention can be effected through both DoLs and UKMHA if the relevant individual suffers from a mental disorder within the meaning of the UKMHA, has to be assessed or /and treated in a hospital for the mental disorder or physical condition related to the disorder as laid down in section 2 and 3 of the UKMHA, the treatment and care plan may or will amount to a deprivation of liberty, lacks capacity to consent to be admitted for the relevant care and

⁹⁹⁰ See, UKMCA (2005) as amended, Schedule A1, part 4, s. 21-73.

⁹⁹¹ See, Ibid, Schedule A1, part 3.s.13.

⁹⁹² See, Ibid, Schedule A1, part 3.s.14.

⁹⁹³ See, Ibid, Schedule A1, part 3.s.15.

⁹⁹⁴ See, Ibid, Schedule A1, part 3.s.16 that states: (1) The relevant person meets the best interests requirement if all of the following conditions are met. (2)The first condition is that the relevant person is, or is to be, a detained resident. (3)The second condition is that it is in the best interests of the relevant person for him to be a detained resident. (4)The third condition is that, in order to prevent harm to the relevant person, it is necessary for him to be a detained resident. (5)The fourth condition is that it is a proportionate response to— (a) the likelihood of the relevant person suffering harm, and (b) the seriousness of that harm, for him to be a detained resident.”

⁹⁹⁵ See, Ibid, Schedule A1, part 3.s.17.

⁹⁹⁶ See, Ibid, Schedule A1, part 3.s.18, 19 & 20 that states: “(18) The relevant person meets the no refusals requirement unless there is a refusal within the meaning of paragraph 19 or 20. 19(1) There is a refusal if these conditions are met— (a) the relevant person has made an advance decision; (b) the advance decision is valid ;(c) the advance decision is applicable to some or all of the relevant treatment. (2)Expressions used in this paragraph and any of sections 24, 25 or 26 have the same meaning in this paragraph as in that section. 20(1) There is a refusal if it would be in conflict with a valid decision of a donee or deputy for the relevant person to be accommodated in the relevant hospital or care home for the purpose of receiving some or all of the relevant care or treatment— (a) in circumstances which amount to deprivation of the person's liberty, or (b)at all. (2)A donee is a donee of a lasting power of attorney granted by the relevant person. (3)A decision of a donee or deputy is valid if it is made— (a) within the scope of his authority as donee or deputy, and (b) in accordance with Part 1 of this Act.”

does not oppose the admission and treatment plan in partial or whole for the mental disorder.⁹⁹⁷

However, practitioners do not have the luxury of picking one Act over the other.

This caution was given in the ruling in *GJ v The Foundation Trust & Anor [2009]* a borderline case where the applicant incapacitated suffering from physical and mental illness, unable to consent was subjected to both standard authorization under UKMCA and to section 2 and 3 UKMHA as his status changed over time.⁹⁹⁸ The Judge in responding to the query as to which Statute took precedence in offering care and treatment through the means of deprivation of liberty pointed out that “this is a borderline case and it provides an excellent example of the point that experienced doctors can take different views on relevant issues and that the position of someone like GJ when in hospital evolves and changes from time to time.”⁹⁹⁹ On which regime took precedence he conclusively emphasized that:

in his view this does not mean that the two regimes are necessarily always mutually exclusive. But it does mean, as mentioned earlier, that it is not lawful for the medical practitioners referred to in ss. 2 and 3 of the MHA 1983, decision makers under the MCA, treating doctors, social workers or anyone else to proceed on the basis that they can pick and choose between the two statutory regimes as they think fit having regard to general considerations (e.g. the preservation or promotion of a therapeutic relationship with P) that they consider render one regime preferable to the other in the circumstances of the given case.¹⁰⁰⁰

Over all, it is appropriate that only one appropriate Act is used at a time because it effectively imposes a restriction on practitioners from haphazardly preferring one regime useful for avoiding risk of arbitrary detentions.¹⁰⁰¹ In order to avoid regime preferences, the UKMCA as amended section 12 provides clear direction when an individual is or should be “within the scope of Mental Health

⁹⁹⁷ See, UK Department of Health, Mental health Act 1983: Code of Practice, Supra note 457, p. 105, para 13.49.

⁹⁹⁸ See, *GJ v The Foundation Trust & Anor [2009]*, Supra note 464.

⁹⁹⁹ See, *Ibid*, para 126.

¹⁰⁰⁰ See, *Ibid*, para 45&59.

¹⁰⁰¹ See, UK Department of Health, Mental health Act 1983: Code of Practice, Supra note 457, p. 107, and para 13.57 & 13.58.

Act”.¹⁰⁰²In addition to the above and going back to the UKMCA as amended, section 17 makes it easy to determine individuals who are ineligible to be deprived of liberty under the Act by providing a table of directions.¹⁰⁰³These individuals or situations are simply illustrated in the UKMCA code of practice that directs practitioners ought to consider using the UKMHA to detain and treat an individual who lacks capacity to consent rather than the UKMCA if:

- (a) It is not possible to give the person the care or treatment they need without doing something that might deprive them of their liberty
- (b) the person needs treatment that cannot be given under the MCA (for example, because the person has made a valid and applicable advance decision to refuse an essential part of treatment)
- (c) the person may need to be restrained in a way that is not allowed under the MCA.
- (d) it is not possible to assess or treat the person safely or effectively without treatment being compulsory (perhaps because the person is expected to regain capacity to consent, but might then refuse to give consent)
- (e) the person lacks capacity to decide on some elements of the treatment but has capacity to refuse a vital part of it – and they have done so, or
- (f) there is some other reason why the person might not get treatment, and they or somebody else might suffer harm as a result.¹⁰⁰⁴

Similar directions are given in the UKMHA code of practice including the footnoted self-explanatory group of Individuals who are ineligible¹⁰⁰⁵

¹⁰⁰² See, UKMCA (2005) as amended, Schedule A1 part 1, s. 12. It states that: “12(1)P is within the scope of the Mental Health Act if—(a)an application in respect of P could be made under section 2 or 3 of the Mental Health Act, and(b)P could be detained in a hospital in pursuance of such an application, were one made.(2)The following provisions of this paragraph apply when determining whether an application in respect of P could be made under section 2 or 3 of the Mental Health Act.(3)If the grounds in section 2(2) of the Mental Health Act are met in P's case, it is to be assumed that the recommendations referred to in section 2(3) of that Act have been given.(4)If the grounds in section 3(2) of the Mental Health Act are met in P's case, it is to be assumed that the recommendations referred to in section 3(3) of that Act have been given. (5)In determining whether the ground in section 3(2)(c) of the Mental Health Act is met in P's case, it is to be assumed that the treatment referred to in section 3(2)(c) cannot be provided under this Act.”

¹⁰⁰³ See, *Ibid*, Schedule A1 part 1, s.17 (2).

¹⁰⁰⁴ See, UK Department for Constitutional Affairs, *Mental Capacity Act 2005: Code of Practice*, *Supra* note 461, p. 225 &226. See also, UK Department of Health, *Mental health Act 1983: Code of Practice*, *Supra* note 457, p. 105, para 13.49.S

¹⁰⁰⁵ See, UK Department of Health, *Mental health Act 1983: Code of Practice*, *Supra* note 457, p. 107, para 13.56. It states that: (a) those persons detained in a hospital under sections 2, 3, 4, 35 – 38, 44, 45A, 47, 48 or 51 of the Act (b) those persons liable to be detained under one of the above mentioned sections of the Act but who are not detained in a hospital under that regime; AND (i) proposed care and treatment in a hospital or care home would conflict with a requirement imposed on them in connection with their liability to detention under the Act (eg as a condition of a leave of absence) OR (ii) the relevant care and treatment consists in whole or in part of treatment for mental disorder in a hospital (c) those persons on a community treatment order (CTO) under the Act AND (i) proposed care and treatment in a hospital or care home would conflict with a condition of their CTO OR (ii) the relevant care and treatment consists in whole or in part of treatment for mental disorder in a hospital (d) those persons subject to guardianship under the Act AND (i) proposed detention or care and treatment would conflict with a requirement imposed on them by the guardian-

3.3.1.2. Capacity & Civil Commitment.

The Mental Capacity Act emphasizes the position in “English law that presumes that, in the absence of evidence to the contrary, adult patients are capable of giving or withholding consent to treatment.”¹⁰⁰⁶ Case law such as *MB, Re [1997]* emphasizes and develops this presumption by claiming from the very outset that “in general it is a criminal and tortious assault to perform physically invasive medical treatment, however minimal the invasion might be, without the patient’s consent [and in this regard], a mentally competent patient has an absolute right to refuse to consent to medical treatment for any reason, rational or irrational, or for no reason at all, even where that decision may lead to his or her own death.”¹⁰⁰⁷ In this sense, “it presumes capacity, rationality, and autonomy of freedom” strongly emphasized by the CRPD.¹⁰⁰⁸

However, contrary to the CRPD, the law also recognizes that in certain circumstances “where there is reason to believe that a patient is unable to understand the decision that they are being asked to make, it is necessary to consider whether an adult presumption of capacity is rebutted in the particular case.”¹⁰⁰⁹ Case law on the issue correspondingly maintains that this presumption is rebuttable and therefore “every person is presumed to have the capacity to consent to or to refuse medical treatment unless and until that presumption is rebutted.”¹⁰¹⁰ This means that sometimes treatment can be administered without consent and in addition, “medical treatment can be undertaken in an emergency even if, through a lack of capacity, no consent had been competently given, provided

ship regime (eg a requirement that they should reside elsewhere) OR (ii) it is proposed that the person will be detained in a hospital for treatment for mental disorder and they object, or are likely to object (and the person’s attorney or deputy has not consented), and (e) those persons who would meet the criteria for being detained under section 2 or 3 of the Act, but who is not liable to be detained under sections 4, 35–38, 44, 45A, 47, 48 or 51 or subject to a CTO or guardianship, AND it is proposed that the person will be detained in a hospital for treatment for mental disorder, AND the person objects to being accommodated in hospital for that treatment, or to being given some or all of that treatment (and the person’s attorney or deputy has not consented where the person objects).

¹⁰⁰⁶ See, Jean McHale & Marie Fox (ed.), *Health Care Law: Text and Materials*, Supra note 611, p. 295.

¹⁰⁰⁷ See, *MB, Re [1997]* EWCA Civ 3093, para 17.

¹⁰⁰⁸ See, Jean McHale & Marie Fox (ed.), *Health Care Law: Text and Materials*, Supra note 611, p. 295.

¹⁰⁰⁹ See, *Ibid.*

¹⁰¹⁰ See, *MB, Re [1997]*, Supra note 1006.

the treatment was a necessity and did no more than was reasonably required in the best interests of the patient”¹⁰¹¹ To ascertain capacity, English jurisprudence provides that “ the test of capacity applied for this purpose was laid down by the Court of Appeal in the *Re MB (Medical Treatment)* , that:

'A person lacks capacity if some impairment or disturbance of mental functioning renders the person unable to make a decision whether to consent to or refuse treatment. The inability to make a decision will occur when:

(a) the patient is unable to comprehend and retain the information which is material to the decision, especially as to the likely consequences of having or not having the treatment in question;

(b) the patient is unable to use the information and weigh it in the balance as part of the process of arriving at a decision . . .¹⁰¹²

The above criterion as shall be seen later on is reflected as well in the Ontario statutory framework and jurisprudence. the UKMCA as amended incorporates this jurisprudential principles and contrary to the CRPD uses a medical model of disability to define lack of capacity when referenced to a person to mean “a person lacks capacity in relation to a matter if, at the material time, the person is unable to make a decision for themselves in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain”¹⁰¹³ According to the Act, it does not matter whether it is temporary or permanent. What is of significance is that two tests, ‘ diagnostics and functional tests’ emanating from the definition above must be conducted and affirmed before an individual is adjudged to lack competence to make decisions. According to the UKMHA Code of practice, “the diagnostic test determines whether the individual has an impairment of, or a disturbance in the functioning of, the mind or brain” while the functional test determines whether the indi-

¹⁰¹¹ See, *Ibid.*

¹⁰¹² See, *Wilkinson, R (on the application of) v Broadmoor Hospital, Responsible Medical Officer & Ors [2001] EWCA Civ 1545, para 65.* See also: *MB, Re [1997] Supra note 1006, para 30 & B, R (on the application of) v SS (Responsible Medical Officer) & Ors [2006] EWCA Civ 28, para 33.*

¹⁰¹³ See, UKMCA (2005) as amended, s.2 (1).

vidual is unable to make the specific decision in question themselves because of the impairment or disturbance.”¹⁰¹⁴

To facilitate these tests the following requirements under section 2 of the UKMCA must be observed. These requirements provide that “a lack of capacity cannot be established merely by reference to (a) persons age or appearance or a condition (b) a condition of his, or an aspect of his behavior, which might lead others to make unjustified assumptions about his capacity.”¹⁰¹⁵ In addition, the elements of the functional test provided in section 3(1) are to be fulfilled in the assessment of capacity.¹⁰¹⁶ The section sets out expanded yet similar requirements as those laid in the case law already mentioned as follows:

For the purposes of section 2, a person is unable to make a decision for himself if he is unable—

- (a) to understand the information relevant to the decision,
- (b) to retain that information,
- (c) to use or weigh that information as part of the process of making the decision, or
- (d) to communicate his decision (whether by talking, using sign language or any other means).¹⁰¹⁷

It should be noted from the foregoing that lack of capacity cannot and should not be construed merely because the relevant individual “is able to understand an explanation of it given to him in a way that is appropriate to his circumstances (using simple language, visual aids or any other means)” or “the fact that a person is able to retain the information relevant to a decision for a short period of time”¹⁰¹⁸ It is thus very important that those involved in assessing or providing care are not overly restrictive and controlling but assist and patiently support the relevant individual to

¹⁰¹⁴ See, UK Department of Health, Mental health Act 1983: Code of Practice, Supra note 457, p. 99, para 13.18 & 13.19.

¹⁰¹⁵ See, UKMCA (2005) as amended, s.2

¹⁰¹⁶ See, UK Department of Health, Mental health Act 1983: Code of Practice, Supra note 457, p. 99, para 13.18 & 13.19.

¹⁰¹⁷ See, UKMCA (2005) as amended, s. 3

¹⁰¹⁸ See, UKMCA (2005) as amended, s. 3(2&3).

understand the relevant information in order to make self-choices.¹⁰¹⁹ All the same the legislation provides test upon which capacity can be determined by stating that “any question whether a person lacks capacity within the meaning of this Act must be decided on the balance of ties.”¹⁰²⁰ Furthermore, the best interest of the individual must be taken into account.¹⁰²¹ This brings up the CRPD Committee on article 12 prohibition on the use of best interest determinations and supports ‘wills and preferences of the person’ without defining what it actually entails. The UKMCA also does not define what best interest means, but it is stated that “the underlying philosophy of the Act is to ensure that any decision made, or action taken, on behalf of someone who lacks the capacity to make the decision or act for themselves is made in their best interests”.¹⁰²² Similar best interest considerations appear in the Ontario legislation. The difference however is that the individuals to take best interest are substitute decision makers and not the health professionals who make incapacity findings.

In order to do the above, the legislation sets out certain determinants to be fulfilled that amount to best interest considerations. Hence, besides, age, personal appearance, condition or behavior at the time of making incapacity finding, it must be considered whether the individual may at a certain time in regards to the matter in question is able to have capacity to make the relevant decision, where reasonably practical, the individual must be allowed and encouraged to participate in the decision making process, consideration must be taken to ascertain past, present and past wishes of the individual including consulting any person engaged in the care of the individual, any done with

¹⁰¹⁹ See, *Ibid*, p. 15, para 1.3.

¹⁰²⁰ See, UKMCA (2005) as amended, s. 2(4).

¹⁰²¹ See, *Ibid*, s. 4.

¹⁰²² See, UK Department for Constitutional Affairs, *Mental Capacity Act 2005: Code of Practice*, *Supra* note 461, p. 15, para 1.3.

lasting power of attorney, any deputy appointed by court and other relevant consideration that concerns the relevant individual and his or her circumstances at the time in question.¹⁰²³

To sum up therefore, in assessing capacity, the first thing is that there is a presumption of capacity and if uncertain both diagnostic and functional tests must be performed on a balance of probabilities with due regard to best interest of the relevant individual before finalizing that at the material time the relevant individual lacked capacity to make specific decision was “because of the impairment or disturbance, as opposed to some other cause.”¹⁰²⁴ In determining and making capacity determinations those making decisions must have the best interest of the individual concerned. Where one has capacity, then they can consent to the relevant treatment, but those incapable, as per the law, consent can be given through advance decisions, power of attorney or court or family. Notice here that under the UKMHA in certain situations treatment may be given without consent (discussed below) and certain treatments may not be given without consent¹⁰²⁵. It can be assumed that determination of capacity does not arise in compulsory detention and treatment under section 3. The subsequent looks at consent.

3.3.1.3. Consent & Civil Commitment

From the discussion afore, it is evident that an individual seeking mental health care must be accorded the presumption that he or she has the capacity to make self-decisions about his or her treatment. Having capacity that is the ability to comprehend the proposed mental treatment and its consequences is the foundation upon which consent to treatment by the relevant individual can be truly valid. This means therefore that in order to have a valid or real consent the patient must be

¹⁰²³ See, UKMCA (2005) as amended, s. 4.

¹⁰²⁴ See, UK Department of Health, Mental Health Act 1983: Code of Practice, Supra note 457, p. 99, para 13.19.

¹⁰²⁵ See, UKMCA (2005 as amended, s. 28.

given all the relevant information pertaining to the treatment in question through a method that the individual can understand or through family, personal representatives or personal care. This places obligation to properly inform upon practitioners,¹⁰²⁶ for the failure to provide information may result in a claim of civil wrong in which a claim of negligence maybe instituted and/or breach of the right to information given under the UKHRA.¹⁰²⁷

The UKMHA Code of Practice further emphasizes that “effective communication is essential in ensuring appropriate care and respect for patients’ rights. It is important that the language used is clear and unambiguous and that people giving information check that the information that has been communicated has been understood.”¹⁰²⁸ In this regard, it additionally stipulates that “those responsible for caring for patients should identify any communication difficulties and seek to address them and that the Act requires hospital managers to take steps to ensure that patients who are detained or are the subject of a community treatment order (CTO) understand important information about how the Act applies to them.”¹⁰²⁹ In order to overcome some barriers that may hinder effective communication of the relevant information, it is advised that career of patients, practitioners and hospital managers should where applicable take into account cultural backgrounds, age, religion or disability such as hearing or reading and make an effort to provide appropriate solutions for example skilled interpreters, sign language experts and independent mental health advocates(IMHAs) and other relevant support to aid in communication and understanding of the relevant care and treatment package including the rights of the individual under the Acts.¹⁰³⁰

Further to the above, it is paramount that patients are engaged in the processes of reaching decisions which affect their care and treatment under the Act through consultations that help them un-

¹⁰²⁶ See, *Chatterton V Gerson* (1981) 1 All E. R. 257.

¹⁰²⁷ See, *B, R (on the application of) v SS (Responsible Medical Officer) & Ors* [2006], *Supra* note 1011, para 31.

¹⁰²⁸ See, UK Department of Health, *Mental Health Act 1983: Code of Practice*, *Supra* note 457, p. 36, para 4.2

¹⁰²⁹ See, *Ibid*, p. 36, para 4.2 & 4.3.

¹⁰³⁰ See, *Ibid*, p. 36, para 4.4- 4.8.

derstand the applicable information relevant to decisions and their responsibilities.¹⁰³¹ In situations “where a decision is made that is contrary to the patient’s wishes, that decision and the authority for it should be explained to the patient using a form of communication that the patient understands [as well as] carers and advocates should be involved where the patient wishes or if the patient lacks capacity to understand.¹⁰³² Therefore with the provided relevant information, the concerned patient or individual or substitute decision maker may provide consent to the relevant treatment and care. Hence, consent must be given before treatment or care is given with relevant exceptions where applicable by law. Failure to do so may result not only in criminal and civil suits but also engage the UKHRA, article 3 (prohibition on torture and 8(right to privacy) as held in the case of *B, R (on the application of) v SS (Responsible Medical Officer) & Ors (2006)*.¹⁰³³ In this appeal case, the appellant suffering from a mental disorder was a patient detainee at Broadmoor hospital pursuant to section 31 & 41 of the UKMHA after a rape charge in 1995 and during his hospitalization due to the disorder he was found to lack capacity and compulsorily treatment. The claimants appeal alleged a violation of his UKHRA rights citing section 58 UKMHA was incompatible with the convention.¹⁰³⁴ The court dismissed the appeal after finding that section 58 was not incompatible as it guaranteed compulsory treatment was only given when it was therapeutically necessary and that the “MHA makes lawful further interference with Article 8 rights in permitting treatment without consent”.¹⁰³⁵ In the judgement they made a very important stipulation relating to consent as follows:

English law attaches great importance to the freedom of the individual to decide what should or should not be done by way of physical interference with or invasion of the body. As a general proposition, deliberate physical interference with or invasion of the body of another without that person's consent will constitute a criminal offence and give rise to a claim in tort. Conversely, where there is consent to such conduct, this will normally provide a defence to any allegation of criminal or civil fault. There are exceptions to these general propositions. In particular the law recognises that there are circumstances in which consent, or apparent consent, should not carry the legal significance that normally attaches to it. One

¹⁰³¹ See, Ibid, p. 37, para 4.8.

¹⁰³² See, Ibid.

¹⁰³³ See, *B, R (on the application of) v SS (Responsible Medical Officer) & Ors* [2006] Supra note 1011, para 1-7.

¹⁰³⁴ See, Ibid, para 6.

¹⁰³⁵ See, Ibid, para 46 & 68.

such exception arises where the individual lacks the mental capacity to give the consent in question. In such circumstances neither refusal of consent nor apparent grant of consent will necessarily be the factor that governs the legality of the conduct in question. The legality of the conduct may fall to be determined by other considerations, such as the common law doctrine of necessity [now codified in the UKMCA].¹⁰³⁶

From the afore paragraph, the court made it clear that while consent is paramount under English law, in certain circumstances however consent shall not carry the legal significance that it normally attaches, and such a circumstance is where the individual is incapacitated. The other is when individuals are subjected to the UKMHA, which primarily concerns compulsory detention of patients suffering from mental disorders in order that they may receive treatment and care for those disorders.¹⁰³⁷ This detention that may involve capacitated and incapacitated patients is justified, not contrary to UKHRA rights such as article 5 or 8 since it ensures that they may receive treatment for those disorders, for the good of their health or safety of the individual and protection of others.¹⁰³⁸

In view of the above, the mental health care package offered under the UKMHA section 2 and 3 respectively is that that entails a deprivation of liberty. One character of deprivation of liberty is that of lack of valid consent discussed in the case of **P v Cheshire West & Chester Council (2014)** where it was stated that “the essential character of deprivation of liberty includes (a) the objective component of confinement in a particular restricted place for a not negligible length of time; (b) *the subjective component of lack of valid consent*; and (c) the attribution of responsibility

¹⁰³⁶ See, Ibid, para 31& 68.

¹⁰³⁷ See, Ibid, para 43.

¹⁰³⁸ See, Ibid, para 46. The court in this paragraph stated that: “The MHA makes lawful further interference with Article 8 rights in permitting treatment without consent. As Baroness Hale pointed out in *B v Ashworth*, until 1983 the legislation dealt expressly only with the right to detain for treatment, taking it for granted that it would be lawful compulsorily to treat those detained. Part IV of the MHA now deals expressly with the power compulsorily to treat where that is the object of the detention. A distinction is drawn between the most invasive treatment, which can only be administered with the capacitated consent of the patient (section 57), medical treatment for mental disorder, which requires capacitated consent or the opinions of two medical officers that the treatment should be given having regard to the likelihood that it will alleviate or prevent a deterioration of the patient's condition (section 58) and other medical treatment for the patient's mental condition, which can be administered without consent (section 63).”

to the state.”¹⁰³⁹ This was an appeal case involving the determination of criteria for ascertaining whether the living arrangements (foster care and homes) made for a mentally incapacitated person amount to a deprivation of liberty.¹⁰⁴⁰ The Supreme Court found in the affirmative by applying the “acid test that prompts the key question “whether the person concerned is under continuous supervision and control and is not free to leave.”¹⁰⁴¹ It held that as stipulated under the UKMCA as amended, individuals with mental incapacitation can only be deprived of their liberty through a court order or DOLs procedures and subject to regular independent review.¹⁰⁴²

Having stated the foregoing, mental health care given under compulsory admission for medical treatment stipulated under section 2 and 3 of the UKMHA do not require consent as they are compulsory in nature. Actually Section 63 of the UKMHA expressly directs that “the consent of a patient shall not be required for any medical treatment given to him for the mental disorder from which he is suffering [F1, not being a form of treatment to which section 57, 58 or 58A above applies,] if the treatment is given by or under the direction of the [F2approved clinician in charge of the treatment].”¹⁰⁴³ The words in section 63 have to be construed as they are according to the case of *Regina V Ashworth Hospital Authority (2005)*, an appeal case that determined the question “whether a patient detained for treatment under the Mental Health Act 1983 can be treated against his will for any mental disorder from which he is suffering or only for the particular form of mental disorder from which he is classified as suffering for the purpose of the order or application authorising his detention.”¹⁰⁴⁴ It was concluded that “the natural and ordinary meaning of the words is that

¹⁰³⁹ See, *P v Cheshire West & Chester Council; P & Q v Surrey County Council* [2014], Supra note 466, p.16, para 37.

¹⁰⁴⁰ See, *Ibid.*

¹⁰⁴¹ See, *Ibid.*, p.20, para 49 & p. 21, para 54.

¹⁰⁴² See, *Ibid.*, p.22&23, para 57.

¹⁰⁴³ See, UKMHA (1983) as amended, s.63.

¹⁰⁴⁴ See, *Regina (B) v Ashworth Hospital Authority* [2005] UKHL 20, para 4. See also para, 4-10. This case involved a convicted patient on charges of manslaughter and who suffered from diagnosed as having psychosis and personality disorder. He was put in a psychiatric hospital for treatment according to the UKMHA provisions on detained patients, nevertheless subject to section 3. After proper medical treatment his condition was stabilized and a recommendation made by the Mental Health Review Tribunal upon an application for discharge. A discharge order to a less secure unit

the patient may be treated without consent for any mental disorder from which he is suffering, and any treatment ancillary to that; but treatment for any physical disorder can only be given with his consent or under the doctrine of necessity as it applies to patients who lack the capacity to consent.”¹⁰⁴⁵ Hence a distinction is made between giving consent for the treatment of mental and physical illness. This indicates the limits the law-mental legislation sets to avoid overreaching other aspects of an individual’s life and rights.

Even though consent is not necessary “the Code of Practice establishes a clear expectation that, from the start of any treatment, consent will be sought and the patient’s capacity to give consent considered, even though the Act provides powers to treat without consent”.¹⁰⁴⁶ Moreover, as mentioned in section 63, consent must be sought before certain treatments are administered to an individual with mental disorder. In addition and as shall be discussed later on, advanced made wishes on consent must be respected even though sometimes they may be overridden in order to provide treatment if it is in the best interest of the individual concerned. Therefore, consent must be given by the individual concerned, representative or through second opinion provided by second opinion appointed doctors (SOADS).¹⁰⁴⁷ These forms of medical treatment necessitating consent include “(a) any surgical operation for destroying brain tissue or for destroying the functioning of brain

was delayed as the tribunal concluded he still needed some therapeutic care. The tribunal did not reclassify him to show whether he had mental illness and psychotic disorder. He was accordingly transferred to a ward for patients with psychotic disorder as the hospital believed this ward would be appropriate to address the remaining problems of his personality type. The applicant’s solicitors off course objected to this transfer and made judicial review application to quash the placement decision. It was granted on the basis that it was unlawful placement by the hospital because consent was not provided. The judge held that “the treatment without consent of the claimant for a psychopathic disorder is unlawful unless and until the claimant is classified as suffering from such disorder by the Mental Health Review Tribunal under section 72(5) of the Mental Health Act 1983.” The Hospital conversely appealed against the decision in this appeal which was granted based on the interpretation of section 63 which sanctioned compulsory treatment to mental disorders classified as such in the UKMHA.

¹⁰⁴⁵ See, *Ibid*, para 22 & 29.

¹⁰⁴⁶ See, Care Quality Commission, *Monitoring the Mental Health Act in 2012/2013*, *Supra* note 478, p.54.

¹⁰⁴⁷ See, UKMHA (1983) as amended, s. 56.

tissue; and (b) such other forms of treatment as may be specified for the purposes of this section by regulations made by the Secretary of State”.¹⁰⁴⁸

As expressed above, the law requires that the individual gives personal consent and which must be certified in writing. “This certification must stipulate that the “individual is capable of understanding the nature, purpose and likely side effect of the treatment in question and has consented to it” and must be done by a registered medical practitioner (who is not the person to administer the treatment or responsible clinician) and two other persons appointed for the purpose of this task in this paragraph.¹⁰⁴⁹ In addition, before giving a certificate of consent, the registered medical practitioner is required to “consult two other persons who have been professionally concerned with the patient’s medical treatment- (a) one shall be a nurse and the other shall be neither a nurse nor a registered medical practitioner; and (b) neither shall be the responsible clinician (if there is one) or the person in charge of the treatment in question.]”¹⁰⁵⁰

Besides the aforementioned forms of treatment, another form of medical treatment where consent or second opinion is a guarantee is that of Electro- convulsive therapy for mental disorder and any other “forms of treatment as may be specified for the purpose of this [section 581A] by regulations made by the appropriate national authority”.¹⁰⁵¹ Furthermore, in order to administer this treatment, a patient besides giving consent must be 18 years of age and above or if not must have consented. Similar to the requirements under section 57, certified copy of consent must be granted by registered medical practitioner or approved clinician in charge stating that the individual is “capable of understanding the nature, purpose and likely effects of the treatment and has consented to it”.¹⁰⁵²

¹⁰⁴⁸ See, *Ibid*, s. 57 (1, a&b).

¹⁰⁴⁹ See, UKMHA (1983) as amended, s. 57 (2, a&b).

¹⁰⁵⁰ See, *Ibid*, s. 57 (3, a&b).

¹⁰⁵¹ See, *Ibid*, s. 58A (1, a&b).

¹⁰⁵² See, *Ibid*, s. 58A (3&4)

In cases however where an individual may “not be capable of understanding the nature, purpose and likely effect of the treatment but, that it is appropriate for the treatment to be given; and that giving him the treatment would not conflict with— (i) an advance decision which the registered medical practitioner concerned is satisfied is valid and applicable; or (ii) a decision made by a donee or deputy or by the Court of Protection.”¹⁰⁵³ The registered medical practitioner is supposed to give a certificate of consent after similar consultations as those individuals who have consented provided above. It is important to emphasize that treatment mentioned in section 581A cannot be given to patients mentioned in “section 56(5) if that individual is not capable of understanding the nature, purpose and likely effect of the treatment and cannot therefore consent”¹⁰⁵⁴. The patients referenced here must be liable to be detained under the Act, but not if:

- (a). [Patients]detained on admission for assessment in cases of emergency in section 4 and whose 72 hours of detention has lapsed and there is no second medical recommendation to warrant further detention or treatment.
- (b). [Patient] who is so liable by virtue of section 5(2)¹⁰⁵⁵ or (4)¹⁰⁵⁶ or 35¹⁰⁵⁷ above or section 135¹⁰⁵⁸ or 136¹⁰⁵⁹ below or by virtue of a direction for his detention in a place of safety under section 37(4)¹⁰⁶⁰ or 45A(5)¹⁰⁶¹ above; or
- (c)[A patient who has] been conditionally discharged under section 42(2)¹⁰⁶² above or section 73¹⁰⁶³ or 74¹⁰⁶⁴ below and he is not recalled to hospital.¹⁰⁶⁵
- (2) is not a community patient; and
- (3) has not attained the age of 18 years.¹⁰⁶⁶

Overall, both rules under the UKMCA and UKMHA must be followed with each regimen applied to respective individuals according to their circumstances. Now, on quick and a comparative basis

¹⁰⁵³ See, Ibid, s. 58A (9).

¹⁰⁵⁴ See, Ibid, s.58A (7).

¹⁰⁵⁵ See, Ibid, s. 5 (2) (Application in Respect of a patient already in Hospital).

¹⁰⁵⁶ See, Ibid, s. 5 (4) (In respect of a patient already in hospital).

¹⁰⁵⁷ See, Ibid, s. 35 (Remand to hospital for report on accused’s mental condition).

¹⁰⁵⁸ See, Ibid, s. 135 (Warrant to search for and remove patients).

¹⁰⁵⁹ See, Ibid, s. 136 (Mentally disordered persons found in public places).

¹⁰⁶⁰ See, Ibid, s. 37 (Powers of courts to order hospital admission or guardianship).

¹⁰⁶¹ See, Ibid, s. 45A (Power of higher courts to direct hospital admission).

¹⁰⁶² See, Ibid, s.42 (Powers of Secretary of State in respect of patients subject to restriction orders.).

¹⁰⁶³ See, Ibid, s. 73 (Power to discharge restricted patients.)

¹⁰⁶⁴ See, IKMHA (1983) as amended, s. 74 (Restricted patients subject to restriction directions).

¹⁰⁶⁵ See, Ibid.

¹⁰⁶⁶ See, Ibid, s. 58A (7), s. 56(5). Read in conjunction with s. 56 (3)

as it shall be shown later on, many of the procedures in the UKMHA may be comparable to that in South Africa, Ghana and Ontario in as far as the law on presumption of capacity, requirements on capacity, right to information and observance of protections. Differences shall be seen as regards compulsory treatment with UK administering even to capable individuals, requirements on second opinion (Ontario not necessary), the use of substitute decision makers and differences in hierarchy of those making decisions for example in Ontario. The following looks at safeguards under the UK law that ensure arbitrariness does not occur. Some of the safeguards have already been mentioned within the text and may not be presented below

3.3.1.4. Substantive and Procedural Safeguards

The rules on determining capacity and treatment without consent are in themselves safeguards for they perform different roles that are inclusive of prevention, remedial and sanction against abuse and arbitrary detention on the already limited right of right to liberty and autonomous decision making. As such they are the following:

(a) The right to refuse treatment and right to use advance directives. In the case of *Nottinghamshire Healthcare NHS Trust v RC (2014)* it was held that:

“In principle, every citizen who is of age and of sound mind has the right to harm or (since 1961) to kill himself. This is an expression of the principle of the purpose of power found in the Declaration of the Rights of Man and of the Citizen (1793) and in John Stuart Mill's essay *On Liberty* (1859) where he stated at pp14 - 15: "That the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant . . . Over himself, over his body and mind, the individual is sovereign".¹⁰⁶⁷

Therefore an individual has the right to make decisions on treatments including refusing treatment as emphasized in *St George's Healthcare NHS Trust v S; Regina -v- Collins and Others ex parte S (1998)* that “having regard to the right of an individual to autonomy and self-determination, an

¹⁰⁶⁷ See, *Nottinghamshire Healthcare NHS Trust v RC* [2014] Supra note 782, para 8.

adult of sound mind was [is] entitled to refuse medical treatment, even when his or her own life depended on receiving such treatment.”¹⁰⁶⁸ This case involved compulsory detention of a pregnant woman under section 2 of the UKMHA after a recommendation by a social worker upon registering her at the local NHS practice where she was found to have eclampsia and in need of immediate care which would involve induced labour.¹⁰⁶⁹ The applicant S objected and opted for normal delivery but was nevertheless detained under the UKMHA on the assumption she lacked the capacity to consent, but later transferred to a general hospital where a cesarean delivery was done.¹⁰⁷⁰ The court found that the standards set under section 2(2- a) had not been met and therefore the compulsory admission for assessment was unlawful and allowed her appeal against the declaration order made to dispense with her consent.¹⁰⁷¹ In addition they emphatically cautioned that just because she was pregnant her capacity to consent was not diminished.¹⁰⁷²

(b). In the light of the above, individuals have the right to have their advance statements and decisions regarding their treatment respected and implemented.¹⁰⁷³ In *St George Healthcare St George's Healthcare NHS Trust v S; Regina -v- Collins and Others ex parte S (1998)*, it was de-

¹⁰⁶⁸ See, *St George's Healthcare NHS Trust v S; Regina -v- Collins and Others ex parte S (1998)* 3 ALL ER 673&674.

¹⁰⁶⁹ See, *Ibid.*

¹⁰⁷⁰ See, *Ibid.*, 673.

¹⁰⁷¹ See, *Ibid.* The court held that: “Having regard to the right of an individual to autonomy and self-determination, an adult of sound mind was entitled to refuse medical treatment, even when his or her own life depended on receiving such treatment. In the case of a pregnant woman, that right was not diminished merely because her decision to exercise it might appear morally repugnant. In the instant case, the declaration involved the removal of the baby from S’s body under physical compulsion and that removal amounted to trespass. Moreover, the declaration was made on an ex parte application in proceedings which had not then been instituted by the issue of a summons, without S’s knowledge or even any attempt to inform her or her solicitor of the application, without any evidence and without any provision for S to apply to vary or discharge the order. In those circumstances, S was entitled to have it set aside, and accordingly the appeal would be allowed”

¹⁰⁷² See, *Ibid.* At 674, the court held that: “The 1983 Act could not be deployed to achieve the detention of an individual against his or her will because his or her thinking process was unusual, even apparently bizarre and irrational, and contrary to the views of the overwhelming majority of the community at large; the Act could only be used to justify detention for mental disorder if the case fell within the prescribed conditions. Moreover, a person detained under the Act for mental disorder could not be forced into medical procedures unconnected with his or her mental condition unless his or her capacity to consent to such treatment was diminished. In the circumstances, therefore, S’s detention, treatment and transfer were all unlawful. Accordingly, the application for judicial review would be granted and appropriate declaratory relief ordered.”

¹⁰⁷³ See, UKMCA (2005) as amended, s. 24-26.

clared that, “If the patient is incapable of giving or refusing consent, either in the long term or temporarily (e g due to unconsciousness), the patient must be cared for according to the authority’s judgment of the patient’s best interests, and where the patient has given an advance directive, before becoming incapable, treatment and care should normally be subject to the advance directive.”

¹⁰⁷⁴ “However if there is reason to doubt the reliability of the advance directive (e g it may sensibly be thought not to apply to the circumstance which have arisen), then an application for a declaration may be made.”¹⁰⁷⁵ Presently, these principles are embodied in the UKMHA and UKMCA as amended and made clear in the UKMHA Code of practice where it is explained that:

Advance statements do not legally compel professionals to meet patients’ stated preferences, though they should be taken into account when making decisions about care and treatment. Advance decisions to refuse treatment are legally binding. Such decisions must be recorded and documented. Advance decisions are concerned only with refusal of medical treatment and are made in advance by a person with the mental capacity to do so. ¹⁰⁷⁶

It should be noted that but for availability of an advance directive to refuse treatment, there are three circumstances where adult citizens may have treatment or other measures imposed on them without their consent as held in the already mentioned case *Nottinghamshire Healthcare NHS Trust v RC (2014)*. This case involved an individual with a mental disorder and a Jehovah witness believer who refused blood transfusion using an advance directive which was held by the courts to be binding and any action contrary will be unlawful and arbitrary. ¹⁰⁷⁷ The court laid down these situations:

- (i). Adults lacking capacity who pursue a self-destructive course may have treatment forced upon them in their best interests pursuant to the terms of the MCA.
- (ii). Similarly, adults who have capacity but who can be categorised as "vulnerable" and who as a consequence of their vulnerability have been robbed of the ability to give a true consent to a certain course of action, may also have treatment or other measures imposed on them in their best interests pursuant to the inherent jurisdiction of the High Court (see *DL v*

¹⁰⁷⁴ See, *St George's Healthcare NHS Trust v S; Regina -v- Collins and Others ex parte S* (1998), Supra note 1067, 703.

¹⁰⁷⁵ See, *Ibid*.

¹⁰⁷⁶ See, UK Department of Health, Mental health Act 1983: Code of Practice, Supra note 457, p.74, para 9.2 & 9.5. See also, UKMCA (2005) as amended, s. 24(Advance decisions to refuse treatment general), s.25 (validity and applicability of advance decisions) & s. 26 (effect of advance decisions).

¹⁰⁷⁷ See, *Nottinghamshire Healthcare NHS Trust v RC* [2014], Supra note 782,.

A Local Authority [2012] 3 WLR 1439, and *Re SA (Vulnerable adult with capacity: marriage)* [2006] 1 FLR 867).

(iii). Under the Mental Health Act 1983 ("MHA") a detained patient may have treatment imposed on him or her pursuant to section 63 which provides, so far as is relevant to this case: "The consent of a patient shall not be required for any medical treatment given to him for the mental disorder from which he is suffering, ... if the treatment is given by or under the direction of the approved clinician in charge of the treatment"¹⁰⁷⁸

(c). The UKMHA endeavors to protect the rights of patients by involving nearest relatives whom the patient may choose to be involved in their care such as making decisions relating the relevant patients care and treatment.¹⁰⁷⁹ It also involves the use of Approved Mental Health Professionals (AMHP) who like the nearest relatives may make applications for admission for assessment, treatment and guardianship on behalf or directions of the relevant patient.¹⁰⁸⁰ Accordingly, AMHP can make application for admission for treatment under section 3 with "written recommendations in the prescribed form of two registered medical practitioners", "one shall be given by a practitioner approved for the purposes of this section by the Secretary of State as having special experience in the diagnosis or treatment of mental disorder; and unless that practitioner has previous acquaintance with the patient, the other such recommendation shall, if practicable, be given by a registered medical practitioner who has such previous acquaintance."¹⁰⁸¹ However, preventatively the AMHP may not make the application for either treatment or guardianship if:

(a) the nearest relative of the patient has notified that professional, or the local social services authority on whose behalf the professional is acting, that he objects to the application being made; or

(b) that professional has not consulted the person (if any) appearing to be the nearest relative of the patient, but the requirement to consult that person does not apply if it appears to the professional that in the circumstances such consultation is not reasonably practicable or would involve unreasonable delay.]¹⁰⁸²

It is from the omission of the first point 'objecting of the nearest relative to admission and treatment' section 11(4) by an AMHP that the court made a finding of unlawful detention under the

¹⁰⁷⁸ See, *Ibid*, para 13.

¹⁰⁷⁹ See, UKMHA (1983) as amended, s. 26.

¹⁰⁸⁰ See, *Ibid*, s. 11 (a).

¹⁰⁸¹ See, *Ibid*, s. 3(3) & s.12 (2).

¹⁰⁸² See, *Ibid*, s. 11 (4).

UKMHA and contrary to section 5 of the UKHRA thereby ordering release of the applicant in the case of *TTM v London Borough of Hackney & Ors (2011)*.¹⁰⁸³ In this case the applicant through an appeal challenged the lawfulness of his detention by applying for a writ of habeas corpus and judicial review against the hospital trust.¹⁰⁸⁴ The contention was that the applicant's brother as the nearest relative objected to the continued admission for treatment of his brother after having concerns about the mental treatment being offered.¹⁰⁸⁵ The applicant became a voluntary patient but had difficulties in taking his medicines which prompted the query between his doctors whether to section him for assessment.¹⁰⁸⁶ The two practitioners familiar with the applicant differed in their opinions.¹⁰⁸⁷ The AMHP then sought the professional advice of two other independent psychiatrists unacquainted with the applicant and who gave similar recommendations which were used by the court to grant the order of admission for assessment and treatment.¹⁰⁸⁸ The high court found the detention by the hospital to be lawful despite the misapplication of the law by the AMHP.¹⁰⁸⁹ However the court of appeal granted the application by relying on the Magna Carta (1297),¹⁰⁹⁰ and words of Sir Thomas Bingham (as he then was) in *S-C* a slightly similar case where the detention was found to be unlawful because an approved social worker failed to consult and get consent from the proper nearest relative for treatment.¹⁰⁹¹ The judge maintained that "As [he] read his judgment in *S-C*, Sir

¹⁰⁸³ See, *TTM v London Borough of Hackney & Ors* [2011] EWCA Civ 4.

¹⁰⁸⁴ See, *Ibid*, para 1-5.

¹⁰⁸⁵ See, *Ibid*, para 13 & 14.

¹⁰⁸⁶ See, *Ibid*, para 14.

¹⁰⁸⁷ See, *Ibid*, para 14 & 15.

¹⁰⁸⁸ See, *Ibid*, para 15.

¹⁰⁸⁹ See, *Ibid*, para 5.

¹⁰⁹⁰ See, *Ibid*, para 32 & 33.

¹⁰⁹¹ See, *Ibid*. Para 46 states that: "The judge goes straight from a finding that the hospital managers were entitled to act upon an apparently valid application to the conclusion that the applicant's detention was therefore not unlawful. That is, in my judgment, a non sequitur. It is perfectly possible that the hospital managers were entitled to act on an apparently valid application, but that the detention was in fact unlawful. If that were not so the implications would, in my judgment, be horrifying. It would mean that an application which appeared to be in order would render the detention of a citizen lawful even though it was shown or admitted that the approved social worker purporting to make the application was not an approved social worker, that the registered medical practitioners whose recommendations founded the application were not registered medical practitioners or had not signed the recommendations, and that the approved social worker had not consulted the patient's nearest relative or had consulted the patient's nearest relative and that relative had objected. In other words, it would mean that the detention was lawful even though every statutory safeguard built into the procedure was shown to have been ignored or violated."

Thomas Bingham reached three conclusions which are directly relevant in the present case. These were, first, that the hospital managers acted lawfully by reason of s6 (3); but secondly, that this fact did not clothe the conduct of the AMHP with lawfulness; and thirdly, that *S-C's* detention was unlawful throughout.”¹⁰⁹² Therefore concluded that the applicant:

Deprived of his liberty as a direct consequence of the AMHP's unlawful act in applying for his admission in breach of s11 (4). The only matter which protects the local authority from liability for false imprisonment is the statutory defence provided by s139 (1). That subsection does not stop the AMHP's conduct from being unlawful. The application was an undoubted breach of the Act. What s 139(1) does is to limit the civil liability of the AMHP (and the local authority) for the AMHP's unlawful act to cases where the act was done in bad faith or without reasonable care. That restriction, however, is subject to the provisions of the Human Rights Act.¹⁰⁹³

(d). From the case above, it is very evident that what Lord Justice Jackson is emphasizing in the case is observing the letter of law as a preventative measure against abuse. To accentuate, he affirms that “our system of law is rightly scrupulous to ensure that in matters affecting individual liberty the law is strictly applied [because] it is a hallmark of a constitutional democracy.”¹⁰⁹⁴ His sentiments are acceptable mainly because of the vulnerability and susceptibility of those with mental illness to arbitrary detention due to blatant disregard of safeguards positioned in the law to balance the interference of their right to liberty and right to health. In the already mentioned case of *Re S-C (Mental Patient: Habeas Corpus) (1995)*, Master of Rolls, Sir Bingham (as he then was) confirms and emphasizes on strict adherence to the rules particularly in compulsory measures as he strictly articulates that:

[Mental patients] present a special problem since they may be liable, as a result of mental illness, to cause injury either to themselves or to others. But the very illness which is the source of the danger may deprive the sufferer of the insight necessary to ensure access to proper medical care, whether the proper medical care consists of assessment or treatment, and if treatment, whether in-patient or out-patient treatment. Powers therefore exist to ensure that those who suffer from mental illness may, in appropriate circumstances, be involuntarily admitted to mental hospitals and detained. But, and it is a very important but, the circumstances in which the mentally ill may be detained are very carefully prescribed by

¹⁰⁹² See, *Ibid*, para 54.

¹⁰⁹³ See, *Ibid*, para 59.

¹⁰⁹⁴ See, *Ibid*, para 100.

statute. Action may only be taken if there is clear evidence that the medical condition of a patient justifies such action, and there are detailed rules prescribing the classes of person who may apply to a hospital to admit and detain a mentally disordered person. The legislation recognizes that action may be necessary at short notice and also recognizes that it will be impracticable for a hospital to investigate the background facts to ensure that all the requirements of the Act are satisfied if they appear to be so. Thus we find in the statute a panoply of powers combined with detailed safeguards for the protection of the patient.¹⁰⁹⁵

(e). In addition to the above given protections, the UKMHA guarantees penalties for offences and breaches of the UKMHA, of which will result in claims of trespass to the person under the UKMHA or/and generally civil and criminal proceedings.¹⁰⁹⁶ It may also bring a claim for breaches of UKHRA rights. In the case of *B, R (on the application of) v SS (Responsible Medical Officer) & Ors [2006]* the appellant appealed against a dismissed judicial review judgement from the administrative court that upheld the decision of the appellants doctors at Broadmoor hospital to provide him medical treatment without consent.¹⁰⁹⁷ The appellant suffered from a bipolar disorder and detained under the UKMHA following a conviction for rape in 1995.¹⁰⁹⁸ The decision to treat him was made according to the rules requiring second opinion appointed doctors certification under s. 58 (treatment requiring consent or second opinion).¹⁰⁹⁹ His claim in the appeal was that he was compulsorily given anti-psychotic drugs to alleviate his condition without consent, whilst at the time he was competent to give or withhold his consent and unless the treatment was imperative for the protection of public or to prevent patient from serious harm, the compulsory imposition of treatment would violate his article 3 right not to be subjected to inhuman or degrading treatment, article 8 right to private life and article 14 right not to be discriminated against, of the UKHRA or Convention.¹¹⁰⁰ In dismissing the appeal and finding that section 58 was compatible with the UKHRA, it explained that “English law attaches great importance to the freedom of the individual to decide what should or should not be done by way of physical interference with or invasion of the

¹⁰⁹⁵ See, Re S-C (Mental Patient: Habeas Corpus) (1995), Supra note 756.

¹⁰⁹⁶ See, UKMHA (1983) as amended, part IX.

¹⁰⁹⁷ See, *B, R (on the application of) v SS (Responsible Medical Officer) & Ors [2006]*, Supra note 1011, para 3.

¹⁰⁹⁸ See, *Ibid*, para 2&3.

¹⁰⁹⁹ See, *Ibid*, para 2, 3 &4.

¹¹⁰⁰ See, *Ibid*, para 6 &7.

body. As a general proposition, deliberate physical interference with or invasion of the body of another without that person's consent will constitute a criminal offence and give rise to a claim in tort".¹¹⁰¹

In addition to the above, the court's reasoning on violation of the convention was informed by the case of *Herczegfalvy v Austria (1992)*, where the applicant was a detained offender with mental disorder and who alleged violations of article 3 and 8 because of being "subjected to the forcible administration of food and neuroleptics and to handcuffing to a security bed".¹¹⁰² In *Herczegfalvy*, the court in dismissing the complaints upheld that these rights can be engaged in such care but it accepted the government's argument that the forced treatment was therapeutically necessary and therefore the "medical necessity justified the treatment in issue".¹¹⁰³ In this case (BR) on breaches of the convention rights the court applied similar principles and analysed whether treatment given based on medical or therapeutic necessity equated with the test of the patient's best interests under section 58 that "having regard to the likelihood of its alleviating or preventing deterioration of Mr. B's condition" was justifiable and "in accordance with the law" as required by article 8(2).¹¹⁰⁴ The answer was affirmatively that "the imposition of the proposed anti-psychotic medication will be

¹¹⁰¹ See, *Ibid*, para 31.

¹¹⁰² See, *Herczegfalvy v Austria (1992)*, *Supra* note 399, in *Ibid*, para 57.

¹¹⁰³ See, *Herczegfalvy v Austria (1992)*, *Supra* note, 399. In para 82-83 the court held that: "**82.** The Court considers that the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with. While it is for the medical authorities to decide, on the basis of the recognised rules of medical science, on the therapeutic methods to be used, if necessary by force, to preserve the physical and mental health of patients who are entirely incapable of deciding for themselves and for whom they are therefore responsible, such patients nevertheless remain under the protection of Article 3, the requirements of which permit of no derogation. The established principles of medicine are admittedly in principle decisive in such cases; as a general rule, a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading. The Court must nevertheless satisfy itself that the medical necessary has been convincingly shown to exist.**83.** In this case it is above all the length of time during which the handcuffs and security bed were used which appears worrying. However, the evidence before the Court is not sufficient to disprove the Government's argument that, according to the psychiatric principles generally accepted at the time, medical necessity justified the treatment in issue."

¹¹⁰⁴ See, *B, R (on the application of) v SS (Responsible Medical Officer) & Ors [2006]* *Supra* note 1011, para 59-62.

lawful under English law and will not infringe the Convention.”¹¹⁰⁵ Resultantly, the complaints alleged were dismissed.

(f). A further protection is in the use of second opinion appointed doctors and independent mental health advocates. As previously remarked the UKMHA and UKMCA are in themselves safeguards and one way besides the already mentioned safeguards is via provisions such as that requiring, the use of “written recommendations in the prescribed form of two registered medical practitioners in the processes of admission for treatment”.¹¹⁰⁶ These types of protection where a second opinion or recommendation is necessary and mandated can be seen reflected in situations where consent is needed for some special treatment. The UKMHA under sections 57 and 58 present those types of treatment that must be administered with the consent of the relevant patient and with the support of a second opinion from a registered medical practitioner who in writing certifies that “the patient is capable of understanding the nature, purpose and likely effects of the treatment in question and has consented to it; and that it is appropriate for the treatment to be given.”¹¹⁰⁷ The registered medical opinion before giving the certificate of consent for the treatment must reach the stated opinion after having consulted “two other persons who have been professionally concerned with the patient’s medical treatment but, of those persons— (a) one shall be a nurse and the other shall be neither a nurse nor a registered medical practitioner; and (b) neither shall be the responsible clinician (if there is one) or the person in charge of the treatment in question[for section 58 neither shall be the responsible clinician or the approved clinician in charge of the treatment in question].”¹¹⁰⁸ The case of *TTM v London Borough of Hackney & Ors (2011)*¹¹⁰⁹ pointed above illustrates the seriousness

¹¹⁰⁵ See, *Ibid*, para 65.

¹¹⁰⁶ See, UKMHA (1983) as amended, s .3 (3).

¹¹⁰⁷ See, *Ibid*, s. 57 (1&2) & s. 58 (1 &3).

¹¹⁰⁸ See, *Ibid*, s. 57 (3) & s. 58 (4).

¹¹⁰⁹ See, *TTM v London Borough of Hackney & Ors [2011]* , *Supra* note 1082.

of following the set standards in the Act. If it is meant a registered medical practitioner or approved clinical officer, then those individuals must perform the given task.

(g). In addition to the use of second opinion, individuals subjected under the Act have the right to be informed about the use of independent mental health advocates (IMHA) who may advise qualifying clients about their rights including consent matters.¹¹¹⁰ In this regard, the IMHA's have the duty to visit and interview patients and look into and inspect from records from relevant authorities.¹¹¹¹ IMHAs can only access the records and any other information of the detention, treatment and aftercare by consent of the relevant individual and where the individual lacks capacity to consent, "the holder of the records must allow the IMHA access if they think that it is appropriate and that the records in question are relevant to the help to be provided by the IMHA".¹¹¹²

(h). Further protection included in the legislation is the use of relative, nearest relative, the power court to appoint upon application and the right of the concerned individual to choose a new relative to provide support.¹¹¹³ On a similar plane, concerned individuals subjected under the Act may upon

¹¹¹⁰ See, UKMHA (1983) as amended, s. 130 (A) & s. 130 C that defines qualifying patients. It states that: "(1) This section applies for the purposes of section 130A above. (2) A patient is a qualifying patient if he is— (a) liable to be detained under this Act (otherwise than by virtue of section 4 or 5(2) or (4) above or section 135 or 136 below); (b) subject to guardianship under this Act; or (c) a community patient. (3) A patient is also a qualifying patient if— (a) not being a qualifying patient falling within subsection (2) above, he discusses with a registered medical practitioner or approved clinician the possibility of being given a form of treatment to which section 57 above applies; or (b) not having attained the age of 18 years and not being a qualifying patient falling within subsection (2) above, he discusses with a registered medical practitioner or approved clinician the possibility of being given a form of treatment to which section 58A above applies."

¹¹¹¹ See, Ibid, s. 130B (3). It states that: "(a) visit and interview the patient in private; (b) visit and interview any person who is professionally concerned with his medical treatment; (c) require the production of and inspect any records relating to his detention or treatment in any hospital or registered establishment or to any after-care services provided for him under section 117 above; (d) require the production of and inspect any records of, or held by, a local social services authority which relate to him."

¹¹¹² See, UK Department of Health, Mental health Act 1983: Code of Practice, Supra note 457, p.59, para 6.31. See also, Ibid, s. 130B (4&5).

¹¹¹³ See, UKMHA (1983) as amended, s. 26-30.

application be subjected to guardianship order, which may confer authority to the guardian to make decision on treatment and care.¹¹¹⁴

(i). Finally, it is the reiterated right to information that is imperative to reaching a decision, the right to review of finding of incapacity, right to appeal and also right to make complaints to Care Quality and Commission which has the mandate to investigate any complaints made under the UKMHA and UKMCA as amended.¹¹¹⁵ Right of review is discussed in-depth in the fourth chapter.

3.3.1.5. Sum Up

The approach of the UKMHA and UKMCA to issues of mental treatment does not match with the CRPD interpretations mainly because of the sanctioning of compulsory measures and the restraint to the right of autonomous decision making. Consent is not required to detain or treat an individual with a mental disorder except in a limited number of treatments such as electro convulsive treatment. In addition advance wishes may be overridden in order to provide treatment if it is in the best interest of the individual concerned. The UKMHA moreover supports the use of guardianship system of support which is contrary to article 12 of the convention. However, its conformity can be seen through the many protections offered in the Act and the mere fact that the legislation and actions undertaken in its name must be compliant to the UKHRA.

3.3.2. South Africa

3.3.2.1. Introduction-Statutory Framework

Matters of capacity consent and civil commitment in the case of South Africa is like the other jurisdictions as it begins from the constitution as discussed in chapter two on admissions and treatment

¹¹¹⁴ See, Ibid, s. 7-10.

¹¹¹⁵ See, Ibid, part IV.

under civil commitment. It is then provided in respective statutory frameworks dealing with provision of health services and other interconnected specific legislation dealing with mental health care under the SMHCA. The discussion on the matter at hand shall therefore first look into the basic document, followed by the National health Act and finally the SMHCA. Briefly, note here that the SMHCA provides for individuals who lack capacity and also for involuntary treatment, just like the UK under the UKMCA and UKMHA. Comparison can be maintained for the case of Ontario that has the OMHA that interlinks with a separate legislation providing for capacity and consent matters. Assisted and involuntary users under the SMHCA shall be examined within discussion.

Thus, the South African constitution first recognizes that “everyone is equal before the law and has the right to equal protection and benefit of the law”.¹¹¹⁶ All individuals have the right to exercise their right to autonomy which may encompass making decisions on how their lives should be protected by the law. The constitution therefore in claiming everyone has the right to enjoy this right, enunciates seventeen prohibited grounds that precludes the State and any person from directly or indirectly discriminating another.¹¹¹⁷ In this regard, everyone, including those with disability (physical and mental), have the right to “full and equal enjoyment of all rights and freedoms [through] legislative and other measures designed to protect or advance persons or categories of persons, disadvantaged by unfair discrimination [that] may be taken [by the State]”.¹¹¹⁸ It is important to note here that the constitution does not limit prohibition of discrimination to the acts of the State, but legislates against the conduct that might happen between private citizens. It circumstances that “no person may unfairly discriminate directly or indirectly against one or more grounds in terms of subsection 3 [which sets the prohibitive grounds of discrimination]”.¹¹¹⁹ This value and principle of equality has been discussed strongly in the jurisprudence of south Africa, particularly the constitu-

¹¹¹⁶ See, The Constitution of the Republic of South Africa (1996), s. 9 (1).

¹¹¹⁷ See, Ibid, s. 9 (3).

¹¹¹⁸ See, Ibid, s. 9 (2).

¹¹¹⁹ See, Ibid, s. 9 (4).

tional court that has heard cases on unfair discrimination on prohibited grounds of sexual orientation,¹¹²⁰ marital status, gender and religion,¹¹²¹ age,¹¹²² disability¹¹²³ and among others such as citizenship a non- enumerated ground,¹¹²⁴ and in doing so laid down the test for determining whether there has been discrimination contrary to the constitution mandate. In *De Vos N.O. and Others v Minister of Justice and Constitutional Development and Others (2015)*, the constitutional court in addressing the constitutional validity of some provisions of Criminal Procedure Act as it relates to procedural appropriate procedural aspects accompanying compulsory detention and hospitalization of adults and children offenders as well as considering the commission of offence due to lack of capacity limited by mental illness, maintained that:

In Hoffmann Ngcobo J held that: “Our constitutional democracy has ushered in a new era – it is an era characterised by respect for human dignity for all human beings. In this era, prejudice and stereotyping have no place. Indeed, if as a nation we are to achieve the goal of equality that we have fashioned in our Constitution we must never tolerate prejudice, either directly or indirectly.”¹¹²⁵

¹¹²⁰ See, National Coalition for Gay and Lesbian Equality V Minister of Home Affairs and Others (2000) 2 SA 1 CC.

¹¹²¹ See, Hassam v Jacobs NO [2009] ZACC 19.

¹¹²² See, Bedderson v Sparrows Schools Education Trust [2009] ZALC

¹¹²³ See, IMATU and another v The City of Cape Town [2005] 11 BLLR 1084. This case involved a blanket ban on employment of insulin dependent diabetics in city of Cape Town municipal fire service. The ban was considered by the court as not rationally connected with purpose that the ban meant to achieve. As such, the blanket ban constituted unfair discrimination.

¹¹²⁴ See, Larbi-Odam and Others V MEC for Education (North-West Province) (1998) 1 SA 745 CC. This case involved a provincial regulation being found to discriminate unfairly on non-citizens by preventing them from being appointed to permanent teaching positions. It is a case that illustrates that the enumerated list in section 9(3) of the constitution is not exhaustive or restrictive therefore giving the court a wide berth to decide upon a complaint whether there has been discrimination on a new ground.

¹¹²⁵ See, Hoffmann v South African Airways 2001 (1) SA 1 (CC) in *De Vos N.O. and Others v Minister of Justice and Constitutional Development and Others (CCT 150/14)* [2015] ZACC 21, para 56. This is a case that concerned the constitutionality of certain provisions of the South African Criminal Procedure Act dealing with serious offences by adult and young offenders lacking the mental capacity due to mental illness and the procedure presided over by a presiding officer to enforce compulsory imprisonment for all accused persons and compulsory hospitalization for children. The contention is that these sections not only violated the constitutional rights to equality, freedom and dignity, but failed to bestow the same discretion over to presiding officers[given to adult offenders] when dealing with young offenders in directing provision of care and therefore using detention as a last resort and for the shortest time possible. The court maintained that one of the provision, is unconstitutional as it second provision is constitutionally invalid as it commends that an accused person who has committed no act or a minor offence be institutionalized, irrespective of whether they are likely to inflict harm to themselves or others and do not require care, treatment and rehabilitation in an institution which violates their freedom and security of the person. It therefore suspended the high court’s order of invalidity in respect of the compulsory imprisonment of adults and the compulsory hospitalization and imprisonment of children for a period of 24 months to allow Parliament to remedy the defects. In addition it gave a reading in as a temporary measure.

Evidently, the South African court's equality jurisprudence illustrates that the existence of a disability alone cannot justify a deprivation of liberty. Further discussion on discrimination is limited herein because the thesis is not about discrimination even though it is a concerning issue for individuals with mental disability and the principle of equality is important for individuals with mental disability as it affects various aspects of their lives including that of making autonomous choice during treatment. It is also important in terms of mental health care access and delivery considering that mental health is a very underfunded, poorly staffed and infrastructured sector. In this case equality and prohibition on discrimination are vital to ensure that mental health care is equally provided and free from discriminatory practices.

Nonetheless, back to the issue of autonomy and when read together with the right to equality discussed above, the constitution under section 12 provides for the right to "freedom and security of the person" which sanctions against any arbitrary deprivation of freedom or without cause among other prohibition of such as torture, detention without trial, and maltreatment.¹¹²⁶ Hospitalization for assessment and treatment as provided in the SMHCA is for a just cause as discoursed in chapter two. This means therefore civil commitment remains to be a just process of treatment as long as it conforms to the law. However as it is, civil commitment does not apply to every individual seeking mental health care and the fact remains that for treatment to be administered it must be consented in advance. Those unable to consent as shall be expatiated afterwards can be given treatment but within the substantive and procedural guidelines set in the SMHCA. As it stands, the principle of exercising ones autonomy to make decision is also engrained in section 12 that also deals with freedom and security of persons. Section 12 (2) provides that:

- Everyone has the right to bodily and psychological integrity, which includes the right—
- (a) to make decisions concerning reproduction;
 - (b) to security in and control over their body; and

¹¹²⁶ See, The Constitution of the Republic of South Africa (1996), s. 12 (1).

(c) not to be subjected to medical or scientific experiments without their informed consent¹¹²⁷

The quoted constitution right visibly empowers every individual the right to choose what has to be done with their bodies through the right to consent. This naturally includes the right to consent to treatment received in hospitals, traditional and spiritual centres of healing as well as in homes. The South African jurisprudence reflects this constitutional right in some of its judgements. The jurisprudence that the thesis uses to underscore this point is not related to mental health, but reflects on the principles that nevertheless apply across. Hence, *Christian Lawyers' Association v National Minister of Health and Others (2004)*, is a case concerning the constitutional right to terminate pregnancy, where what entails to have capacity and right to consent was explained in the following manner; "valid consent can only be given by someone with the intellectual and emotional capacity for the required knowledge, appreciation and consent. Because consent is a manifestation of will "capacity to consent depends on the ability to form an intelligent will on the basis of an appreciation of the nature and consequences of the act consented to" ¹¹²⁸ These elements of what constitutes capacity to be able to provide valid consent resemble those given in the UK and Ontario definition of capacity but as shall be seen, the SMHCA does not offer a description of what capacity is in its definition section. Regardless, the court jurisprudence and the National Health Act as shall be presented afterwards, indicate that there is a presumption of capacity and directions on what capacity entails.

The jurisprudence additionally highlights on the right to exercise self-autonomy through the act of consenting. In the above case of *Christian Lawyers Association*, it was maintained that the "fundamental right to self-determination itself-lies in the very heart and base of the constitutional right

¹¹²⁷ See, Ibid.

¹¹²⁸ See, Van Heerden Belinda, Boberg's, Law of Persons and the Family, Juta Legal and Academic Publishers (2nd ed) 849 (1999) In *Christian Lawyers' Association v National Minister of Health and Others* [2004] 10 BCLR 1086 (T)

...now imperative under the constitution and particularly article 12(2) of the Bill of Rights”.¹¹²⁹ Moreover it was held that “in the leading judgment on the requirement of informed consent, Ackermann J on behalf of the full bench of the CPD) in *Castell v De Greef* (supra) made it clear that the ratio for that requirement was to give effect to the patient's fundamental right to self-determination.”¹¹³⁰ *Castell V De Greef (1994)* was a successful appeal case for damages after a botched up mastectomy on the appellant and where the issue concerned “deciding whether a medical practitioner has incurred liability for negligence as a result of his failure to warn his patient of the material risks and complications which might flow from a surgical operation or other medical treatment the issue of consent to medical treatment.”¹¹³¹ It also included the “the question of whether emphasis should be placed on the autonomy and right of self-determination of the patient, on the one hand, or on the right of the medical profession to determine the meaning of reasonable disclosure, on the other, come to the fore.”¹¹³² In reaching his conclusion, Judge Ackermann emphasized that “it is clearly for the patient to decide whether he or she wishes to undergo the operation, in the exercise of the patient's fundamental right to self-determination, [that] informed decision to undergo or refuse the proposed intervention should be that of the patient and not that of the doctor.”¹¹³³ Therefore in South African law:

For consent to operate as a defence the following requirements must, *inter alia*, be satisfied: (a) the consenting party must have had knowledge and been aware of the nature and extent of the harm or risk; (b) the consenting party must have appreciated and understood the nature and extent of the harm or risk; (c) the consenting party must have consented to the harm or assumed risk; (d) the consent must be comprehensive, that is extend to the entire transaction, inclusive of its consequences.¹¹³⁴

From the proceeding it is possible to review that the right to self-determination is a constitutionally protected right which may be exercised to receive or refuse treatment. The right to self-

¹¹²⁹ See, *Christian Lawyers' Association v National Minister of Health and Others* 2004 (10) BCLR 1086 (T), p.6.

¹¹³⁰ See, *Ibid*

¹¹³¹ See, *Castell V De Greef* (1994) 4 SA 408 (C), p. 409.

¹¹³² See, *Ibid*.

¹¹³³ See, *Ibid*.

¹¹³⁴ See, *Ibid*, p. 410.

determination as regards treatment is exercised upon receiving full information that forms the basis of providing or withholding consent. Therefore, medical practitioners or health care providers have an obligation to provide full information as it relates to the relevant treatment of the concerned individual. The failure to do so may result in civil liability claims, criminal and also human rights violation contrary to the Bill of Rights in the constitution. These same principles and criteria run parallel to the UK and Ontario as set out in their respective legislation and further cemented in case law.

The National Health Act & Medical Ethics Charter.

As severally mentioned above, in addition to the constitution and court jurisprudence, the National Health Act (2003) explains further the rights of health care users in regards to capacity and consent matters.¹¹³⁵ Through its sections it makes a connection between the right to make autonomous decision making and providing consent in context to treatment when enjoying the right to health enounced under section 25 of the constitution. In view of that, the Act presumes every individual has legal capacity save for certain exceptional circumstances, yet even then it provides ways in which capacity can be exercised through proxy, prior written notice or court order. But in the foremost the health care provider must provide the user with treatment information together with the information on the chances of success and associated risks associated if received and when treatment is refused as well as the costs in a language that the individual understands.¹¹³⁶ With the information the user must weigh whether to consent to the treatment and give make the decision.

¹¹³⁵ See, National Health Act, 2003 (Act No. 61 of 2003), s.7.

¹¹³⁶ See, Ibid, s.6. It states that: “(1). Every health care provider must inform a user of- (a) the user’s health status except in circumstances where there is substantial evidence that the disclosure of the user’s health status would be contrary to the best interests of the user; (b) the range of diagnostic procedures and treatment options generally available to the user;(c) the benefits, risks, costs and consequences generally associated with each option; and (d) the user’s right to refuse health services and explain the implications, risks, obligations of such refusal. (2) The health care provider concerned must, where possible, inform the user as contemplated in subsection (1) in a language that the user understands and in a manner which takes into account the user’s level of literacy.”

However, health service can be provided to a user without informed consent in the following exceptional circumstances:

- (a) the user is unable to give informed consent and such consent is given by a person-
 - (i) mandated by the user in writing to grant consent on his or her behalf; or (ii) authorised to give such consent in terms of any law or court order;
 - (b) the user is unable to give informed consent and no person is mandated or authorised to give such consent, and the consent is given by the spouse or partner of the user or, in the absence of such spouse or partner, a parent, grandparent, an adult child or a brother or a sister of the user, in the specific order as listed;
 - (c) the provision of a health service without informed consent is authorised in terms of any law or a court order;
 - (d) failure to treat the user, or group of people which includes the user, will result in a serious risk to public health; or
 - (e) any delay in the provision of the health service to the user might result in his or her death or irreversible damage to his or her health and the user has not expressly, impliedly or by conduct refused that service.
- 2) A health care provider must take all reasonable steps to obtain the user's informed consent.
- 3) For the purposes of this section "informed consent" means consent for the provision of a specified health service given by a person with legal capacity to do so and who has been informed as contemplated in section 6.¹¹³⁷

The requirements above are straightforward and self-explanatory. They show clearly that there is presumption of legal capacity, the necessity of consent and the assured guarantee to exercise the right to refuse treatment. What also comes through and may be considered CRPD compliant is the active role that the user undertakes during treatment. This active role is also legally provided in section 8 where it is emphasized that "a user has the right to participate in any decision affecting his or her personal health and treatment."¹¹³⁸ Participation is a guarantee even in situations where consent is substituted due to incapacity since the Act mandates that the user must be consulted.¹¹³⁹ In circumstances where the user is totally unable to participate in decisions affecting his or her health and treatment, the information about the care must be given after the treatment or health service has been administered.¹¹⁴⁰ The excerpt also highlights two important things; The protection of an indi-

¹¹³⁷ See, Ibid, s. 7.

¹¹³⁸ See, Ibid, s. 8 (1).

¹¹³⁹ See, Ibid, s. 8 (2- a & b).

¹¹⁴⁰ See, Ibid, s. 8 (3).

vidual right to consent through the acceptance of the use advance decision making and the use of substitute decision makers who become bound by law. The point being made is that even in exceptions the law provides though protective guarantees that ensure checks and balances.

In continuation to the above, it is important to observe that disclosure of information may be restricted if it is in the best interest of the user.¹¹⁴¹ In a related note to treatment without consent and in circumstances where an individual is admitted to a health establishment without consent, the legislation sets out directional protection by requiring that that the head of the provincial department in the province in which it is located is notified within 48 hours after the user has been admitted with other relevant information.¹¹⁴² It is imperative to note here that if the expiration of the 48 hours falls within the weekend days or public holiday, the notice must be given “at any time before noon of the next day that is not a Saturday, Sunday or public holiday”.¹¹⁴³ The notification does not apply if within the 24 hours upon admission the individual consents.¹¹⁴⁴ This requirement of notification is also subject to any other applicable rule that may have different notification procedure.¹¹⁴⁵ Hence, different scenarios are taken into consideration to avoid adducing treatment without proper procedures and safeguards.

In addition to the National Health Act that provides for capacity and consent of health care users, the Ministry of Health in communication with various other bodies, including Health Professions Council of South Africa, came up with a National Patients’ Rights Charter which purports to uphold and further the right to access of health under the constitution by ensuring it is observed by

¹¹⁴¹ See, *Ibid*, s. 8 (3).

¹¹⁴² See, *Ibid*, s. 9 (1).

¹¹⁴³ See, *Ibid*, s.9 (2).

¹¹⁴⁴ See, *Ibid* s. 9 (3).

¹¹⁴⁵ See, *Ibid*, s. 9 (1).

health care professions as “as a common standard for achieving the realisation of this right”.¹¹⁴⁶ The Charter has to be applied by interns, accredited facilities and health authorities.¹¹⁴⁷ The author believes this is important because everybody in the health care sector gets to apply the ethics and law thereby minimizing the risks of abuse and unlawfulness. The Charter in essence provides the duties of professionals expressed in terms of patients’ rights and obligations of patients similar to the rights engraved in the National Health Act. For example and in regards to decision making, the The Charter pronounces that “every citizen has the right to participate in the development of health policies, whereas everyone has the right to participate in decision-making on matters affecting one’s own health.”¹¹⁴⁸ Therefore to exercise this right as it relates to treatment, “everyone has a right to be given full and accurate information about the nature of one’s illnesses, diagnostic procedures, the proposed treatment and risks associated therewith and the costs involved.”¹¹⁴⁹ With this information, “a person may refuse treatment and such refusal shall be verbal or in writing, provided that such refusal does not endanger the health of others.”¹¹⁵⁰

The charter also guarantees certain protections such as those obliging “information concerning one’s health, including information concerning treatment that may only be disclosed with informed consent, except when required in terms of any law or any order of court”.¹¹⁵¹ It also provides a right to everyone “to complain about health care services, to have such complaints investigated and to receive a full response on such investigation.”¹¹⁵² This Charter as mentioned applies to professions and patients. While patients have the rights in form of duties upon professions, the same rights

¹¹⁴⁶ See, Health Professions Council of South Africa, National Patients’ Rights Charter: Guidelines for Good Practice In the Health Care Professions, Book 3 Pretoria (2008), p. 1.

¹¹⁴⁷ See, Ibid.

¹¹⁴⁸ See, Ibid, p. 2, para 2.2.

¹¹⁴⁹ See, Ibid, p.2, para 2.8.

¹¹⁵⁰ See, Ibid, p.2 para 2.9.

¹¹⁵¹ See, Ibid, p.2 para 2.7.

¹¹⁵² See, Ibid, p.3 para 2.12.

come with responsibilities for the patients.¹¹⁵³ This is very fair and significant that patients have also responsibilities as it connects to their care because giving and receiving health care are mutually exclusive and more often than naught we only discuss about the duties of the health care professions. Comparable duties and obligations of professions and patients are provided in the National Health Act, providing a more legally binding effect and basis for the Charter guidelines.¹¹⁵⁴ The legislation and the soft law apply to everyone seeking or receiving health care. As aforesaid however in the Act, this law is subject to other relevant applicable laws. In context to this thesis it is the Mental Health Care Act which provides guidelines for capacity, consent in civil commitment circumstances as is discussed below.

3.3.2.2. Capacity & Civil Commitment

The SMHCA provides more detailed requirements on matters of capacity and consent. It differentiates between persons who lack capacity to consent to treatment and those under involuntary treatment. From the definition section the difference is made by the definition of “assisted care, treatment and rehabilitation” [taken to] mean the provision of health interventions to people inca-

¹¹⁵³ See, *Ibid*, p.3. The rights include the following: “3.1 To take care of his or her own health. 3.2 To care for and protect the environment. 3.3 To respect the rights of other patients and health care providers. 3.4 To utilise the health care system properly and not to abuse it. 3.5 To know his or her local health services and what they offer. 3.6 To provide health care providers with relevant and accurate information for diagnostic, treatment, rehabilitation or counselling purposes. 3.7 To advise health care providers of his or her wishes with regard to his or her death. 3.8 To comply with the prescribed treatment or rehabilitation procedures. 3.9 To enquire about the related costs of treatment and/or rehabilitation and to arrange for payment. 3.10 To take care of the health records in his or her possession.”

¹¹⁵⁴ See, National Health Act, 2003 (Act No. 61 of 2003). s. 19 states that: “A user must- (a) adhere to the rules of the health establishment when receiving treatment or using health services at the health establishment (b) subject to section 14 provide the health care provider with accurate information pertaining to his or her health status and-co-operate with health care providers when using health services (c) treat health care providers and health workers with dignity and respect and (d) sign a discharge certificate or release of liability if he or she refuses to accept recommended treatment” See also s. 20 that states: “(1) Health care personnel may not be unfairly discriminated against on account of their health status. 2) Despite subsection (1) but subject to any applicable law, the head of the health establishment concerned may in accordance with any guidelines determined by the Minister impose conditions on the service that may be rendered by a health care provider or health worker on the basis of his or her health status. 3) Subject to any applicable law, every health establishment must implement measures to minimise- (a) injury or damage to the person and property of health care personnel working at that establishment; and (b) disease transmission 4) A health care provider may refuse to treat a user who is physically or verbally abusive or who sexually harasses him or her”.

pable of making informed decisions due to their mental health status and who do not refuse the health interventions and “assisted care, treatment and rehabilitation services” has a corresponding meaning”. Therefore “assisted mental health care user” means a person receiving assisted care, treatment and rehabilitation”.¹¹⁵⁵ This description mirrors the UKMCA purpose, though the UKMCA is much more extensive in terms of procedures and safeguards as already discussed (H.L v UK case). Nevertheless “‘involuntary care, treatment and rehabilitation’ means the provision of health interventions to people incapable of making informed decisions due to their mental health status and who refuse health intervention but require such services for their own protection or for the protection of others and ‘involuntary care, treatment and rehabilitation services’ has a corresponding meaning.”¹¹⁵⁶

As it follows then “‘involuntary mental health care user’ means a person receiving involuntary care, treatment and rehabilitation.”¹¹⁵⁷ The difference between assisted and involuntary patents under the Act as it can be seen lies in willingness to receive treatment (for assisted individuals they do not refuse but hampered by lack of capacity caused by the mental illness whereas involuntary are incapable of making decision and still refuse treatment). The other difference is the underlying reason for intervention which for involuntary is when the individual is a danger to himself or herself and others making the treatment imperative based on protection grounds. However these differences do not come into play if and when “due to mental illness, any delay in providing care, treatment and rehabilitation services or admission may result in the-(i) death or irreversible harm to the health of the use, (ii) user inflicting serious harm to himself or herself or others or (iii) user causing serious damage to or loss of property belonging to him or her or others.”¹¹⁵⁸

¹¹⁵⁵ See, SMHCA (2002) as amended, s.1.

¹¹⁵⁶ See, Ibid.

¹¹⁵⁷ See, Ibid, s. 1.

¹¹⁵⁸ See, Ibid, s. 9 (3).

Accordingly assisted care can be provided upon approval of “a written application for care, treatment and rehabilitation services by head of the health establishment concerned.¹¹⁵⁹ This application can be made by “the spouse, next of kin, partner, associate, parent or guardian of a mental health care user” or healthcare provider where the group mentioned list of user supporters are unwilling, incapable or not available to consent to treatment.¹¹⁶⁰ The reasons for the application seeking care, treatment and rehabilitation must be given, particularly it must be indicated that at the time when it is made:

- (i) there is a reasonable belief that the mental health care user is suffering from a mental illness or severe or profound mental disability, and requires care, treatment and rehabilitation services for his or her health or safety, or for the health and safety of other people; and
- (ii) the mental health care user is incapable of making an informed decision on the need for the care, treatment and rehabilitation services.¹¹⁶¹

In addition to the above substantive requirements that must be evidently substantiated as discussed in chapter two to show that an individual has a mental illness of nature that needs treatment and affects capacity to consent, the Act sets forth a couple of procedural steps that must be fulfilled for the application to be considered and approved. This include that before making the request for assisted care, the applicant/s must have interacted with the mental health user within seven days beforehand evidenced by giving dates and times and also must detail the nature of their relationship-“if the applicant is a health care provider, must state (i) the reasons why he or she is making the application and (ii) what steps were taken to locate the relatives of the user in order to determine their capability or availability to make the application.”¹¹⁶² Hence, once the head of the relevant health establishment has received the application, he also must ensure that the documents are in order and

¹¹⁵⁹ See, Ibid, s. 26 (a).

¹¹⁶⁰ See, Ibid, s. 27 (1- i&ii).

¹¹⁶¹ See, Ibid, s. 27 (2b-(i&ii) & (c).

¹¹⁶² See, Ibid, s. 27 (1b& 2b).

importantly that the required procedures relating to assessment of the details of the application are thoroughly conducted.¹¹⁶³

These assessments involve that he or she “must cause the mental health care user to be examined by two mental health care practitioners”.¹¹⁶⁴ Take notice of the fact that “such mental health care practitioners must not be the persons making the application and at least one of them must be qualified to conduct physical examinations.”¹¹⁶⁵ These criteria’s are quite comparative to the conditions in the other research domestic legislations. Naturally, the results of the examination must be given to the relevant head of the relevant health establishment and must have considered the already mentioned grounds of presence of mental illness that due to it may cause harm aspect, and capacity to make decision.¹¹⁶⁶ The practitioners should also indicate in the results whether “the mental health care user should receive assisted care, treatment and rehabilitation services as an outpatient or inpatient.”¹¹⁶⁷ This is essential because not all persons with mental illness need to have forced treatment or inpatient care.¹¹⁶⁸ Therefore, it is imperative that the findings of the two mental health practitioners coincide, because they are central to the final decision that the relevant head of health establishment may make.¹¹⁶⁹ However in cases where their opinions differ, the mental health user must be examined by another practitioner.¹¹⁷⁰ This feature is important for it ensures thorough perspective into the results substantiating the need to treat without treatment and in so doing provides the protection that prevents the imposition of unnecessary treatments and substituted decisions.

¹¹⁶³ See, *Ibid*, s. 27 (7 &8).

¹¹⁶⁴ See, *Ibid*, s. 27 (4 a).

¹¹⁶⁵ See, *Ibid*, s. 27 (4b).

¹¹⁶⁶ See, *Ibid*, s. 27 (5a).

¹¹⁶⁷ See, *Ibid*, s. 27 (5b).

¹¹⁶⁸ See, *De Vos N.O. and Others v Minister of Justice and Constitutional Development and Others* [2015], *Supra* note 1124, para, 49.

¹¹⁶⁹ See, *SMHCA* (2002) as amended, s. 27 (7).

¹¹⁷⁰ See, *Ibid*, s. 27 (6a).

The relevant head of a health establishment upon receiving the results from the two practitioners and before granting an approval for assisted care, treatment and rehabilitation must ensure that as expressed, their opinions concur in regards to the nature of mental illness, lack of capacity and necessity of the inpatient care.¹¹⁷¹ He or she must also be “satisfied that the restrictions and intrusions on the rights of the mental health care user to movement, privacy and dignity are proportionate to the care, treatment and rehabilitation services required.”¹¹⁷² If and when all the requirements are met, then a written approval mentioning the reasons of the decision should be given to the relevant mental health user and within five days of the notice the user must be admitted into the referred health establishment or another with appropriate facilities.¹¹⁷³ This issue of appropriate facilities is very important yet neglected. Borrowing from the European Court of Human Rights jurisprudence as seen in the detention cases, the environment in which someone is admitted must fit the purpose. It is also imperative because poor and under infrastructured facilities lead to poor mental health care and treatment which breeds acts and omission that end up being arbitrary in nature contrary to the exception guaranteed in the right to liberty and security of persons.

The guidelines given above when examined closely are in themselves substantive and procedural safeguards. Some however may appear peculiar for example the law accepting that a relevant mental health user and who though lacks capacity to make an informed choice on the treatment is otherwise willing to receive the treatment should receive compulsory treatment. It may be argued that this acceptance by the law is too broad because it may be difficult to determine whether a person who lacks capacity in the absence of an advanced directive authorizing the care is indeed willing to receive treatment. Similarly it may be argued that bestowing these powers upon the practitioners mentioned, particularly on psychiatrists is basically relying on the medical model that the CRPD is

¹¹⁷¹ See, *Ibid*, s. (7 & 8a).

¹¹⁷² See, *Ibid*, s. 27 (8b).

¹¹⁷³ See, *Ibid*, s. 27 (9&10).

set against. Two responses may be forwarded here, the first being that compared to the UK or Ontario the provisions on protections and procedures are simple here, but nevertheless better than nothing compared to the Ghanaian legislation as it does not leave persons without capacity without any form of protection. Second, the legislation tries to guarantee that encroachment on the right to make autonomous decision making including right to liberty is not done without recourse to any judicial review mechanisms that may be able to provide relief in form of injunction orders on certain actions, sanction other actions and or provide compensation for harm done.

As it follows therefore, the SMHCA in addition to the foregoing standards further mandates that the head of the relevant health establishment transmits his decision to the Review Board within seven days of approving assisted care, treatment and rehabilitation of all mental health users concerned with the relevant documents citing the reason.¹¹⁷⁴ The Board as it goes has to conduct inquiry within thirty days upon receiving the documents into the “ (a) incapacity of the mental health care user to make an informed decision on the need for the assisted care, treatment and rehabilitation services; and (b) circumstances under which the mental health care user is receiving care, treatment and rehabilitation services.”¹¹⁷⁵ The findings of the tribunal have to be given to the head of the health establishment concerned and individual, and according to the law it may either request the continuation of the assisted care, treatment and rehabilitation services, or discharge the mental health user according to clinical practice.¹¹⁷⁶ The provincial department where the relevant health establishment is located must also be informed of this decision.¹¹⁷⁷ Underscore here that the reviewing process by the Board shall be stopped if an appeal is lodged against the decision of the head of health establishment to provide the relevant care and treatment services.¹¹⁷⁸ This then brings the

¹¹⁷⁴ See, *Ibids.* 27 (9) & 28(1).

¹¹⁷⁵ See, *Ibid.*, s. 28 (2).

¹¹⁷⁶ See, *Ibid.*, s. 28 (3a-(i&ii) & b).

¹¹⁷⁷ See, *Ibid.*, s. 28 (3b).

¹¹⁷⁸ See, *Ibid.*, s. 28 (4).

discussion into appeals as a judicial review mechanism discussed afterward. Observe that this kind of procedures and powers of the Board or Tribunal cuts across the four jurisdiction.

Now, appeal against the decision of the relevant head of health establishment may be made by within thirty days of receiving the decision by the same individuals who may make an application for assisted care except for relevant health practitioner who is not named in the category of people eligible to appeal to the review board.¹¹⁷⁹ The appeal must contain the grounds upon which it is being contested. The Board has the thirty day duration to consider the appeal, duration similar to when it is considering the relevant head of health establishment decision.¹¹⁸⁰ It must afford the appellants or other participants the chance to adduce oral or written submissions in support of their claim and when it reaches a decision it is mandated to give or send a written decision with reasons as to why it reached the relevant conclusion.¹¹⁸¹ This requirement practically appears in all the jurisdictions and accordingly serves the promotion of the right to information that is correspondingly very imperative in decision making in terms of treatment. It is furthermore essential for further appeal processes if the mental health user or supporters are not satisfied with the decision and an additional safeguard against arbitrary detention and treatment. Akin to the effect of the decision it gives to the head of establishment, the Board shall give to the applicants and when it upholds the appeal, all assisted care, treatment and rehabilitation must be stopped and patient discharged unless the mental health user consents.¹¹⁸² Care only proceeds if the appeal is rejected.

An additional procedural safeguard in the Act which should materialize when a mental health user has been subjected to the assisted care, treatment and rehabilitation is that of a periodic review that has to be undertaken under the supervision of the head of health establishment concerned six

¹¹⁷⁹ See, *Ibid*, s. 29 (1a).

¹¹⁸⁰ See, *Ibid*, s. 29(2).

¹¹⁸¹ See, *Ibid*, s. 29 (2).

¹¹⁸² See, *Ibid*, s. 29 (3).

months from the initial inpatient admission and twelve months after.¹¹⁸³ This periodic review according to the SMHCA must include details on the capacity status of the user concerned and his or her expression on the relevant care and treatment and must state whether the care, treatment and rehabilitation given is less intrusive or restrictive to the “right to movement, privacy and dignity of the user” must contain “recommendations regarding a plan for further care, treatment and rehabilitation services”.¹¹⁸⁴ This review receives further evaluation by the Review Board upon receiving a summary copy and as such the nature of its inquiry is to determine whether the relevant legal procedures have been adhered to and the situation of the user.¹¹⁸⁵ It must grant a written decision to all the parties involved and if its decision is to stop treatment and discharge, then the relevant head of health establishment in question must comply.¹¹⁸⁶ With all these it shows that there is thorough review of an individual’s detention for assisted care, treatment and rehabilitation provided by the legislation even though it is not extensive as the UK.

Finally, a constant safety measure that transverses in all the jurisdiction including South Africa for those that lack capacity is understanding that capacity evolves all the time and that mental health users can at any time when they have regained their capacity exercise their right to make autonomous choices on their care, treatment and rehabilitation.¹¹⁸⁷ They can stop the treatment or consent to the continuation thereby becoming voluntary users under the Act, whichever is in their best interest.¹¹⁸⁸ This protection, as it is puts the mental health practitioners and head of establishment attentive at all time to the expressions of assisted mental health care user in order to ensure that arbitrary detention or treatment is not conducted against the user. However there is a little twist to the continuation of treatment which may be challenged to be unfair, on one hand and on the other it

¹¹⁸³ See, *Ibid*, s. 30 (1).

¹¹⁸⁴ See, *Ibid*, s. 30 (2 a, b &c).

¹¹⁸⁵ See, *Ibid*, s. 30 (3 &4).

¹¹⁸⁶ See, *Ibid*, s. 30 (5 a&b).

¹¹⁸⁷ See, *Ibid*, s. 31 (1).

¹¹⁸⁸ See, *Ibid*, s. 31 (1&2).

may be considered as providing care under best interest concerns. The head of health establishment is mandated to vet whether the user unwilling to continue treatment should be discharged or should be recommended for involuntary treatment under the Act.¹¹⁸⁹ To determine whether to undertake the two options an unwilling individual in order to qualify for discharge must not meet the criteria for inpatient assisted care, treatment and rehabilitation user whereas the individual going into involuntary treatment must be unwilling and must meet the set criteria.¹¹⁹⁰ Persons who have an involuntary treatment recommendation have thirty days upon which to make the application for involuntary treatment, failure to do so the person must be discharged.¹¹⁹¹

Take note that there is no precise provision on involuntary treatment and capacity to consent in the SMHCA. However from the above discussion on regaining of capacity, it is inferred that a person even if a user has the capacity to make his or her autonomous decision on the care, treatment and rehabilitation, he/she can nevertheless be treated without consent under the involuntary treatment sections of the Act. In addition, it can be inferred from the definition of involuntary care given in chapter two and as provided in the Act that it contains elements of capacity and consent.”¹¹⁹² It is important to remember as discussed in chapter two, that from the moment an individual seeks mental health care, treatment and rehabilitation, an individual’s consent has to be solicited before any assessment and treatment is undertaken. Compulsory treatment is given under the Act in accordance with the procedures given therein. As for those who are incapacitated, the presentation above details on how care, treatment and rehabilitation is administered. The difference between the two is in the ability to make decision. Whereas assisted do not refuse treatment, for those under involun-

¹¹⁸⁹ See, Ibid, s. 31 (3).

¹¹⁹⁰ See, Ibid, s. 31(3).

¹¹⁹¹ See, Ibid, s. 31 (3b, 4 & 5).

¹¹⁹² See Ibid, s. 1. For reiteration purposes, the Act states that: “involuntary care, treatment and rehabilitation’ means the provision of health interventions to people incapable of making informed decisions due to their mental health status and who refuse health intervention but require such services for their own protection or for the protection of others.” While “involuntary care, treatment and rehabilitation services’ has a corresponding meaning; ‘involuntary mental health care user’ means a person receiving involuntary care, treatment and rehabilitation”

tary are incapacitated yet refuse treatment. The following looks at the issue of consent in the SMHCA.

3.3.2.3. Consent & Civil Commitment

In the section where constitution and capacity to consent was reviewed, it was highlighted that it is a fundamental standpoint that individuals have the right to make autonomous decisions regarding their lives including health matters as safeguarded by article 9 and 12 of the constitution. It was also maintained that the right is equally buttressed by jurisprudence in *Castille V De Greef (1994)* where it was held that:

It is clearly for the patient, in the exercise of his or her fundamental right to self-determination, to decide whether he or she wishes to undergo an operation, and it is in principle wholly irrelevant that the patient's attitude is grossly unreasonable in the eyes of the medical profession: the patient's right to bodily integrity and autonomous moral agency entitles him or her to refuse medical treatment. It would be equally irrelevant that the medical profession was of the unanimous opinion that it was in given circumstances the surgeon's duty to refrain from bringing the risk to his patient's attention.¹¹⁹³

And therefore that:

for a patient's consent to constitute a justification that excludes the wrongfulness of medical treatment and its consequences, the doctor is obliged to warn a patient so consenting of a material risk inherent in the proposed treatment; a risk being material if, in the circumstances of the particular case: (a) a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it; or (b) the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it. This obligation is subject to the therapeutic privilege, whatever the ambit of the so-called 'privilege' may today still be.¹¹⁹⁴

The 'therapeutic privilege' in our times and as evidenced by all the mental health legislations in the research jurisdictions is that care, treatment and /or rehabilitation can be given compulsorily without consent to an individual suffering from a mental illness, who is unable to understand his/her

¹¹⁹³ See, *Castell V De Greef (1994)*, Supra note 1130, p. 410.

¹¹⁹⁴ See, *Ibid*, p. 427.

actions, given out of best interests of the individual concerned to purposely restore health, prevent harm to the individual or others or/and property. This care can be administered in emergencies situations. Regardless, the cardinal rule still stands that information must be given to the individual, representatives and the court so as to facilitate proper substituted or supported decision making.

The Cardinal rule- consent first before care, treatment and rehabilitation is postulated in the SMHCA. In this aspect it acts as a criterion and protection. However, from the capacity analysis a prior, care can be given without consent to individuals who are incapacitated through assisted care, treatment and rehabilitation following the prescribed procedures. Equally, in compulsory care, treatment and rehabilitation of individuals with mental illness, consent is not prerequisite as such and compulsory care can be given. This is not contrary to section 12 of the constitution as put in the case of *De Vos N.O. and Others v Minister of Justice and Constitutional Development and Others (2015)*, where based on the evidence given to the court it was maintained that “as mentioned earlier, I have been furnished with extensive references to international and foreign law in order to demonstrate what type of measures are acceptable in other open and democratic societies. Although it is universally accepted that persons of unsound mind may, in suitable circumstances, be detained involuntarily, this is invariably done with proper consideration for the rights of the individual and the circumstances of the case.”¹¹⁹⁵ However, the limitation for example of the right to liberty and security of persons for compulsory treatment may be at per with the constitution when it has been “shown that the law in question serves a constitutionally acceptable purpose and that there is sufficient proportionality between the harm done by the law (the infringement of fundamental rights) and the benefits it is designed to achieve (the purposes of the law).”¹¹⁹⁶ From the *De Vos N.O. and*

¹¹⁹⁵ See, *De Vos N.O. and Others v Minister of Justice and Constitutional Development and Others [2015]*, Supra note 1124, para, 66.

¹¹⁹⁶ See, *Ibid*, para 64.

Others v Minister of Justice and Constitutional Development and Others case, the SMHCA presents that proportionality and purpose of law.¹¹⁹⁷

But what does the Act provide per se about consent? Section 9 expressly provides that a mental health user may be admitted to a health establishment or may be given care, treatment and rehabilitation services by a health care provider if the user has consented or is ‘authorized by a court order or a Review Board’ or owing to mental illness, any delay in giving the stated care services or admission may result in the “(i) death or irreversible harm to the health of the user, (ii) user inflicting serious harm to himself or herself or others or (iii) user causing serious damage to or loss of property belonging to him or her or others.”¹¹⁹⁸ As it is seen the last part presents treatment during emergency situations where care, treatment and rehabilitation services may be given without consent. But notice also that the Act does not leave such users without protection because immediately after providing the care, the relevant health care provider, or head of health establishment must in the prescribed standards report the matter to the relevant Review board and at the same time the health care services being administered may not be given longer than 24 hours.¹¹⁹⁹ Continuation of care is possible as voluntary, assisted or involuntary care user if appropriate application is filled and approved within the 24 hour duration.¹²⁰⁰

It is subsequently established that care treatment and rehabilitation in certain circumstances can be given without consent either in an inpatient or outpatient basis. Hence whether it is during assisted or emergency situations, the SMHCA benchmarks the following procedures that must be followed to prevent any actions that may tantamount to arbitrariness and unlawfulness.¹²⁰¹ Accordingly, the

¹¹⁹⁷ See, Ibid, para 34, 54 &62.

¹¹⁹⁸ See, SMHCA (2002) as amended, s.9 (1).

¹¹⁹⁹ See, Ibid, s. 9 (2).

¹²⁰⁰ See, Ibid, s. 9(2-b).

¹²⁰¹ See, Ibid, s. 32 (a).

first thing that has to occur is an application in writing that has to be made by anyone from the already given group of individuals (providing support) to the head of the relevant health establishment where care is intended to be given and received.¹²⁰² The application can only be granted if it satisfies that:

- (b) at the time of making the application, there is reasonable belief that the mental health care user has a mental illness of such a nature that- (i) the user is likely to inflict serious harm to himself or herself or others; or (ii) care, treatment and rehabilitation of the user is necessary for the protection of the financial interests or reputation of the user; and
- (c) at the time of the application the mental health care user is incapable of making an informed decision on the need for the care, treatment and rehabilitation services and is unwilling to receive the care, treatment and rehabilitation required.¹²⁰³

These criteria's are analogous to the criteria that have to be satisfied for involuntary and assisted care, treatment and rehabilitation. They are also akin to the other three research jurisdictions. However when compared to the requirements of the CRPD previously stated, then they do not satisfy the set standards. Contrariness to the CRPD is equally noted as regards the mentioned group of individuals who can make substitute decision making for those incapacitated. Nevertheless, from the discussion it is discernible that universally, treatment and care can be given without consent and with due regard to set out guarantees. The following looks at protections. Many have already been mentioned in the discussion above and may be briefly repeated for emphasis.

3.3.2.4. Substantive & Procedural Safeguards

(a). The constitutional principles mentioned previously are non-derogable guarantees (except those with limitations) in themselves and therefore afford direct protection against any abuse to mental health users.¹²⁰⁴ The SMHCA in its preamble recognizes the constitution as it prohibits any unfair discrimination of individuals with mental disabilities and emphasizes that in any conflict that may

¹²⁰² See, Ibid, s. 32(a)

¹²⁰³ See, Ibid, s.32.

¹²⁰⁴ See, The Constitution of the Republic of South Africa (1996), s.37 (5).

arise between the SMHCA and the constitution, the constitution shall prevail.¹²⁰⁵ Just to recap, the constitution protects the right to equality, freedom and dignity including the right to liberty and security of persons which provides exceptional circumstances for limiting the right and the right to exercise autonomy.¹²⁰⁶ It also provides the right to access health which also encapsulates mental health care, treatment and rehabilitation.¹²⁰⁷ The failure to respect these rights may result in the aggrieved individual seeking remedy from the courts for the breach of constitutional rights.¹²⁰⁸

(b). In further connection to rights, the SMHCA underscores similar rights (right to information, from abuse, from unfair discrimination) as those in constitution. In context to capacity and consent, it requires respect of all human rights even those in other laws, respect of human dignity of every mental health care user and emphasizes that “every mental health care user must be provided with the [least intrusive] care, treatment and rehabilitation services that improve the mental capacity of the user to develop to full potential and to facilitate his or her integration into community life”.¹²⁰⁹ In promoting these entitlements, it bestows upon all mental health care providers the obligation of empowering mental health care users with the knowledge of their rights in a proper manner before administering any care treatment and rehabilitation services.¹²¹⁰ This obligation however may not be automatic in situations where the individual lacks the capacity to comprehend due to a mental illness; nevertheless, whenever possible and when capacity is regained the duty has to be fulfilled.¹²¹¹ In addition, knowledge of rights should be explained to spouses, guardians and curators. Equivalent provisions appear in the UK and Ontario as shown in chapter two.

¹²⁰⁵ See, SMHCA (2002) as amended, the preamble, s.2 (2) & 9.

¹²⁰⁶ See, The Constitution of the Republic of South Africa (1996),

¹²⁰⁷ See, SMHCA (2002) as amended, s. 27.

¹²⁰⁸ See, The Constitution of the Republic of South Africa (1996), s. 34&38.

¹²⁰⁹ See, SMHCA (2002) as amended, s. 7, 8 &

¹²¹⁰ See, Ibid, s. 17.

¹²¹¹ See, Ibid, s.9 (1-c) & 17 read together.

(c). An additional important protection is the presumption of capacity. As already discoursed above from the National Health Act, the SMHCA and case law, a mental health user has the right to exercise autonomy in the decisions pertaining his or her health. Even in those circumstances where an individual lacks capacity, there are procedures to be followed to ensure that the right of autonomy is not excessively encroached on. Importantly, health care practitioners are required to understand that exercise of capacity and consent are not static but a continuous process which may change. Meaning therefore that they must be very observant and attentive to the users for an individual may at the time of admission lack capacity but at the time of administering treatment gain capacity and may decide to exercise their right to accept or reject care, treatment and rehabilitation.

(d). In continuation to the above and paralleled to the other three jurisdiction, is the right to information. According to the SMHCA and National Health Act, consent can only be given and become valid or rather become informed consent if the mental health user has been fully given the information relating to the care and the individual has weighed all the benefits and risks of the proposed care, treatment and rehabilitation plan.¹²¹² Consent may be given by a curator appointed by court, spouse, family member, next of kin and guardian where the user is incapable to consent and the information must also be given to these groups of individual where applicable.¹²¹³ It may also be given by head of health establishment but the consent must be without undue pressure.

(e). Akin to the other research jurisdictions, there is a prohibition of performing certain procedures without consent. Certain procedures can only be carried out with the valid informed consent of the mental health user, curator, guardian, parent etc. For example psychosurgery can only be performed when an informed consent of the mental health user has been given, where there is a “a medical

¹²¹² See, Ibid.

¹²¹³ Se, Ibid, Regulation 35 (1 &2) of SMHCA (2004).

report constructed and signed by at least two independent psychiatrists must state whether in their opinion, all mental health treatment previously applied has failed and psychosurgery is necessary” [and] performed by a registered neurosurgeon who has actually agreed to do the procedure.¹²¹⁴ Homogenous principles apply to electroconvulsive therapy with minor difference in procedural requirement, that is it has to be done by a “registered medical practitioner with special training in mental health and may only be carried out under a general anesthetic together with a muscle relaxant”, that not more than one treatment can be carried out in a 24 hour period, that it can only administered on alternate days when applicable, that the head of provincial department concerned of a health establishment run by State or private may perform the procedure, that records must be kept in the proper forms signed by medical practitioner or psychiatrist and that the transcript is submitted to the Review Board on a quarterly basis in the prescribed form under the SMHCA.¹²¹⁵ Sleep therapy is a mentioned and prohibited procedure on any mental health care user under the SMHCA.¹²¹⁶ It is not mentioned in the other research jurisdictions.

(f). Abuse under the Act is prohibited under section 11. The regulation buttresses this prohibition by requiring that any “person witnessing any form of abuse against a mental health care user as contemplated in section 11(1) of the Act-(a) must report this fact to the Review Board concerned in the form of Form MHCA 02 of the Annexure; or (b) may lay a charge with the South African Police Service who shall in writing notify the Review Board concerned of that charge.” The Review Board upon receiving the report or notification is obliged to investigate and lay a charge/s with the South African Police Service.¹²¹⁷

¹²¹⁴ See, Ibid, Regulation 32(1, 2&3) (2004).

¹²¹⁵ See, Ibid, Regulation 33 (1-5) (2004).

¹²¹⁶ See, Ibid, Regulation 34 (2004).

¹²¹⁷ See, Ibid, s. 11 & Regulation 7 (1&2) (2004).

(g). In relation to the prohibition of abuse, the SMHCA makes it an offence to disobey any substantive and procedural aspects articulated within it and as it is applied to each relevant individual and circumstance.¹²¹⁸ This infers therefore all the procedures on capacity and consent conversed previously must be observed and put into effect.

3.3.2.5. Sum Up

Without repeating the already mentioned, the South African statutory framework though not extensive like the UK or Ontario provides similar fundamental principles and protections regarding capacity and consent generally and during civil commitment. Compared to Ghana, it sets out more guidelines. The South African legislation emphasizes more on balancing of rights and provision of mental health care, with principles of least intrusive measures being given the upper hand before other measures are engaged. Substitute decision making is not prohibited and encouraged just like supported decision making. It equally emphasizes use of two health professional opinion during the assessment of capacity and consent a feature that is not emphasized in the other jurisdictions. Finally, the statutory framework and case law purporting to sanction involuntary care, treatment without consent and use of substitute decision making stand antagonistic to the CRPD position, even with the protections enumerated therein. Take note here that the SMHCA does not regulate traditional or spiritual centers of healing in South Africa, which means that issues of capacity and consent are not regulated in this sphere which leaves a gap for the occurrence of encroaching into the right of autonomous decision making without protection and remedy.

¹²¹⁸ See, *Ibid*, s. 70.

3.3.3. Ontario (Canada)

3.3.3.1. Introduction: Statutory Framework

The statutory framework regulating capacity, consent and civil commitment in Ontario is the same as that introduced in chapter two. Briefly, they include the Constitution, the Health Consent and Capacity Act, the Substitute Decisions Act and other related Acts such as Personal Information's Act that regulates the use and retention of information as far as it relates to patients information. This Act is not discussed herein but mentioned where relevant. Therefore the following looks into how these legislations relate to capacity, consent and civil commitment. The starting point is the analysis of the constitution and recognition of the right to equal recognition before the law, then capacity followed by discussion on consent and finally safeguards as provided in the given legislation and in relation to civil commitment and CRPD compatibility.

Thus, comparable to the other jurisdictions, the starting point for capacity, consent and civil commitment in Ontario also begins from the basic legal document of the State. In this regard, the right to equal protection before the law for Ontarians begins in section 15 of the Charter which makes it very clear that every individual in Canada "is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability".¹²¹⁹ Compared to the other jurisdictions, the Canadian Charter is the only one that distinguishes between mental and physical disability. Though it is alike the South African constitution in terms of interpretation and expansion of protected groups on the equality clause. The Canadian Supreme court and other courts have established that section 15 is not limited to the grounds provided therein, but upholds equality on the basis of other characteristics not specifically detailed

¹²¹⁹ See, The Constitution Act of Canada, Charter of Rights and Freedoms (1982), s.15 (1).

therein such as sexual orientation, citizenship and marital status.¹²²⁰ It is also analogous to the others in terms of section 15 (2) which protects equality rights of those marginalized individuals or communities by permitting the enactment and implementation of specific laws that target the advancement of the marginalized for example women or those with mental or physical disabilities.¹²²¹

It is important to take notice as mentioned in chapter two that the Canadian Charter applies to laws and government actions and does not relate to individual relations or businesses. Therefore, for these kinds of complaints provincial human rights documents such as the Ontario Human Rights Code will apply. This is a slight difference from the other research jurisdictions where the constitution is applied directly to the people and reviews government legislation and Acts. The Canadian way is as such because of the differences in governmental structure and devolution of provinces. Nevertheless and back to the discussion, the interpretation of section 15 is limited herein but for emphasis purposes, legislations and government actions must be in accordance with the constitutional norms and can “only be subject to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society”.¹²²² In *R V Oakes (1986)* it was held by the Supreme court held that the burden of justifying a Charter breach lies on the party seeking to uphold the limitation which is always the government and who must therefore show that the “objective of the impugned legislation or government action is sufficiently ‘pressing and substantial’ to warrant overriding a charter right, and the means adopted to attain that objective must be reasonable and

¹²²⁰See, *Canada (Attorney General) v. Hislop (2007) SCC 10*. Case where a statutory distinctions restricting same-sex partners eligibility for and access of Canada Pension Plan survivors benefits was found violation was found to be in violation of section 15(1). See, also, *Andrews v. Law Society of British Columbia (1989) 1 S.C.R. 143*-discrimination on citizenship grounds. Compare to *Minister of Home Affairs and Another v Fourie and Another; Lesbian and Gay Equality Project and Others v Minister of Home Affairs and Others*, [2005] ZACC 19.

¹²²¹See, *The Constitution Act of Canada, Charter of Rights and Freedoms (1982)*. The section states that “subsection (1) does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups including those that are disadvantaged because of race, national or ethnic origin, colour, religion, sex, age or mental or physical disability” See also, *Constitution of the Republic of South Africa (1996)*, s.9 (2), *The Constitution of The Republic of Ghana (1992)*, s. 17(4).

¹²²² See, *Ibid*, s.1. It provides that “the *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society”

demonstrably justifies.”¹²²³ This process of justifying is essentially a proportionality test –balancing of societies interests vis a vis those of individuals or groups and it requires the fulfilment of three components. The first is that the measures adopted must be rationally connected to the objective(to prevent arbitrary, unfair or based on irrational considerations), the second requires that the means even though rational should impair “as little as possible” the right or freedom in question and the third is that there must be a proportionality between effects of the measures and the objective which has been identified as of ‘sufficient importance’¹²²⁴This proportionality principle comparatively emerges in the South African constitutional jurisprudence and also in the UKHRA which requires all government legislations and actions be in conformity with the rights therein.

On account of the above, the process of judicial review in the Charter ensures that legislation enacted and actions executed therein are in accordance with the norms of a free and democratic society. This goes without say that mental health legislation and other related Acts must be enacted and implemented in conformity with the Constitution. In Chapter two, it was illustrated that so far, the provisions relating to compulsory treatment and community treatment orders under the OMHA have been found to be compatible with the constitution. However when this interpretation of the OMHA and its constitution validity is paralleled to the CRPD, the compatibility may be lacking. As already mentioned in the introduction section, Canada is among those countries that have a reservation on Article 12 of the CRPD on the issue of continued use of supported and substituted decision making mechanisms.¹²²⁵

Despite this reservation, an individual who cannot exercise legal capacity still has those ‘effective safeguards’ provided in the law such as the Charter. The Charter as given a prior protects individu-

¹²²³ See, *R v Oakes* (1986) 1 S.C.R. 103, para 66 &69.

¹²²⁴ See, *Ibid*, para 70.

¹²²⁵ See, United Nations Treaty Collection Database, Convention on the Rights of Persons With Disabilities (2008). Supra note 956.

al's rights by ensuring that any limitation of the rights therein is reasonable and can be demonstrably justified in free and democratic society.¹²²⁶ Therefore just like the scrutiny applied to section 15 on equal rights before the law, the constitution extends the same to the right to liberty and security of persons and the right not to be arbitrarily deprived except in accordance with the principles of fundamental justice as expressed in section 7.¹²²⁷ Thus, the regulatory scheme provided under the OMHA for involuntary hospitalization and treatments become validated. The same goes for the OHCCA and the Substituted Decision Making Act (OSDA) that deal with matters of capacity and consent to treatment as shall be discussed further below. Having said that, the right to liberty under section 7 has been interpreted as not only encompassing freedom from physical restraint and interference of physical freedom by the State, but also "fundamental concepts of human dignity, individual autonomy and privacy."¹²²⁸ This is summarily held in the case of **Godbout v. Longueuil (City) (1997)** where the court explained that:

Right to liberty enshrined in s. 7 of the Charter protects within its ambit the right to an irreducible sphere of personal autonomy wherein individuals may make inherently private choices free from state interference. I must emphasize here that, as the tenor of my comments in B. (R.) should indicate, I do not by any means regard this sphere of autonomy as being so wide as to encompass any and all decisions that individuals might make in conducting their affairs. Indeed, such a view would run contrary to the basic idea, expressed both at the outset of these reasons and in my reasons in B. (R.), that individuals cannot, in any organized society, be guaranteed an unbridled freedom to do whatever they please. Moreover, I do not even consider that the sphere of autonomy includes within its scope every matter that might, however vaguely, be described as "private". Rather, as I see it, the autonomy protected by the s. 7 right to liberty encompasses only those matters that can properly be characterized as fundamentally or inherently personal such that, by their very nature, they implicate basic choices going to the core of what it means to enjoy individual dignity and independence.¹²²⁹

¹²²⁶ See, The Constitution Act of Canada, Charter of Rights and Freedoms (1982), s.1 & 15.

¹²²⁷ See, Ibid, s.7.

¹²²⁸ See, *Godbout v. Longueuil (City)*, (1997) 3 S.C.R. 844, para. 65. See also, *R. v. Morgentaler*, (1988) 1 S.C.R. 30, para 166. It was similarly held that: "[A]n aspect of the respect for human dignity on which the Charter is founded is the right to make fundamental personal decisions without interference from the state. This right is a critical component of the right to liberty. Liberty, as was noted in [*Singh v. Minister of Employment and Immigration*, [1985] 1 S.C.R. 177], is a phrase capable of a broad range of meaning. In my view, this right, properly construed, grants the individuals degree of autonomy in making decisions of fundamental personal importance."

¹²²⁹ See, Ibid, para 66.

Treatment decisions include one of those core decisions that involve the dignity and independence of an individual. And because of this consequential nature it is imperative that where limitations are exercised, there are appropriate safeguards as highlighted in the above case to ensure that rights such as the rights to liberty and autonomy are not further encroached on or abused and that the right to dignity remains intact. The use of the Charter in matters of decision making during forced hospitalization is illustrated by the case of *Fleming V Reid (1990)*. This is a case concerning an applicant admitted for psychiatric care and who was incapable of consenting to treatment but nevertheless had exercised the right to autonomous decision making by utilizing the protection of the law that guaranteed the use of prior expressed wishes and which was executed by a substitute decision maker through the Substitute Decision Making Act.¹²³⁰ However, the law at the time gave the health care provider power to override any such made prior wishes, which was done in this case prompting the contention and allegation of rights violation. The Ontario Court of Appeal found a violation by asserting that:

The impugned scheme under the Mental Health Act fails to meet the requirement of s. 7 that the principles of fundamental justice be observed with respect to involuntary incompetent patients. Those patients are arbitrarily deprived of their right to security of the person insofar as they are denied any hearing in which they may assert, through their substitute consent-givers, their competent wishes with respect to treatment and, thus, their right to be free of unwanted medical treatment. Such a violation of the principles of fundamental justice, in my opinion, can be neither "reasonable" nor "demonstrably justified in a free and democratic society."¹²³¹

In regards to the right to security of persons and autonomy of the individual, the court deemed that:

The right to personal security is guaranteed as fundamental in our society. Manifestly, it should not be infringed any more than is clearly necessary. In my view, although the right to be free from nonconsensual psychiatric treatment is not an absolute one, the state has not demonstrated any compelling reason for entirely eliminating this right, without any hearing or review, in order to further the best interests of involuntary incompetent patients in contravention of their competent wishes. To completely strip these patients of the freedom to determine for themselves what shall be done with their bodies cannot be considered a minimal impairment of their Charter right. Safeguards can obviously be formulated to balance

¹²³⁰ See, *Fleming v. Reid (1990)*, *Supra* note 529.

¹²³¹ See, *Ibid*, para (VII).

their wishes against their needs and ensure that their security of the person will not be infringed any more than is necessary.¹²³²

This judgment indicates three things. First, that the rights in the Charter are not absolute and can be restricted even when it comes to matters of autonomy.¹²³³ Second, these limitations are subject to the application and scrutiny of those protections that balance the limitation on the right and the objective of the limitation which is normally providing care, prevention of harm to self and others and best interest's considerations in cases of providing mental health care without consent and including to incapacitated individuals.¹²³⁴ The third is that it indicates the importance of observing safeguards to those capable and incapable of making decisions lest actions become arbitrary in nature. For it is emphasized that “the fact that these patients, whether voluntarily or involuntarily, are hospitalized in a mental institution in order to obtain care and treatment for a mental disorder does not necessarily render them incompetent to make psychiatric treatment decisions [that] they may be incapacitated for particular reasons but nonetheless be competent to decide upon their medical care”.¹²³⁵

In sum, the discussed has revealed that constitutionally, proportionality is the test is important when right to equal recognition before the law and capacity and consent are engaged and are restricted for civil commitment purposes. Having established this, the following looks at the statutory framework governing mental health care and treatment particularly compulsory treatment alongside matters of capacity and consent. It should be noted from the outset that discourse on long term care facilities and capacity is limited hereafter as it was limited in the discussion on UK, even though the legislation providing for mental capacity regulations are merged with those concerning mental health treatment.

¹²³² See, *Ibid*, para. 60.

¹²³³ See, *Ibid*, para VII.

¹²³⁴ See, *Ibid*, para VII.

¹²³⁵ See, *Ibid*, para IV.

3.3.3.2. Capacity & Civil Commitment

For clarity it is prudent to recap on the relevant legislative framework for capacity and consent in Ontario. They include the OMHA that deals with voluntary and involuntary mental health care and treatment, the OHCCA which governs all matters relating to consent to health care and OSDA which provides standards for legal capacity to make decision in matters involving property and personal care which encompasses decisions relating to health care, shelter, clothing and safety etc.¹²³⁶ Essentially, where an individual lacks legal capacity to make decisions in one of the mentioned areas, decisions may be made by a person exercising a power of attorney or guardian appointed for that purpose.¹²³⁷

With the above review, the following discusses how capacity and civil commitment is regulated within these legislations particularly in regards to protections. Capacity and guardianship matters are not key issues regulated under the OMHA.¹²³⁸ However, it does not mean that it is not provided particularly when concerns relating to capacity during care and treatment of those with mental disorders. As it is the Act links the OHCCA to the OMHA and OSDA thereby providing standards and protections to patients and care providers respectively. This linkage is evidently established through the articulated conditions for involuntary admission, requiring that before a certificate of involuntary admission is issued the individual concerned must have “been found incapable, within the meaning of the *Health Care Consent Act, 1996*, of consenting to his or her treatment in a psychiatric facility and the consent of his or her substitute decision-maker has been obtained”.¹²³⁹ Besides this provision, part III of the Act regulates property of those individuals with a mental disorder admitted into psychiatric facility by necessitating that “forthwith on a patient’s admission to a psychi-

¹²³⁶ See, OMHA (1990), OHCCA (1996) as amended & OSDA (1992) as amended respectively.

¹²³⁷ See, OSDA (1992) as amended.

¹²³⁸ See, Law Commission of Ontario, *Legal Capacity, Decision-Making and Guardianship: Discussion Paper* (Toronto: May 2014).p. 43.

¹²³⁹ See, OMHA (1990) as amended, s. 20 (1.1-e).

atric facility, a physician shall examine him or her to determine whether the patient is capable of managing property.”¹²⁴⁰ Where it has been established that the relevant individual is incapable a certificate of incapacity shall be issued in the prescribed form and the public guardian and trustee must be informed.¹²⁴¹ The individual enjoys the right to a rights advisor, an application to the capacity and consent Board for review, cancellation of certificate and also the right to be discharged.¹²⁴² Remember that this section does not apply if “the patient’s property is under guardianship under the Substitute Decisions Act, 1992 or (the physician believes on reasonable grounds that the patient has a continuing power of attorney under that Act that provides for the management of the patient’s property.”¹²⁴³ This is as far as the Act goes with capacity and where the thesis discussion on capacity and managing property concludes since the topic is primarily focused on civil commitment.

With the above hindsight emphasis here is that the OHCCA stands to be the leading authority in issues concerning capacity and consent in all matters related to care and treatment. In this regard, the starting point emphasized in the Act and in the leading jurisprudence of *Starson v Swayze* (2003) is that all persons in Ontario are presumed to be capable of making autonomous decisions with respect to their care, treatment, and admission to a care facility and person’s assistance services.¹²⁴⁴ This emphasis on presumption of capacity makes it an obligation for health care practitioners to uphold an individuals or patients right to self-determination unless they have reasonable grounds to believe that the person lacks the capacity to do so.¹²⁴⁵ This in turn gives them protection

¹²⁴⁰ See, *Ibid*, s. 54 (1).

¹²⁴¹ See, *Ibid*, s. 54 (4).

¹²⁴² See, *Ibid*, s. 56-60.

¹²⁴³ See, *Ibid*, s. 54 (6).

¹²⁴⁴ See, OHCCA (1996) as amended, s. 1 & 4(1&2). See also, *Starson v Swayze*, (2003), *Supra* note 559.

¹²⁴⁵ See, OHCCA (1996) as amended, s. 1 & 4.

from any liability if and when they make decisions of incapacity under the OHCCA on reasonable grounds and good faith.¹²⁴⁶

According to the case of *Starson V Swayze (2003)*, the Supreme Court noted that the OHCCA tries to make this difficult balance between preserving the value of individual autonomy, the right to medical treatment particularly for those with mental disorders and are unwilling to receive treatment, the societal protection where the individual maybe a harm to individual self or others and liabilities of those who provide care such as health care providers.¹²⁴⁷ The court emphasized further that OHCCA task of balancing the intrusion and preservation of the right to autonomy ensures that “mental illness is not conflated with incapacity, mental illness without more does not remove capacity and autonomy [and] only where it can be shown that a person is unable to understand relevant factors and appreciate the reasonably foreseeable consequences of a decision or lack of decision can treatment be imposed.”¹²⁴⁸ Therefore, set in this background that involves a challenging balance of rights and duties, the legislation lays down capacity test and protections to be implemented in situations where it is reasonably believed an individual may lack the capacity to consent to treatment. The test is set out in section 4 (1) of the OHCCA as follows:

A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.¹²⁴⁹

¹²⁴⁶ See, Ibid, s. 29(1).

¹²⁴⁷ See, *Starson v Swayze*, [2003], *Supra* note, 559, para 6. It stated that: “The *HCCA* confronts the difficult problem of when a mentally ill person may refuse treatment. The problem is difficult because it sets in opposition fundamental values which we hold dear. The first is the value of autonomy — the ability of each person to control his or her body and consequently, to decide what medical treatment he or she will receive. The second value is effective medical treatment — that people who are ill should receive treatment and that illness itself should not deprive an individual of the ability to live a full and complete life. A third value — societal protection — comes into play in some cases of mental illness. Where the mentally ill person poses a threat of injury to other people or to him- or herself, it may be justified to impose hospitalization on the basis that this is necessary in the interests of public safety.” See also, p. 730-732, para 6-11.

¹²⁴⁸ See, Ibid, para 10.

¹²⁴⁹ See, OHCCA (1996), as amended.

What this test really entails and how it should be understood was enunciated very comprehensibly in the case. In this regard, up-to-date it has come to be understood that based on the Act, an assessment of capacity involves two tests or component with the following considerations articulating the first part:

The first component of the test for capacity is that the person be “able to understand the information that is relevant to making a decision about the treatment” at issue. The person must be capable of intellectually processing the information as it applies to his or her treatment, including its potential benefits and drawbacks. Two types of information would seem to be relevant: first, information about the proposed treatment; and second, information as to how that treatment may affect the patient’s particular situation. Information relevant to the treatment decision includes the person’s symptoms and how the proposed treatment may affect those symptoms. The patient must be able to acknowledge his or her symptoms in order to be able to understand the information relevant to a treatment decision.¹²⁵⁰

From the quotation above, the centrality of the right to information in evaluating capacity is emphatically reiterated. The reiteration of its importance is comparably presented in the other research jurisdictions. Another similarity from the excerpt is that capacity is only at issue when treatment is in issue at that relevant time. In other words, capacity is not static and can fluctuate with time and in different situations. The OHCCA stipulates that “a person may be incapable with respect to some treatments and capable with respect to others and/ or may be incapable with respect to a treatment at one time and capable at another.”¹²⁵¹ For that reason, “if, after consent to a treatment is given or refused on a person’s behalf in accordance with this Act, the person becomes capable with respect to the treatment in the opinion of the health practitioner, the person’s own decision to give or refuse consent to the treatment governs.”¹²⁵² Here again as has been stated before requires health care professionals to be observant and attentive to their patients needs and expressions. The second part of the test is “characterized as more stringent than a mere understanding test since it includes both

¹²⁵⁰ See, *Starson v Swayze*, [2003], *Supra* note 559, para 16.

¹²⁵¹ See, OHCCA (1996) as amended, s. 15 (1&2).

¹²⁵² See, *Ibid*, s. 15 (3).

cognitive and an effective component,”¹²⁵³ the ability to appreciate the reasonably foreseeable consequences of their decisions. In *Starson V Swayze (2003)*, the court commented that:

The second point that the test relates to a person’s capacity or ability to understand and appreciate is reflected by the use of the word “able” in relation to “understand” and “appreciate”. It means that a person cannot be found to lack capacity on the basis of lack of information about his or her illness or the fact that he or she holds contrary views to a prescribed diagnosis.¹²⁵⁴

The court further exemplified the above by drawing attention to the fact that these components do not require that the individual concerned agrees with a specific conclusion, professional or otherwise.¹²⁵⁵ The position of the patient is to weigh the advantages and disadvantages of the proposed treatment and arrive at a possibly dissimilar opinion than the professionals.¹²⁵⁶ Moreover, the individuals understanding and appreciating the information should and does not amount to a best interest standard, and as a result affording the individual the right to refuse treatment, even if that care and treatment from a medical point of view is in the individual’s best interest.¹²⁵⁷ Accordingly, thoughtfulness has to be observed to prevent interpreting a difference in opinion with a particular diagnosis or proposed care and treatment plan as a justification in itself of a confirmation of incapacity.¹²⁵⁸ Nevertheless, the court emphasized that as it is imperative that individual exercise their right to autonomy to refuse care and treatment it is equally important that care and treatment is provided to patients who are unable to make autonomous decisions due to incapacity.¹²⁵⁹ This sounds more like the provision in the Ghanaian legislation that links capacity and the right not to deprive any one of treatment due to lack of capacity. Finally, “a person may be found incapable if he or she

¹²⁵³ See, *Starson v Swayze*, [2003] Supra note 559, para 17.

¹²⁵⁴ See, *Ibid*, para 14.

¹²⁵⁵ See, *Ibid*, para 19.

¹²⁵⁶ See, *Ibid*.

¹²⁵⁷ See, *Ibid*.

¹²⁵⁸ See, *Starson v Swayze*, [2003] 1 S.C.R. p. 736, para 19.

¹²⁵⁹ See, *Ibid*.

does not meet one part of the test or both”¹²⁶⁰Once this is established, then decision-making has to be given by substitute decision maker as discussed hereafter.

Note that before a decision is substituted for an individual who lacks the capacity to make decisions on care and treatment through consenting, the OMHA has inbuilt safeguards. One of these protections requires that patients admitted to a psychiatric facility and found to be incapable of consenting to treatment, must be given a notice of incapacity finding in the prescribed form (form 33).¹²⁶¹The same requirement applies to OHCCA.¹²⁶²The second needs prior wishes of the individual must be taken into account by the health care provider.¹²⁶³Third, as a procedural and substantive protection, where there has been a finding of incapacity, the health care provider is required to locate the patient’s relevant substitute decision maker for the purpose of seeking their informed consent for the proposed treatment.¹²⁶⁴Even then, the patient must be engaged in the process.¹²⁶⁵The fourth is that under the OMHA the patient has the right to a rights adviser who has the obligation to inform the patient the relevance of the certificate of incapacity whereas in the OHCCA information is from the

¹²⁶⁰ See, Ontario Hospital Association, *A Practical Guide to Mental health and the Law in Ontario*, Supra note 526, p. 10. See also, OHCCA (1996) as amended, s. 4(3).

¹²⁶¹ See, OMHA (1990) as amended, s.54 (4).

¹²⁶² See, OHCCA (1996) as amended, s. 17.

¹²⁶³ See, *Ibid*, s.5.

¹²⁶⁴ See, *Ibid*, s. 17. It states that: “A health practitioner shall, in the circumstances and manner specified in guidelines established by the governing body of the health practitioner’s profession, provide to persons found by the health practitioner to be incapable with respect to treatment such information about the consequences of the findings as is specified in the guidelines.” See also, College of Physicians and Surgeons of Ontario, *Consent to Medical Treatment*, Policy Number: #4-05 (February 2006), p.2. It states that: “Briefly, the following must occur when a physician proposes a treatment: •The physician determines if a patient is capable of consenting. If the patient is capable, the physician must provide information about the treatment. The patient either provides consent or refuses the treatment. If the patient consents, then the physician proceeds with the treatment until the patient’s capacity changes or the treatment changes. •If the patient is determined to be incapable, then the physician must identify the substitute decision-maker, and go through the same process to obtain consent.”

¹²⁶⁵ See, *Ibid*, p.2. It states that: “Even when there is a substitute decision-maker, a physician must still involve the patient. The College advises the physician to take the following steps: 1. Tell the incapable patient that a substitute decision-maker will assist the patient in understanding the proposed treatment and will be responsible for making the final decision. 2. Involve the incapable patient, to the extent possible, in discussions with the substitute decision-maker. 3. If the patient disagrees with the need for a substitute decision-maker, or disagrees with the involvement of the present substitute, the physician must advise the patient of his or her options. These include finding another substitute of the same or more senior rank, and/or applying to the Consent and Capacity Board for a review of the finding of Incapacity. 4 Reasonably assist the patient if he or she expresses a wish to exercise the options outlined above in paragraph 3.”

proposing health practitioner.¹²⁶⁶The OMHA speaks of right to apply for a review of incapacity for managing property whereas OHCCA provides for incapacity for treatment and personal assistance service.¹²⁶⁷The fifth and last is that upon an issuance of notice of incapacity, the concerned individual or their substitute decision makers have the right to apply to the CCB for a review of this finding.¹²⁶⁸This right however has an exception to the effect that those with guardians with authority to give or refuse treatment or attorney for personal care with power of attorney containing a provision waiving the person's right to apply to for review and is effective under the Substitute decisions Act, may not rely on the right to a review.¹²⁶⁹

3.3.3.2.1. Substitute Decision Making

Accordingly, comparable to the other research jurisdictions herein, the Ontario legislation provides support in decision making through substitute decision making. Of course as reiterated previously, this does not fit within the CRPD standard requiring the use of supported decision making. Be that as it may, substitute decision making or the use of guardianship, attorney for personal care and public guardian trustees is legally acceptable in Ontario.¹²⁷⁰Ontario equally makes use of the listed group of individuals in the Act who are authorized to provide substituted decisions for those incapacitated. However the only difference is that Ontario provides a separate legislation containing a

¹²⁶⁶ See, OMHA (1990) as amended. S. 59 (1&2) states that: "(1) A physician who issues a certificate of incapacity or a certificate of continuance shall promptly advise the patient of the fact and shall also promptly notify a rights adviser. (2) The rights adviser shall promptly meet with the patient and explain to him or her significance of the certificate and the right to have the issue of the patient's capacity to manage property reviewed by the Board." See also, OHCCA (1996) as amended. S. 17.

¹²⁶⁷ See, Ibid, s. 59 (2). It states that: "The rights adviser shall promptly meet with the patient and explain to him or her the significance of the certificate and the right to have the issue of the patient's capacity to manage property reviewed by the Board."

¹²⁶⁸ See, OHCCA (1996) as amended, s. 32 (1)

¹²⁶⁹ See, Ibid, s. 32 (2). It states that: "**Exception** (2) Subsection (1) does not apply to, (a) a person who has a guardian of the person, if the guardian has authority to give or refuse consent to the treatment; (b) a person who has an attorney for personal care, if the power of attorney contains a provision waiving the person's right to apply for the review and the provision is effective under subsection 50 (1) of the *Substitute Decisions Act, 1992*. 1996, c. 2, Sched. A, s. 32 (2)."

¹²⁷⁰ See, Ibid, s. 20, See also Substitute Decisions Act (1992) as amended & OMHA (1990) as amended s. 20 (1.1-e), 33.1 (4-f) & 54 (4).

hierarchical ranking.¹²⁷¹ The decision by those on top outweighs that given by those in the bottom, unless the higher ranking individual is not available then the bottom ranked can provide the relevant decision for care and treatment.¹²⁷² The listing contains the guardian, attorney for personal care, representative appointed by the Board, spouse or partner, child or parent or children's aid or other authorized, parent who has only right of access, a brother or sister or any other relative respectively of whom must have the authority to give or refuse consent.¹²⁷³ It is important to take into consideration that being one of the above does not necessarily and automatically qualify one to make decisions on behalf of the concerned individual. As part of promoting proper decision making and protection against abuse the legislation requires more in terms of the following requirements that qualify the kind of persons who should have the authority to provide or withhold consent:

- (a) is capable with respect to the treatment;
- (b) is at least 16 years old, unless he or she is the incapable person's parent;
- (c) is not prohibited by court order or separation agreement from having access to the incapable person or giving or refusing consent on his or her behalf;
- (d) is available; and
- (e) is willing to assume the responsibility of giving or refusing consent. 1996, c. 2, Sched. A, s. 20 (2).¹²⁷⁴

In addition to the above protective qualification is that, in the event that there is no one to substitute decision or where there is a disagreement between two ranked individuals to give or withhold consent, the legislation resolves this gap by empowering the public guardian and trustee the responsibility of decision making.¹²⁷⁵ Therefore, at that moment when it is established there is an appropriate substituted decision maker, he or she upon receiving the relevant proposed treatment information may provide or refuse consent.¹²⁷⁶ Again, it is imperative to understand that the substitute decision maker does not haphazardly make a decision but must execute previous made wishes, or if

¹²⁷¹ See, *Ibid*, s. 20 (1).

¹²⁷² See, *Ibid*, s. 20 (4).

¹²⁷³ See, *Ibid*, s. 20 (1).

¹²⁷⁴ See, *Ibid*, s. 20 (2).

¹²⁷⁵ See, *Ibid*, s. 20 (6).

¹²⁷⁶ See, *Ibid*, s. 22 (1).

aware of prior wishes that are relevant and applicable to the situation at hand, he or she must act in accordance with those wishes. However, where these wishes do not exist or the substitute decision maker is not aware, then he or she must make the decision founded on the patient's best interest, taking the following into account:

- (a) the values and beliefs that the person knows the incapable person held when capable and believes he or she would still act on if capable;
- (b) any wishes expressed by the incapable person with respect to the treatment that are not required to be followed under paragraph 1 of subsection (1); and
- (c) the following factors:
 1. Whether the treatment is likely to, (i). improve the incapable person's condition or well-being, (ii). prevent the incapable person's condition or well-being from deteriorating, or (iii). reduce the extent to which, or the rate at which, the incapable person's condition or well-being is likely to deteriorate.
 2. Whether the incapable person's condition or well-being is likely to improve, remain the same or deteriorate without the treatment.
 3. Whether the benefit the incapable person is expected to obtain from the treatment outweighs the risk of harm to him or her.
 4. Whether a less restrictive or less intrusive treatment would be as beneficial as the treatment that is proposed. 1996, c. 2, Sched. A, s. 21 (2).¹²⁷⁷

Observe that the foregoing principle of best interest consideration is constitutes one of those principles that reiterated in the entire research jurisdiction during decision making for incapacitated individuals as laid down in the corresponding legislation. It is contrary to the CRPD "wills and preferences" principle. Yet, it can be reasoned that these are the same principles the only difference being the semantics. This is so since best interest for example as the Ontario legislation indicates, takes cognizant of prior and current wishes of the patient concerned and they fall within the CRPD "wills and preference" notion. These principles are taken as procedural guarantees that provide protection against arbitrary detention and treatment of an individual particularly by legalizing the recognition of and use of prior made wishes. Similarly, having a substitute decision maker is a protective measure if viewed and appreciated from the perspective where an or some individuals may lack any

¹²⁷⁷ See, Ibid, s. 21 (2).

family to provide the support or substitute decisions on their behalf, including guaranteeing the enforcement and enjoyment of their rights like even if through substitute decision making.

To finalize on the matter of substitute decision making for those incapable to make decisions, it is worth mentioning that any individual may also rely on the Substitute Decisions Act if dissatisfied with the provisions of a substitute under the OHCCA. The OSDA comprises of provisos allowing patients with mental disability or other to create in writing and signed by two witnesses a power of attorney for personal care which gives the authority to make personal care decisions on his or her behalf.¹²⁷⁸ This power of attorney for personal care can only be valid or revoked if “at the time it was executed, the grantor was capable of giving it even if the grantor is incapable of personal care.”¹²⁷⁹ This means therefore, that the power of attorney can only be given by an individual who “has the ability to understand whether the proposed attorney has a genuine concern for the person’s welfare; and appreciates that the person may need to have the proposed attorney make decisions for the person.”¹²⁸⁰ These decisions may include the authority to make capacity assessment, treatment and care decisions, if the individual has been determined incapable under the OHCCA.¹²⁸¹ In addition to these, the power of attorney may be used to grant the following summarized powers:

- (a) Authorizing the reasonable use of force to determine whether the patient is incapable as given in the OHCCA.
- (b) Authorizing the reasonable use of force to admit and/or detain the patient in the place where the patient is to or is receiving care or treatment;
- (c) Powers waiving the patient’s right to apply for review by the CCB of a finding of incapacity by a health practitioner or an evaluator.¹²⁸²

These powers authorizing use of force are too great and susceptible to arbitrary abuse. Favourably, the OSDA counteracts the possibility of abuse by providing preventative inbuilt protections that

¹²⁷⁸ See, OSDA (1992) as amended, s. 46 & 46-54 (sections on power of attorney for personal care).

¹²⁷⁹ See, Ibid, s. 47 (2, 3&4).

¹²⁸⁰ See, Ibid, s. 47 (1).

¹²⁸¹ See, Ibid, s. 49 (1&2).

¹²⁸² See, Ibid, s. 50 (2).

instruct and impel that for these powers to be effective and valid, the power of attorney must contain a statement in the prescribed form from the grantor. The form must indicate that within 30 days after executing the power of attorney the grantor understood its effect; and a statement showing that on a specified date an assessor performed assessment of the grantors capacity, the opinion of the assessor during the assessment that the grantor was capable of personal care which must be substantiated according to the rules set out in OHCCA as required in a review.¹²⁸³ Note that in a review the burden of proof is normally upon the person alleging the lack of capacity. Generally, the power of attorney is parallel to prior made wishes the only difference is that it is granted in a power of attorney. In a contrasting view with the research jurisdictions, this provision does not appear in the South African or Ghanaian legislations, but is equivalent to the UK independent mental health advocates.

It is further worth to comment on the availability of and the role of a guardian, who according to the OSDA may also be given powers to make decisions on behalf of an incapacitated individual.¹²⁸⁴ Hence like the other jurisdiction, “a guardian of the person” in Ontario is also appointed by court and it can be full guardianship or partial depending on the incapacity of an individual.¹²⁸⁵ The court when granting a guardianship order specifies the functions of the guardian as far as decision making powers are concerned. It is imperative to bear in mind that according to the legislation, guardianship orders can only be granted, if there is a lack of an alternative course of action for decision making for an incapable person for personal care and a less restrictive way of decision making that does not encroach on the persons concerned decision making rights.¹²⁸⁶ As a precautionary measure against undue influence and conflict of interest, the court shall not appoint a person “who provides health care or residential, social, training or support services to an incapable person for compensa-

¹²⁸³ See, *Ibid*, s. 50 (1).

¹²⁸⁴ See, *Ibid*, s. 55-77.

¹²⁸⁵ See, *Ibid*, s. 58.

¹²⁸⁶ See, *Ibid*, s. 55 (2).

tion”.¹²⁸⁷ Well, where the court appoints a guardian with the authority to give or refuse consent to proposed treatment, he or she becomes the substitute decision maker for the relevant incapable individual and the hierarchical ranking does not apply.¹²⁸⁸ Like the substitute decision makers in the OHCCA, the guardian has to respect the limits of the order, involve the persons concerned in decision making, execute wishes of the persons concerned in the order and where there are no wishes, take into account his or her best interest.¹²⁸⁹ Guardianship can be terminated or varied according to the case presented before the court or where an individual regains capacity.¹²⁹⁰

As a final concluding point on the issue of substitute decision making and its relating protections, is that there is another method of getting a substitute decision maker referred as “representative” upon a made application and granting thereof by the CCB¹²⁹¹ An incapable individual of sixteen years and above or another person who wants to make decisions on behalf of the incapable individual may make this application.¹²⁹² However, this application and its process does not apply to incapable individuals who have court appointed guardians or power of attorney for personal care with the relevant authority to give or refuse consent to the proposed care and treatment.¹²⁹³ As a protection imbued in the OHCCA, proposed treatment cannot begin when this application is pending.¹²⁹⁴ Then again, this does not apply to emergency situations as provided in the legislation.¹²⁹⁵ The following looks into consent.

¹²⁸⁷ See, *Ibid*, s. 57 (1).

¹²⁸⁸ See, *Ibid*, s. 59 (4) & 66.

¹²⁸⁹ See, *Ibid*, s. 66(1-5).

¹²⁹⁰ See, *Ibid*, s.63.

¹²⁹¹ See, OHCCA (1996) as amended, s. 33.

¹²⁹² See, *Ibid*, s. 33 (1&2).

¹²⁹³ See, *Ibid*, s. 33 (3).

¹²⁹⁴ See, *Ibid*, s. 18 (2-3).

¹²⁹⁵ See, *Ibid*, s. 25.

3.3.3.3. Consent & Civil Commitment

From the preceding discussion, it has been established that care and treatment according to the legal framework in Ontario can only be given with free and informed consent by a capable individual or an incapable individual's substitute-decision maker, guardian, representative or attorney for personal care with conferred authority. It is also emphasized that capacity is presumed for everybody and it's upon who alleges otherwise that has the burden to prove. In light of this understanding, the following enriches the discussion by analysing consent as articulated and required to be implemented in the legal framework and as it relates to preventing arbitrariness and abuse of rights.

Hence, analogous to the other jurisdictions, the right to consent in Ontario traditionally was governed by the common law (before being codified in the OHCCA) which obliged caregivers to first obtain a patient's consent before the administration of medical care and treatment, failure of which would result in criminal penalties on charges of battery, assault or/and civil law on negligence.¹²⁹⁶ The locus case of *Reibl v Hughes (1980)*, illustrates the point having involved the applicant- a patient who had given consent to undergo elective surgery- endarterectomy in order to reduce the risk of a stroke, however the consent given was not informed because it had been obtained without having understood the most relevant information that also included the likelihood of a stroke resulting from the surgery.¹²⁹⁷ On this basis, the patient pleaded negligence on the part of the physician for the omission and not assault or battery for he had given consent, though uninformed. The Supreme Court found for the applicant after being satisfied that the applicant had satisfactorily proven the negligence standard which asks "what the average reasonable person in the patient's

¹²⁹⁶ See, *Cuthbertson V Rasouli*, (2013) SCC 53, para 17-19.

¹²⁹⁷ See, *Reibl v. Hughes*, [1980] 2 S.C.R. 880.

position would have done in the circumstances”, by submitting that he would have made a different choice.¹²⁹⁸ The court is held to have emphasized that:

The physician cannot override the patient’s wishes to be free from treatment, even if he believes that treatment is in the vital interests of the patient. The patient’s consent must be given voluntarily and must be informed, which requires physicians to ensure the patient understands the nature of the procedure, its risks and benefits, and the availability of alternative treatments before making a decision about a course of treatment. The requirement for informed consent is rooted in the concepts of an individual’s right to bodily integrity and respect for patient autonomy.¹²⁹⁹

Key important points arise from the court’s decision that shall be examined further below and they involve the right to information, respect of patient’s wishes and autonomy. Meanwhile and on an important comparative basis is the fact that alike the UK which codified its common law on consent (UKMCA & UKMHA as amended) after the case of HL V UK (2004) also known as the Bourne-wood case, “in enacting the *HCCA*, the Ontario legislature both codified and in important ways modified the common law of consent to medical treatment.”¹³⁰⁰ The reasons are quite related, the similarity existing in the fact that “the common law of consent to medical treatment works well for patients who have the capacity to decide on consent to treatment, in the sense of being able to understand the nature, purpose, and consequences of the proposed treatment.”¹³⁰¹ “However, the traditional common law approach to medical treatment is more problematic when a patient is incapable of appreciating the nature, purpose, and consequences of the proposed treatment.”¹³⁰²

In *Malette v. Shulman* (1990), the court substantiated this principle by reasoning that the common law doctrine of informed consent “presupposes the patient’s capacity to make a subjective treatment decision based on her understanding of the necessary medical facts provided by the doctor

¹²⁹⁸ See, *Ibid*.

¹²⁹⁹ See, *Ibid* in *Cuthbertson V Rasouli*, (2013) *Supra* note 1296, para 18.

¹³⁰⁰ See, *Cuthbertson V Rasouli*, (2013) *Supra* note 1296, para 17.

¹³⁰¹ See, *Ibid*, para 19.

¹³⁰² See, *Ibid*, para 20.

and on her assessment of her own personal circumstances”.¹³⁰³Therefore, “when such capacity is lacking, the patient is not in a position to exercise his autonomy by consenting to or refusing medical treatment.”¹³⁰⁴Thereby leaving an incapacitated individual without protection in law like in *HL v UK* where arbitrary detention was made out by the ECHR. In some jurisdictions courts are left to adjudge on incapacity and consents based on best interest determinations. With the codification however in the OHCCA, incapacitated individuals have set out safeguards guaranteeing the exercise and protection of their right to autonomy such as the already mentioned use of prior wishes, substitute decision makers, guardians, representatives and attorney for personal care.

Accordingly, it suffices to mention that the same principles discoursed above applies to date in view of the fact that what was laid down in *Reibl V Hughes (1980)* is reiterated in the recent Supreme Court decision in the footnoted case of *Cuthbertson V Rasouli (2013)*, a case involving consent to termination of life support.¹³⁰⁵The case also emphasizes the role of the OHCCA as that that “provides a statutory framework governing consent to treatment for capable and incapable patients.”¹³⁰⁶Therefore as a starting point the OHCCA cuts right in and states its purpose as to regulate consent as summarily mentioned.¹³⁰⁷It defines capable to mean mentally capable, and “capacity” has a corresponding meaning while “incapable” means mentally incapable, and “incapacity” has a corresponding meaning”.¹³⁰⁸“Mental disorder” has the same meaning as in the *Mental Health Act*; as well as psychiatric.”¹³⁰⁹This definitions including the treatment description is comparable (where provided)across the research legislations with Ontario providing that it “means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose,

¹³⁰³ See, *Malette v. Shulman* (1990), 72 O.R. (2d) 417 (C.A.), p. 423-24 in *Ibid*, para 20.

¹³⁰⁴ See, *Ibid*.

¹³⁰⁵ See, *Cuthbertson V Rasouli*, (2013), *Supra* note 1296.

¹³⁰⁶ See, *Ibid*, para 22.

¹³⁰⁷ See, OHCCA (1996) as amended, s. 1. See, chapter two, footnote 554 for full provision.

¹³⁰⁸ See, *Ibid* s. 2(1).

¹³⁰⁹ See, OHCCA (1996) as amended, s. 2(1).

and includes a course of treatment, plan of treatment or community treatment plan.”¹³¹⁰ It equally applies to those with mental disorders with capacity and without under the OMHA.

Corresponding to the common law jurisprudence, the OHCCA commands that a health practitioner may not administer treatment without the consent of a patient or his/her substitute decision maker.¹³¹¹ In *Fleming V Reid (1991)*, the court emphasized that “the common law right to determine what shall be done with one's own body and the constitutional right to security of the person can be treated as co-extensive” and therefore,

A patient, in anticipation of circumstances wherein he or she may be unconscious or otherwise incapacitated and thus unable to contemporaneously express his or her wishes about a particular form of medical treatment, may specify in advance his or her refusal to consent to the proposed treatment. A doctor is not free to disregard such advance instructions, even in an emergency. The patient's right to forgo treatment, in the absence of some overriding societal interest, is paramount to the doctor's obligation to provide medical care. This right must be honored, even though the treatment may be beneficial or necessary to preserve the patient's life or health, and regardless of how ill-advised the patient's decision may appear to others. These traditional common law principles extend to mentally competent patients in psychiatric facilities. They, like competent adults generally, are entitled to control the course of their medical treatment. Their right of self-determination is not forfeited when they enter a psychiatric facility. They may, if they wish, reject their doctor's psychiatric advice and refuse to take psychotropic drugs, just as patients suffering other forms of illness may reject their doctor's advice and refuse, for instance, to take insulin or undergo chemotherapy. The fact that these patients, whether voluntarily or involuntarily, are hospitalized in a mental institution in order to obtain care and treatment for a mental disorder does not necessarily render them incompetent to make psychiatric treatment decisions. They may be incapacitated for particular reasons but nonetheless be competent to decide upon their medical care. The Act presumes mental competency, and implicitly recognizes that a mentally ill person may retain the capacity to function competently in all or many areas of everyday life.¹³¹²

¹³¹⁰ See, *Ibid*, s 2(1).

¹³¹¹ See, *Ibid*, s. 10(1). It states that: “**No treatment without consent 10. (1)** A health practitioner who proposes a treatment for a person shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless, (a) he or she is of the opinion that the person is capable with respect to the treatment, and the person has given consent; or (b) he or she is of the opinion that the person is incapable with respect to the treatment, and the person's substitute decision-maker has given consent on the person's behalf in accordance with this Act. 1996, c. 2, Sched. A, s. 10 (1).”

¹³¹² See, *Fleming v. Reid*, (1991), *Supra* note 529, para IV.

Consequently, the excerpt emphasizes very pertinent issues that have hitherto emerged in this chapter on capacity and consent when enforcing compulsory treatment measures and which have been and are equally presented as protections. From the basic, presumption of capacity is a value that must be respected even for those with mental disorders and that the right to make decisions should not be waived merely because an individual has mental illness and has is admitted into a mental institution. The segment additionally articulates that it is a right of the patient to make advance wishes that must be dutifully followed by the doctor or professionals involved. It equally indicates that the right to make autonomous decision making is neither absolute for it can be overridden where there is compelling societal interest. It remains then that the right to consent is promoted first before any other action is carried out. Thus, consent may be oral or in writing, expressed or implied in an advance wish or given by substitute decision maker according to the circumstances at hand.¹³¹³ As it stands, consent for treatment under the legislation will be valid if the following elements are satisfied:

1. The consent must relate to the treatment.
2. The consent must be informed.
3. The consent must be given voluntarily.
4. The consent must not be obtained through misrepresentation or fraud.¹³¹⁴

These mentioned elements were already articulated in the case of *Reibl V Hughes* particularly the importance and necessity of consent being informed. To be informed according to the case of *Reibl* means furnishing the client with the relevant information pertaining to the proposed treatment including the attached risks in a manner that can be understood by the concerned person.¹³¹⁵ The *Reibl* principles can be seen in the OHCCA under section 11(2 & 3) where it is expressed that “a consent to treatment is informed, if before giving it, the person received the information about the matters set out in subsection (3) that a reasonable person in the same circumstances would require

¹³¹³ See, OHCCA (1996) as amended, s. 11(4).

¹³¹⁴ See, *Ibid*, s. 11(1).

¹³¹⁵ See, *Reibl v. Hughes*, [1980], *Supra* note 1296.

in order to make a decision about the treatment; and the person received responses to his or her requests for additional information about those matters.”¹³¹⁶ These matters include the following:

1. The nature of the treatment.
2. The expected benefits of the treatment.
3. The material risks of the treatment.
4. The material side effects of the treatment.
5. Alternative courses of action.
6. The likely consequences of not having the treatment.¹³¹⁷

It can be recalled that the above including other matters such as the age, religion disability and other important information of the individual must be considered when requiring consent and providing information are comparable to that articulated in the UKMHA. In any case, upon receiving the relevant information and the patient has had a clear understanding of the proposed treatment including benefits, risks and long term implications, he or she may give the consent.¹³¹⁸ According to the law, the health practitioner is “entitled to presume that the consent to treatment includes “consent to variations or adjustments in the treatment, if the nature, expected benefits, material risks and material side effects of the changed treatment are not significantly different from the nature, expected benefits, material risks and material side effects of the original treatment”.¹³¹⁹ The practitioner can also presume that “consent to the continuation of the same treatment in a different setting, if there is no significant change in the expected benefits, material risks or material side effects of the treatment as a result of the change in the setting in which it is administered.”¹³²⁰ This is similar to the UK provision on what treatment can and should encompass. In any case, a health practitioner must

¹³¹⁶ See, OHCCA (1996) as amended.

¹³¹⁷ See, Ibid.

¹³¹⁸ See, *E. (Mrs.) v. Eve*, [1986] 2 S.C.R. 388. This is or was a contentious case about a mentally incompetent lady who was subject to a sterilization order made under the OMHA, even though it was not for therapeutic purposes as defined under the Act and the role of court to intervene under its parens patrie powers to consent on her behalf.

¹³¹⁹ See, OHCCA (1996) as amended, s. 12 (a).

¹³²⁰ See, Ibid, s. 12 (b).

have a plan of treatment, which according to the OHCCA may also encompass future treatments as long as they are part of the proposed treatment plan.¹³²¹

To surmount, in Ontario consent must be given before treatment and all the requirements to the exception including the use substituted decision makers must be followed. Having mentioned this, the following section considers standards.

3.3.3.4. Substantive & Procedural Safeguards

The frameworks provided by the OMHA, OHCCA and OSDA are in themselves protections because they provide a legal framework which compels those providing mental health services and any other related activities to enforce those them as they are set out. To be more specific they balance rights of those subjected to this framework and the duty to provide health care services by the following substantive and procedural guarantees.

(a). Any individual has the fundamental guarantees of presumption of capacity with respect to treatment and the right to consent before any treatment is administered. According to the jurisprudence in *Masih v Siekierski (2015)* “the onus of proving incapacity is on the person alleging it” and not the patient.¹³²² Additionally, in ascertaining capacity, it is required that a patient is monitored with constant conversations maintained to ensure that patients concerns and decisions are taken into account even when they are presumed incapacitated because “capacity can fluctuate overtime” and patient at any time he regains capacity may be able to make autonomous decisions where it was substituted.¹³²³ Hence, the person alleging incapacity, normally the health practitioner must fulfill the two part test under section 4 of the OHCCA with credible evidence substantiating the claim of incapacity. It should be noted here as well that the Ontario legislation unlike the other jurisdictions

¹³²¹ See, *Ibid*, s. 13.

¹³²² See, *Masih v Siekierski*, (2015) ONSC 2877, para 23.

¹³²³ See, *Ibid*, para 23. See also, *Starson v Swayze*, [2003], *Supra* note 559, para 119.

“corroboration does not require a second opinion from another psychiatrist.”¹³²⁴The courts have maintained that “to impose such a requirement would be inconsistent with s. 10 of the *HCCA*, which only requires the opinion of one healthcare practitioner.”¹³²⁵In the mentioned case, the Superior court of Ontario in determining an appeal from the CCB on a finding of incapacity of a mentally ill applicant, provided that the CCB erred in finding incapacity of consenting to treatment of a mental disorder using antipsychotic drugs- benzodiazepines because the applicant understood its effects and refused this medication. The court in finding this err maintained that “in that one part of the appeal, the appellant succeeded due to a lack of evidence, not because, on the evidence the Board ought to have concluded that he was able to appreciate the reasonably foreseeable consequences of a decision or lack of decision with respect to that treatment.”¹³²⁶

(b). In connection to the preceding, it is a right and protection under the statutory framework and the Charter for a patient to exercise the right to consent to treatment and refuse treatment. Similarly, consent when given can be withdrawn and when this is done, it means that consent has been denied.¹³²⁷ Observe that as highlighted in the cases, the right to consent is not absolute, (in situations of involuntary hospitalization, emergency and crisis situations), yet consent must be sought in all circumstances before treatment is given.

(c). The right to review of incapacity decisions and all other complaints relating to capacity, consent and treatment under the *OHCCA* is an integral protection in the legislation that ensures set out principles are properly applied.¹³²⁸ In **Fleming V Reid (1991)**, a violation of the Charter was found because the appellant wishes not to consent to treatment was overridden by the Board according to

¹³²⁴ See, *Masih v Siekierski*, (2015) , Supra note 1322, para 45.

¹³²⁵ See, *Ibid*.

¹³²⁶ See, *Ibid*, para 49.

¹³²⁷ See, *OHCCA* (1996) as amended. Section 45 states that: “Authority to consent on an incapable person’s behalf to his or her admission to a care facility includes authority to withdraw the consent at any time before the admission.”

¹³²⁸ See, *Ibid*, s.65.

the law without affording a hearing or review of any kind to the appellant or his substitute decision maker.¹³²⁹ The court found a breach of the Charter as regards the appellant's right to consent as well as the incompatibility of the provision in the MHA to the Charter.¹³³⁰ It goes without say that for consent to be validly made, a patient has to receive the relevant information on treatment, the risks of the treatment and the consequences of consenting and not consenting to the treatment. This concepts as already discussed are envisaged in the OHCCA and reiterated in the Case of *Starson v Swayze*. In this case, it was held that the patient does not necessarily need to agree with the doctors in order to be considered capable of consenting.¹³³¹ According to the court, the Board erred in confirming incapacity merely because the applicant denied he suffered from a mental disorder but from the evidence showed that he acknowledged that his brain did not function normally, and that while he appreciated the intended effects of the medication, there was no evidence to substantiate the fact that it will likely ameliorate his condition.¹³³² Hence in confirming incapacity and approving compulsory treatment on the basis that the treatment would improve his chances was entirely speculative, arbitrary and contrary to the statutory test placed in the law.¹³³³

(d). In order to prevent unnecessary and arbitrary detentions for treatment, the OHCCA guarantees that individuals advance made wishes are respected when made and when they are presented through substitute decision making mechanisms in the hierarchical system, the Board and the

¹³²⁹ See, Fleming v. Reid, (1991), Supra note 529.

¹³³⁰ See, Ibid, part VIII. The court stated that: "The right to personal security is guaranteed as fundamental in our society. Manifestly, it should not be infringed any more than is clearly necessary. In my view, although the right to be free from non-consensual psychiatric treatment is not an absolute one, the state has not demonstrated any compelling reason for entirely eliminating this right, without any hearing or review, in order to further the best interests of involuntary incompetent patients in contravention of their competent wishes. To completely strip these patients of the freedom to determine for themselves what shall be done with their bodies cannot be considered a minimal impairment of their Charter right. Safeguards can obviously be formulated to balance their wishes against their needs and ensure that their security of the person will not be infringed any more than is necessary. Recognizing the important objective of state intervention for the benefit of mentally disabled patients, nonetheless, the overriding of a fundamental constitutional right by the means chosen in this Act to attain the objective cannot be justified under s. 1 of the Charter."

¹³³¹ See, Starson v Swayze, [2003], Supra note 559.

¹³³² See, Ibid.

¹³³³ See, Ibid.

Courts respectively. The right to express ones treatment wishes in advance on whether to accept or refuse treatment must be observed as strongly emphasized in *Fleming V Reid*.

(e). In connection to the aforementioned is that under the law one has the right to refuse treatment. In *Starson V Swayze (2003)*, the court underscored the exercise of this right in the following manner- that “the right to refuse unwanted medical treatment is fundamental to a person’s dignity and autonomy [and] this right is equally important in the context of treatment for mental illness as held in *Fleming V Reid*”¹³³⁴ Hence in *Fleming V Reid (1991)*, the supreme court upheld the appellants appeal setting aside the orders of the previous court, the review board and health practitioner confirming psychiatric medical treatment of the appellants whilst there was a prior expressed wish held by their substitute decision makers refusing medical treatment.¹³³⁵ It found it arbitrary that medical treatment was being imposed contrary to the expressed consent of the appellant through substitute decision maker and the fact that the then OMHA provision empowered the review board to override prior wishes of incompetent patients and order psychiatric care.¹³³⁶ The actions of the health practitioners were contrary to the law and the review board unreasonable even if claimed that it is done in the best interest of the appellants. This cases go to show that the laws are clear (in this case, prior wishes come before best interests), but carers disregard them resulting in abuse of those under their care.

(f). Finally, individuals with disabilities subjected to civil commitment under any of the legal framework have the general protection of the Charter. This means therefore that it all begins with the recognition and respect of individuals as equal before the law with the power to exercise autonomous decisions regarding themselves. It also means autonomy can be exercised through the use of

¹³³⁴ See, *Ibid*, para 75.

¹³³⁵ See, *Fleming v. Reid, (1991)*, *Supra* note 529.

¹³³⁶ See, *Ibid* , part IV & VIII.

wishes and advance directives concerning their health in accordance with the laid procedures of the law and have those wishes respected when the relevant treatment is in question. In view of this, a failure to uphold these rights may engage a violation of the Charter. A Charter breach may also be found if the impugned legislation or statutory framework contains provisions that stand contrary to the fundamental justice in the Charter and cannot be justified under section 1.¹³³⁷ These rights were emphasized in *Fleming V Reid (1991)* where the court asserted that:

Except in the case of involuntary incompetent patients, the Act acknowledges the paramountcy of the "prior competent wishes" test over the "best interests" test where the prior competent wishes of the patient are known. In the case of involuntary incompetent patients alone, the review board is obliged to apply the objective test of the patient's best interests and to ignore prior competent wishes, and the substitute consent-giver scheme is rendered nugatory. A legislative scheme which permits the competent wishes of a psychiatric patient to be overridden, and which allows a patient's right to personal autonomy and self-determination to be defeated, without affording a hearing as to why the substitute consent-giver's decision to refuse consent based on the patient's wishes should not be honoured, violates the basic tenets of our legal system and is not in accordance with the principles of fundamental justice."¹³³⁸

As it is, the current legislations as amended and as they legislate on involuntary detention and treatment have been considered constitutional in various cases such as the Thompson case given in chapter two.

3.3.3.5. Sum up

The Ontario legislative framework so far illustrates a lot of protection given to those subjected to civil commitment. For this reason, it can be surmised that it explicates a balanced approach to upholding and limiting certain rights of individuals with disabilities in order to ensure that their

¹³³⁷ See, *Ibid*, para VII. The court stated that: "The impugned scheme under the [Mental Health Act](#) fails to meet the requirement of [s. 7](#) that the principles of fundamental justice be observed with respect to involuntary incompetent patients. Those patients are arbitrarily deprived of their right to security of the person insofar as they are denied any hearing in which they may assert, through their substitute consent-givers, their competent wishes with respect to treatment and, thus, their right to be free of unwanted medical treatment. Such a violation of the principles of fundamental justice, in my opinion, can be neither "reasonable" nor "demonstrably justified in a free and democratic society"

¹³³⁸ See, *Ibid*.

right to mental health is respected. This balancing also extends to the power of the State in terms of their obligation to provide services and respect of the citizens' rights as regulated by the Charter. Having stated this and contrasting it to the CRPD interpretations, the Ontario legislation stands wanting because it does not guarantee absolute personal autonomy, it promotes the use of substitute decision making and the limitation of the right to liberty to provide mental treatment to those with mental disorders. Domestically, this usage is neither unconstitutional and has the backing of the Canadian reservation on article 12 of the CRPD. This reflects the dissonance between the interpretation of the CRPD and circumstances on the ground in the jurisdiction of Canada. Contrasting Ontario with the other research domains, they all present comparable principles on capacity and consent. The difference emerges in certain procedural aspects for instance Ontario guaranteeing slightly more standards such as a no treatment before consent approach first, a hierarchical system of substitute decision making and non-use of second opinions in matters of capacity. Despite the difference in approach, the foremost similarity is that civil commitment, treatment without consent during emergencies and use of substitute decision making mechanisms are used across the four jurisdictions. It is also seen from the cases that abuse happens through misapplication of the law, lack of law and sheer arbitrariness. For these reason it is reasonable to maintain that it is a concerning problem in the entire research jurisdiction.

3.3.4. Ghana

3.3.4.1. Introduction: Statutory Framework

Like all the other jurisdictions, the right to autonomous decision making for Ghanaians begins with the formal recognition of this right under the right to equal recognition before the law in the constitution. Article 17 of the constitution expresses that “ all persons shall be equal before the law and [that]a person shall not be discriminated against on grounds of gender, race, colour, ethnic origin,

religion, creed or social or economic status.”¹³³⁹ As it is, the constitution does not mention disability among the prohibited grounds, but one can argue it is inferred by the phrase “all persons” and in subsection three which provides a definition of discrimination.¹³⁴⁰ In addition, the constitution mandates the parliament to legislate for the implementation of policies and other programmes where applicable for individuals who need special attention or/and suffered or suffer socio-economic injustice in the Ghanaian society.¹³⁴¹ The GMHA comprises one of those legislations that the parliament has enacted in order to provide a legal framework as regards the provision of health care services and the protection of human rights for those seeking mental health care, considering that this sector has been ignored. It has indeed been ignored for long particularly in the regulation of mental health care services delivered by spiritual and traditional mental health care centers. To this end and as shall be explained later, the recommendation shall be for the Ghanaian parliament to take the initiative and enact a legislation to that effect, in order to guarantee a balanced approach to access to mental health care and preservation of human rights.

Besides the constitution, the Ghanaian National Health Policy, and the Health Care Assurance Manual, calls for equality in health provision and respect of the client wishes by physicians.¹³⁴² The call for respect is also in the GMHA and as previously mentioned it provides a framework for vol-

¹³³⁹ See, The Constitution of the Republic of Ghana (1982), Article. 17(1&2).

¹³⁴⁰ See, Ibid, Article 17 (3). The subsection mentions that: For the purposes of this article, "discriminate" means to give different treatment to different persons attributable only or mainly to their respective descriptions by race, place of origin, political opinions, colour, gender, occupation, religion or creed, whereby persons of one description are subjected to disabilities or restrictions to which persons of another description which are not granted of persons of another description are not made subject or are granted privileges or advantages which are not granted to persons of another description.”

¹³⁴¹ See, Ibid, Article 17 (4). It states that: “(4) Nothing in this article shall prevent Parliament from enacting laws that are reasonably necessary to provide- (a) for the implementation of policies and programmes aimed at redressing social, economic or educational imbalance in the Ghanaian society.; (b) for matters relating to adoption, marriage divorce, burial devolution of property on death or other matters of personal law; (c) for the imposition of restrictions on the acquisitions of land by persons who are not citizens of Ghana or on the political and economic activities of such persons and for other matters relating to such persons; or (d) for making different provision for different communities having regard to their special circumstances not being provision which is inconsistent with the spirit of this Constitution. (5) Nothing shall be taken to be inconsistent with this article which is allowed to be done under any provision of this Chapter”.

¹³⁴² See, Ghana Health Service, HealthCare Assurance Manual (2004), p. 4, para 1.3.3. Available at: http://ghanahqhp.org/fileadmin/user_upload/OHP/Healthcare_Quality_subdistrict.pdf

untary and involuntary mental health care and treatment.¹³⁴³ It protects the individual with mental disabilities by proscribing discrimination, the availability of tribunal to determine resolutions, appeal procedures to the courts for redress and monitoring, and evaluation of treatment terms.¹³⁴⁴ Accordingly, the Ghanaian mental health legislation akin the other jurisdictions promote the right to equality for individuals with mental disability as well as admonishing acts of discrimination. The GMHA recognizes that “a person with mental disorder is entitled to the fundamental human rights and freedoms as provided in the constitution [which includes civil, political, social, cultural and economic rights].”¹³⁴⁵ It therefore emphasizes that it does not matter whether an individual has a past or present mental disorder because acts of discrimination are prohibited and shall not be subjected upon or towards such individuals.¹³⁴⁶ It is also not an issue as to the “cause or nature or degree of the mental disorder” because the underlying factor is that individuals with mental disability have the “same fundamental rights as fellow citizens”.¹³⁴⁷

Consequently, in matters of mental health care, the Act unequivocally commands that individuals with disability have the right to the highest attainable standard of mental health care a resounding right given in UNCESCR on the right to health, including section 25 of the CRPD and WHO.¹³⁴⁸ It does not just stop at this declaration but goes forth to prohibit “torture, cruelty, forced labour and many other inhuman treatment”, prohibition of administration of certain treatments such as” electro

¹³⁴³ See, GMHA (2012), s. 39,40,41,42,43,44,45,47,48,50,51,52&53.

¹³⁴⁴ See, Ibid s. 25-33, 34-38, 43-44 & 59.

¹³⁴⁵ See, Ibid, s. 54. See also s. 55. It states that: “55. (1) A person with mental disorder has the right to enjoy a decent life as normal and as full as possible which includes, the right to education, vocational training, leisure, recreational activities, full employment and participation in civil, economic, social, cultural and political activities and any specific limitations on these rights shall be in accordance with an assessment of capacity. (2) A person with mental disorder is entitled to humane and dignified treatment at any time with respect to personal dignity and privacy. (3) A person with mental disorder has (a) the right to wear personal clothes while in a treatment facility and to maintain personal belongings subject to space limitations, and (b) the right to have access to and spend personal money for personal purchases unless the mental capacity of the person does not allow that. (4) A person with mental disorder has the right to information provided by newspapers and other media. (5) At the time of admission, patients, their caregivers or their personal representatives shall be informed of the relevant information pertaining to admission including their rights.”

¹³⁴⁶ See, Ibid, s. 54(1).

¹³⁴⁷ See, Ibid, s. 54(2).

¹³⁴⁸ See, Ibid, s. 57(1).

convulsive therapy and psychosurgery in emergency cases” or without informed consent of the individual, personal representative or tribunal.¹³⁴⁹ Unlike the counterpart jurisdictions, the Ghanaian legislation mandates that in providing health care, the quality of services should not be different when treating physical and mental illnesses. In verbatim it underscores that “a person with mental disorder is entitled to the same standard of care as a person with physical health problems and shall be treated on an equitable basis including quality of inpatient food, bedding, sanitation, buildings, levels and qualifications of staff, medical and related services and access to essential medicines.”¹³⁵⁰

It is possible to actually assert that this provision is the very essence of this research hypothesis. The author postulates it as such because of two reasons. One is that if mental health care was provided in such manner described by the Ghanaian legislation in the institutions and in community settings, we would not be having the difference in debate on which model is better over the other but on promoting them as parallel options. The second reason compliments the first by deriving from the realities of care given to persons with mental disabilities. Ghana is a good case to illustrate the second reason particularly when reference is made to the mental health care provided in unregulated traditional and prayer camps. It is sadly reported that in this centers “nearly all the residents [were] chained by their ankles to trees in open compounds, where they slept, urinated and defecated, and bathed [and] none of the camps employ a “qualified medical or psychiatric practitioner.”¹³⁵¹ This unsafe conditions and poor services including arbitrary detentions by families in homes and in the prayer camps are seen in many African countries including State run institutions that have improper facilities for the care of those with mental illness.¹³⁵² Similar improper facilities

¹³⁴⁹ See, *Ibid*, s. 57 (3 & 5). See also, s. 40, 45(2), 61(3) & 68.

¹³⁵⁰ See, *Ibid*, s. 57(2).

¹³⁵¹ See, Benedict Carey, *The Chains of Mental Illness in West Africa*, *The New York Times* (11th October 2015).

¹³⁵² See, *Ibid*. See also, Vera Okeyo & Eunice Kilonzo, *Abandoned and Neglected: Kenya’s Mentally ill Suffer in Bitter Silence*, *Daily Nation Kenya* (24th February 2015).

poor environments and arbitrary abuses are also recorded in institutions such as psychiatric facilities, long and short term care facilities and homes in western and Asian countries.¹³⁵³

Back to the discussion on standards, standard of care and the already mentioned rights work together with the right to privacy and autonomy guaranteed in the GMHA. This right requires that individuals detained or admitted for mental health care must exercise their “freedom to receive in private, visits from a legal practitioner, relatives and any other visitors, unless the attending psychiatrist or head of the facility considers it unsafe [and] right to be examined in private and in the absence of observers other than the psychiatrist or medical staff specifically required for the consultation or examination”.¹³⁵⁴ As shall be discussed below, the right to autonomy is also protected through the recognition of capacity to consent.

3.3.4.2. Capacity & Civil Commitment

In continuance to the above, the mental health Act protects the rights of those with mental disability through the provision of capacity and consent processes that must be fulfilled before treatment and care is given. In view of that, the GMHA, in the first instance defines “competence” [to mean] sufficient capacity to understand an issue and manage a situation as determined by a court”, and ““capacity” [as] the functional ability to understand or form an intention with regard to an act and a person including someone with mental disorder is presumed to have capacity until reliably proven otherwise.”¹³⁵⁵ This definition and the requirements therein are analogous to those already expressed in the other research jurisdiction. However, unlike the other jurisdictions, the provisions of capacity in terms of procedures relating to capacity lack, a lack of which needs to be challenged considering

¹³⁵³ See, The Bristol Post, Cruel Nurse Struck Off for Bullying Patients at Winterbourne View, (4th June 2015). See also, Benedict Carey, The Chains of Mental Illness in West Africa, Supra note 1350.

¹³⁵⁴ See, GMHA (2012), s.61.

¹³⁵⁵ See, Ibid, s. 98.

the maltreatment faced by many individuals with mental illness in their society as reiterated in the thesis. It is also dissimilar in that it does not provide verbatim that there shall always be presumption of capacity as provided in the UKMCA or OHCCA. Instead, the Act provides the presumption in the meaning and in the text by links incapacity with human rights in terms of guaranteeing the provision of mental health treatment by emphasizing that “a person who by reason of a mental disorder is unable to give consent shall not be deprived by another person of medical treatment, education or any other social or economic benefit.”¹³⁵⁶ While this is grand, it does not define or outline capacity matters.

However as it shall be seen it anticipates that in certain circumstances an individual seeking mental health care may lack the capacity to understand relevant treatment information or manage his financials and properties. In such situations and as a procedural safeguard, the Act provides for the use of representatives and guardians. It lumps together ‘competence, capacity and guardianship’ and preconditions that “a person with mental disorder who is unable to manage that person's personal affairs because of the mental disorder shall be protected in matters such as finances, business, occupation, marriage, the right to found a family, the right to treatment of choice, testamentary capacity and other legal issues for the benefit of that person.”¹³⁵⁷ Therefore a court order appointing a representative must be sought in order to substitute or support the individual in decision making, but as a last resort.¹³⁵⁸ The Act here provides that an application to be a guardian full or limited may be made by “family members or a social welfare officer [who] may apply to the court for the appointment of a guardian and on the assessment by a clinical team of mental health professionals including a psychiatrist, the appointment may be made.”¹³⁵⁹

¹³⁵⁶ See, *Ibid*, s. 56.

¹³⁵⁷ See, *Ibid*, s. 68(1).

¹³⁵⁸ See, *Ibid*, s. 68 (8).

¹³⁵⁹ See, *Ibid*, s. 68(2 & 4). Subsection (4) provides that: “Where, after an application to the court, a person is found be lacking in mental capacity on examination by a clinical team of mental health professionals including a psychiatrist and

Accordingly, in matters of treatment vis-a vis information, choices and “where the patient is incapable of understanding the treatment,[the Act anticipates this limitation and remedies by using substituted forms of decision making comparable to the other research jurisdictions by authorizing that] the personal representative [or primary care givers] of that patient shall have access to this information.”¹³⁶⁰ There are exceptions applicable here such as information cannot be given and decision made if the patient objects or the clinical representatives or head of facility considers that providing such information may be harmful to the relevant individual.¹³⁶¹ It is important to underscore that akin to the UK, Ontario and South Africa legislation, the Ghanaian legislation mandates that the personal representative or the “guardian shall consult with the incapacitated person where possible and is responsible for taking treatment, financial and any other welfare decisions on behalf of the incapacitated person using a high standard of substituted judgement.”¹³⁶² Well, a high standard of substituted judgement is not defined in the Act and as already reiterated it is not a mechanism that is pro-CRPD an interesting fact considering that this Act was passed post CRPD. The fact that the use of substituted decision making was legislated post-CRPD firmly buttresses the thesis concern on the challenges of implementing some of the CRPD requirement as interpreted by the CRPD Committee. The reality is that for some provisions there are stark differences between the requirements called for, State practice and what the citizenry execute. The following examines consent.

the court finds the person not competent in the matters referred to in subsection (1), the court shall appoint a guardian for the personal protection of that person”. See also, S. (69) that states that: “Where a person's incapacity only requires assistance in decision making in a specific area, a limited guardian may be appointed by the court through the same procedure as stated in section 68 and the court shall specify the areas of guardianship reserving those areas in which the person retains capacity.”

¹³⁶⁰ See, Ibid, s. 62(1, 2 & 3).

¹³⁶¹ See, Ibid, s. 62 (3, 4 &5).

¹³⁶² See, Ibid, s. 68(6).

3.3.4.3. Consent & Civil Commitment

From the foregoing review on capacity, it is apparent that an individual must have capacity to consent. According to the GMHA informed consent means “an agreement or consent for procedure given freely without coercion by a person with capacity when the person has been made fully aware of the nature of the procedure, its implications and available alternative”.¹³⁶³ The right to consent hence comprises of elements of voluntariness, capacity to understand the treatment, its consequences and any alternatives that are of least intrusive exercised through the information given to the relevant individual. This right to consent also involves the right to refuse treatment as regards voluntary patient.¹³⁶⁴ It is as such because for persons placed under involuntary admission and treatment they are compulsorily admitted and treated under a temporary court order.¹³⁶⁵ Therefore, until they opt to become voluntary patients or regain capacity when applicable, then they can exercise the right to consent to and refuse treatment.¹³⁶⁶ Consent can also be given by relevant family member, personal representative or guardian through a high standard of substituted judgement as aforesaid in the capacity discussion. Again the similarities on consenting during involuntary placement and use of substitute decision making comparatively arises here.

Well, in order to make an informed choice by the relevant individual, personal representative or guardian, the Act obliges mental health care providers to provide and make it accessible the relevant and necessary treatment information. Section 62, expresses that:

- (1) A patient shall have free and full access to information about the mental disorder and the treatment plan of that patient.
- (2) Where the patient is incapable of understanding the treatment, the personal representative of that patient shall have access to this information.
- (3) Access to that information may be granted or denied by the clinical representative of the head of the facility if the information is harmful to the wellbeing of the patient

¹³⁶³ See, Ibid, s. 97.

¹³⁶⁴ See, Ibid, s. 40(2&3). It states that :“(2) The consent of a voluntary patient shall be obtained before treatment is given. (3) A voluntary patient reserves the right to refuse treatment.”

¹³⁶⁵ See, Ibid, s. 42.

¹³⁶⁶ See, Ibid, s. 40 (2&3). See also, S. 42.

- (4) Primary care givers shall have access to information about the illness of the patient except where the patient objects.
- (5) The objection may not apply if the information is absolutely essential in the interest of the patient or for the safety of the care giver.¹³⁶⁷

In addition to the relevant information, patients under temporary treatment court order must have a treatment plan which is also provided to them giving them the opportunity to be involved in their own treatment plan. It is accordingly mandated in the GMHA that:

- (1) A patient whether voluntary or involuntary, shall have a treatment plan which shall be regularly reviewed and revised as necessary
- (2) An involuntary patient shall not be subjected to irreversible treatment such as psychosurgery.
- (3) The treatment plan for a patient on involuntary admission shall be for one month after which it shall be reviewed.
- (4) A patient and the caregiver of the patient shall be involved in the treatment plan of the patient.¹³⁶⁸

These provisions on accessible relevant information and treatment plan are comparative across the research jurisdictions and can also be found in the MI Principles. What also analogizes is the complete forbiddance of on administration of certain mental health treatments for those under compulsory measures. In the GMHA as provided in section 45 (2), “an involuntary patient shall not be subjected to irreversible treatment such as psychosurgery”.¹³⁶⁹ In addition, they cannot be subjected to “sterilization, a major surgical surgery without the informed consent or the informed consent of a personal representative if that person is incapable of giving the consent”.¹³⁷⁰ Similarly, “electroconvulsive therapy shall not be administered without informed consent and where the patient is incapable of giving consent, consent shall be obtained from the Tribunal.”¹³⁷¹ Abortion cannot be done on a woman merely because she has a mental disorder.¹³⁷² Note that in cases of emergency, particularly where major life saving surgeries are involved and “where a delay in obtaining the informed consent may be dangerous to the life of that person, the procedure may be carried out and the Tri-

¹³⁶⁷ See, Ibid.

¹³⁶⁸ See, Ibid, s.45.

¹³⁶⁹ See, Ibid.

¹³⁷⁰ See, Ibid, s. 71 (1).

¹³⁷¹ See, Ibid, s. 71(5).

¹³⁷² See, Ibid, s. 71(3).

bunal shall be informed at the earliest possible time after the procedure.”¹³⁷³ Besides special treatment where consent of the relevant individual or representative or tribunal must be given, it also applies for teaching and research purposes if the person involved as a subject is an individual with mental disability.¹³⁷⁴ The GMHA, strictly sanctions teaching and research where the person with mental disability is capable to give consent and “is not necessary for promoting the health of the person or the health of the population represented by the patient.”¹³⁷⁵

Having presented the above and analyzing the impact of this legislation in terms of consent, it can be reasonably presented that that the law has not brought about the desired absolute enjoyment of the consensual right to treatment to many Ghanaians especially for those seeking mental health care and treatment from traditional and spiritual centers of healing. This assertion however does not mean that because the GMHA regulates psychiatric centers, individuals receiving care therein receive better protection from the Act. Investigative reports reveal that patients detained in psychiatric hospitals and centers are exposed to various forms of abuse that include being beaten, chained, and also receive electroconvulsive treatment without their consent contrary to the GMHA.¹³⁷⁶ Nevertheless, as has been mentioned before, the GMHA, recognizes "spiritual mental health facility" which means a faith-based facility for the treatment of persons with mental disorders”,¹³⁷⁷ and requires the mental health authority to “collaborate with the Traditional and Alternative Medicine

¹³⁷³ See, Ibid, s. 71 (1 & 3).

¹³⁷⁴ See, Ibid, s. 61 (3).

¹³⁷⁵ See, Ibid, s. 61 (4).

¹³⁷⁶ See, See, Human Rights Watch, *Like a Death Sentence: Abuse Against Persons with Mental Disability in Ghana*, Supra note 367, p.63 &64. It states in p. 63 that: “Psychiatrists in Ghana continue to use electroconvulsive therapy (ECT), a method of treatment which involves passing electricity through one’s brain, to treat persons with severe depression. Dr. Akwasi Osei, chief psychiatrist for the Ghana Mental Health Service and head of Accra Psychiatric Hospital, explained the process of administering the electroshocks: “We don’t give anesthesia because we don’t have a machine and personnel. ECT is a little uncomfortable, but it gets better. Some patients get four to six shocks, two or three times a week and not more because it can lead to permanent memory loss.” See also p. 64 that states that: “Dr. Osei told Human Rights Watch that before treatment is administered, the patient’s consent is sought. In cases where hospital staff deem patients incapable of giving their informed consent, family members (if they are accompanied) consent on their behalf; unaccompanied patients are treated without consent.”

¹³⁷⁷ See, GMHA (2012), s. 98 &

Council and other providers of unorthodox mental health care to ensure the best interest of persons with mental disorder”.¹³⁷⁸

As repeated in the thesis and above, these centers are unregulated and are a hotbed of human rights violations including arbitrary deprivation of liberty, inhumane treatment and torture and non-consensual treatment.¹³⁷⁹ Many human rights reports disclose that persons with mental disability are normally sent to these traditional and spiritual centers by their families to be “be exorcised of evil spirits or cured of their physical or mental illnesses for periods often lasting until the persons held at the camps were considered healed.”¹³⁸⁰ These individuals end up being shackled using ropes and wires in trees, beaten or flogged up, or/and suspended over fire in a bid to drive away the evil causing the mental illness, deprived of food and placing them in fasting at times for week on end considered part of a purifying process from all evil spirits possessing the body of the person with mental disability.¹³⁸¹

All these degrading processes are done to persons with mental disability through coercion and some because of lack of adequate information on the treatment as well as desperation. Assessment of capacity is never conducted, neither review of detention and conditions of facilities. Patients in these camps or psychiatric hospitals do not know or have the right to change their personal representatives like the UK provision. As the Human Rights Watch and other inspective report discloses, “persons with mental disabilities in psychiatric institutions and prayer camps, as well as hospital and camp staff, reported that family members or staff routinely decided on a person’s admission to, treatment within, and discharge from mental health facilities even when they voluntarily brought

¹³⁷⁸ See, *Ibid*, s. 3 (m).

¹³⁷⁹ See, Jocelyn Edwards, *Ghana’s Mental Health Patients Confined to Prayer Camps*, 383 *The Lancet* 16 (2014).

¹³⁸⁰ See, Human Rights Watch, *Like a Death Sentence: Abuse Against Persons with Mental Disability in Ghana*, *Supra* note 367, p. 49-51 & 61-64. See also, Benedict Carey, *The Chains of Mental Illness in West Africa*, *Supra* note 1350.

¹³⁸¹ See, *Ibid*.

themselves to such facilities, effectively denying them their legal capacity to make their own decisions.”¹³⁸² In addition, Hannah Roberts maintain that these physical and mental abuses go unreported or when reported, police refuse to intervene denying those wronged any recourse to justice.¹³⁸³ The Human Rights Reports adds to Hanna’s exposé claiming that “although criminal statutes outlawing assault might, in theory, be used to prosecute instances of forced treatment, it was unclear at the time of writing whether authorities had ever pursued criminal charges against psychiatric hospital staff for use of ECT.”¹³⁸⁴ Thus as stated before, it is important to have internal review and external reviews of these centers including mechanisms for individual complaints.

Overall, the GMHA requires that an individual who has the capacity to consent to treatment must provide the consent. Informed consent is only informed if relevant treatment information is provided to the relevant patient. Consent can be provided by personal representative or a court appointed guardian. Patients under compulsory regime can only get the treatment after the temporary court order has been given upon the application by personal representative or guardian. Compulsory patients according to the Act though not provided directly have the right to refuse treatment. The Act clearly sets a number of requirements that must be met and which rights are to be respected. However, the Act does not mention the criterion to be observed when consent is waived, as well as when capacity is determined unlike the other research jurisdictions. Too much discretion is left to physicians, the mental health tribunal, and the family members. It should be noted here that family members may have privileges to make judgments about their incapacitated loved one, especially in Ghana, where principles of ‘Ubuntu’ abounds, giving family members a greater say in the affairs of

¹³⁸² See, Ibid, p.56.

¹³⁸³ See, Hannah Roberts, A Way Forward for Mental Health Care in Ghana? 357 *The Lancet* 1859 (2001).

¹³⁸⁴ See, Human Rights Watch, Like a Death Sentence: Abuse Against Persons with Mental Disability in Ghana, *Supra* note367, p.65.

incapacitated individuals.¹³⁸⁵ While it is very important and great that family members are the primary caretakers it is here that greater caution has to be observed in a carefully manner in order to avoid violations of privacy, autonomy, and other human rights of the incapacitated persons.¹³⁸⁶ The thesis reasons that where families members believe in such practices highlighted above and lack enough knowledge on mental health, it is a disadvantage to the individual with mental illness as it easy to impose unjustified and detrimental paternalistic decisions on their behalf. The following asses protections that may prevent and address acts of abuse and arbitrariness as provided in the GMHA.

3.3.4.4. Substantive & Procedural Safeguards

The mental health legal framework that includes the constitution and the GMHA provide general and specific relevant standards for providing compulsory care and treatment to those with mental disorders.

(a). The right to provide informed consent. The GMHA sets out the rule that informed consent must be given before treatment is administered. Where an individual lacks the competence and capacity to consent, it requires that a court order must be sought or it is given by the personal representative and guardian who have been appointed by court. However as it is for those under involuntary treatment, treatment is compulsorily administered after a temporary court order has been given.

(b). In connection to the above is the prohibition on administering certain treatments without informed treatment. It is an offence under the Act to administer certain treatments such as electroconvulsive therapy, major surgeries and conduct research etc. without the informed consent of the relevant patient, personal representative or guardian or court order.

¹³⁸⁵ See, Peter Bartlet et al., *Mental Disability and the European Convention on Human Rights*, Martinus Nijhoff Publishers 133 (2007).

¹³⁸⁶ See, *Ibid.*

(c). The right to review of detention, compulsory treatment and guardianship is available for those individuals subjected to civil commitment under the Act.¹³⁸⁷ A further discussion on this is presented in the subsequent chapter.

(d). In relation to review, the Act offers protection through the right of appeal. Individuals subjected to the Act personally, through their representatives, guardian or primary care giver have the right to appeal against any involuntary admission or treatment. This essentially means one can challenge a ruling of incapacity to consent including general consent to treatment given by personal representative or guardian.¹³⁸⁸

(e). A further guarantee in the legislation is that patients and their representatives have the right to make any complaints regarding and misconduct by the staff or concerning their care and treatment (including on complaints on consent) while in the psychiatric facility or mental health centers to the head of the facility who shall act within forty eight hours. Failure to do these, the complainant/s may apply to the tribunals who have a mandated duration of twenty one days to respond.¹³⁸⁹

(g). The right to confidentiality is a further guarantee to every individual subjected to the Act. This right ensures that the consent of the relevant individual or/and representatives is acquired in written form before treatment or in relation to disclosing confidential information. Breach of this right may result in complaint applications made to the tribunal or the court.¹³⁹⁰ However, it should be noted that the right to confidentiality may be waived if there is ‘risk of imminent danger to another person or where the disclosure is required by law’.¹³⁹¹

¹³⁸⁷ See, GMHA (2012),s. 32

¹³⁸⁸ See, Ibid, s. 44.

¹³⁸⁹ See, Ibid, s. 59.

¹³⁹⁰ See, Ibid, s. 60. It states that: “(1) A person with mental disorder has the right to confidentiality. (2) Records which identify a person, the manner of behaviour of the person as well as the diagnosis and treatment shall not be disclosed to another person or agency without the person's written consent or the written consent of the personal representative of the person where the person is unable to give consent. (3) Despite subsection (2), written consent to provide confidential information may be waived where there is a risk of imminent danger to another person or where the disclosure is required by law (4) A patient, caregiver or the personal representative of the patient has the right to appeal to the Tribunal against waiving the right of the patient to nondisclosure of information.”

¹³⁹¹ See, GMHA (2012), s. 60 (2).

3.3.4.5. Sum Up.

The Ghanaian is a post-CRPD legislation that should have more of the CRPD requirements than most of the jurisdictions researched herein. However, as discussed it contains rights, obligations and duties, for both the users and care providers, but not in the extreme sense of the CRPD. It sanctions compulsory detention for treatment, recognizes incapacity, sanctions treatment without consent but with due regard to the substantive and procedural safeguards and use of substitute decision making mechanisms. It stands parallel to the other jurisdiction and MI principles in so far as basic provisions and principles go on capacity, consent and civil commitment, yet it lacks a lot in terms of legislation with procedural guidelines for capacity and consent. In this regard it is proposed herein that Ghana has to supplement its GMHA with more of these protections in order to mitigate the risk of further abuse, arbitrariness and unlawful detentions in the provision of mental health care in formal and orthodox institutions.

3.4. CONCLUSION

The aim of this chapter was to look at the international and national trends concerning capacity, consent and civil commitment in light with the CRPD. In addition it was to bring into focus the thesis assertions that the legislative schemes provided in mental health legislations are pertinent in providing balanced approach to the general delivery of mental health care services and the protection of rights. Consequently, the discussion so far connotes that the International and National practice recognizes both voluntary and involuntary detention and treatment, presumption of capacity, lack of capacity, right to consent and the acceptability as to the limitation to the right of consent in civil commitment. The analysis also shows that that there are a number of protective standards articulated in the legislations and that they are enforced by the Tribunals, Boards and Courts respectively in order to guarantee that the limitations of the right to autonomous decision making is not

excessively encroached. In view of that, some jurisdictions (Ontario & UK) present extensive procedures and safeguards whereas others have limited (South Africa & Ghana). However, having stated this, the legal decisions drawn upon revealed the occurrence of unlawful and arbitrary acts despite the law and in some situations they occurred because of the gap in the law. This finding underscores the thesis view that arbitrariness is a major issue and it is imperative that it is tackled through dissemination of information and enforcement of standards. The question that naturally arises is whether these procedures and protections reviewed are enough to tackle this issue. To reasonably answer the thesis maintains that for the most part, these standards present a reasonable form of protection. Moreover, while other countries may need to supplement their standards to offer more protection, effective implementation and enjoyment of these rights can be achieved with the addition and improvement of other factors such as proper financial backing into the mental sector, better infrastructure, education of the communities on mental health etcetera. All these shall be discussed in the concluding chapter five.

The finding in the chapter also reiterated the view that the CRPD interpretation does not coincide with many of the procedures given, of which it could be accommodated by these procedures with emphasis on protections. Distinctively it was shown that the MI principles are very close to the principles envisaged in the national legislative framework. For this reason and the fact that the thesis maintains that it is imperative to have safeguards despite the CRPD position, it is argued herein that these procedures and protections are adequate and provide a starting point bearing in mind that situations evolve and may require new ways of combating arbitrariness and abuse. In any case, there is need for law reform for countries such as South Africa and Ghana in terms of adding more into their legislations, including legislating on access to traditional and spiritual mental health services to curb the ongoing arbitrariness and abuse in detention and treatment of individuals with mental disabilities. It is equally important that all the research jurisdictions promote the support

decision making mechanism envisaged by the CRPD and by doing this it ensures that individuals with mental disability incapacitated or subjected to limitation on their autonomous decision making may have access to different options. Additionally, States should sensitize individuals about mental health, access to mental health and protections in terms of obligations and rights under the law. To ensure all these and in promoting equality in health access, governments have to provide the necessary financial means to facilitate proper infrastructure and human resource in mental health care, because a lack of this has led to human rights abuse of those accessing mental health care services.

To surmount, the following are the fundamental principles and safeguards that comparatively traverse the four jurisdictions and tend to protect the rights of those treated without consent or are without capacity:

- (a)** The right to equal recognition before the law under the respective bill or charter of rights in the constitution. This requires States to take all legislative and other measures to guarantee same treatment of those with disabilities with others.
- (b)** Every individual must be accorded a presumption of capacity until proven otherwise. Onus on the person alleging incapacity with substantiated evidence. The relevant tests determining capacity must ascertain that; the relevant individual has a mental disorder or impairment of the mind or brain that impairs the functioning of the brain and as a result the individual is unable to make a specific decision at the time in question. It must also be shown that the individual cannot understand the information given, retain it or weigh the consequences and unable to communicate their decision. Note that these tests are similar within UK, Ontario and South Africa but not specified in Ghana.
- (c)** The exercise of the right to autonomy in decision making entails receiving all the necessary information in a manner understood by the person concerned, weighed and reviewed includ-

ing risks of receiving and consequences of not receiving the treatment then making the informed choice.

- (d) The Right to consent is not absolute. However, in situations such as civil commitment where consent is not absolute, the individual concerned must be informed of this right. It is also considered that despite the non-absolute nature, consent is a continuous process as is capacity and individuals must be engaged at all times to ensure that when capable of making consent then the person exercises this right and it is made voluntarily.
- (e) While individual's liberty may be limited for compulsory treatment, individuals have the right to refuse treatment. Note that in some jurisdictions such as Ontario it is directly provided in the legislative framework, for UK those subjected to compulsory detention for treatment cannot refuse treatment except through Advance directives which are acceptable under the law. For South Africa, the right is not construed in the legislation but can be deduced from the provisions on patient's rights to refuse treatment upon regaining capacity while Ghana not directly provided but can also be construed from the right of an involuntary patient becoming a voluntary patient and hence exercising the right to refuse treatment.
- (f) Recognition of persons incapable to consent and providing protections through separate legislation (UKMCA, OHCCA) or in the mental health legislations (SMHCA).
- (g) As mentioned above, information is pertinent in reaching a decision whether to accept or refuse treatment. It follows therefore that, it is a right that information is exercised before administering of any care and treatment or rehabilitation to the concerned individual or representative with applicable restrictions as it relates to the right to privacy given in the law.
- (h) In all the jurisdictions, individuals subjected to the legislative framework voluntary, informal or involuntary have the right to use substitute decision makers. There are slight differences as illustrated such as the direct specification in the hierarchical list like in Ontario. South Africa and Ghana have a limited number of individuals that include "spouse, next of

kin, partner, associate, parent or guardian.” Whereas UK and Ontario have a diverse list “Power of attorneys, personal representative, independent mental health advisors etc.). These individuals have the power to make decisions as instructed by the individuals concerned.

- (i) Individuals with mental disability have the right to accept or refuse treatment through the use of prior wishes and advance directives. UK and Ontario have this in their legislations but neither does South Africa nor Ghana. However, there are provisions requiring respect of patient’s wishes and the obligation to involve patients in their care where they get to give their opinion on their care. This includes those wishes made through their substitute or support decision makers. Note however that for the UK, prior wishes maybe overridden but not those made in advance directives.
- (j) It is forbidden under the legislative scheme of all these jurisdictions to administer certain treatments without the explicit consent of the individual concerned, the substitute decision maker or independent representative and the Court. These include invasive mental disorder treatments such as electroconvulsive therapy and sleep therapy.
- (k) In relation to the above and finding of capacity, the laws in these jurisdictions save for Ontario, require second concurring opinion of a health practitioner confirming that an individual has a mental disorder and is unable to make autonomous decision due to the mental disorder before the order of incapacity to consent to treatment is made. Some where there is no concurrence require a further investigation.
- (l) The right of review by a Board, Tribunal or Court on any decision concerning capacity and consent is available to all individuals in the four jurisdictions. When an application of review is made, the treatment may not be given until an order has been made. Conversely, this does not apply in emergency situations.

(m)Procedures of consent in the entire jurisdictions are also regulated by Common law now codified in the respective legislations. Still it is a civil wrong to administer treatment without consent s it may attract a negligence, assault or battery claims. Hence another protection that is accessible to individuals with mental disability.

CHAPTER 4: REVIEW, DISCHARGE & CIVIL COMMITMENT

4.1. Introduction

Chapter four is the last themed chapter of the whole thesis and it deals with “Review, Discharge and Civil Commitment”. Akin to the other chapters that dealt with substantive and procedural aspects of civil commitment and the protections therein necessary to prevent arbitrariness and abuse in the course of involuntary placement for treatment and care, the same shall be done for this chapter. Actually, review and discharge are in themselves substantive and procedural guarantees which are recognized under international law and are equally present in every mental health legislation (at least in the chosen research jurisdictions). The duty and the right of review of reasons and circumstances of an individual’s detention, guarantee checks and balances of the right to liberty particularly when it is limited for the purpose of treatment, care or/ and rehabilitation. Discharge serves the purpose of effecting release where the purpose of detention, normally treatment has ceased to apply, where treatment needs no further detention and /or the detention was unlawful in itself. In addition to this, review ensures that individuals wrongfully detained for treatment or abused, receive remedies for the harm incurred. Some of these remedies may be inform of compensation, orders such as habeas corpus, mandamus or injunctive relief against any future detention and forced treatment.

It goes without say again that the practice of civil commitment is shunned by the CRPD Committee and various other activists and scholars. It therefore becomes obvious that the issue of review and discharge of those under compulsory measures should not arise. However, this is not the case and as State practice indicates, the use of compulsory measures is a norm rather than the exception and that review and discharge are the safeguards embedded in the mental health legislations to ensure that imposed compulsory measures in practice do not encroach further into other rights. These rights are similarly imperative in ensuring that rights of those already subjected to compulsory

measures and benefiting from such measures, including those who willingly through self-advance directive or wishes accept to be subjected to compulsory measures when necessary are protected. This reasoning is considered to have been missed out in the CRPD standpoint on civil commitment.

Hence, this chapter looks at Review and Discharge as a substantive and procedural right beneficial in combating unlawful and arbitrary detentions for the purpose of treatment and care. It is also intended that this chapter by comparatively analysing the State practice (legislation, case law and articles) may set out those guidelines on review and discharge cutting across the jurisdictions, including the differences. The idea is to have tangible workable guarantees of review and discharge. Furthermore it is to recommend these best practices to the jurisdictions where it is lacking, for example South Africa and Ghana that do not have regulation on review and discharge for those receiving treatment in informal mental health settings (traditional and spiritual mental health establishment) is concerned. The first analysis presents the international perspective which is then followed by jurisdiction perspectives and finally by a conclusion.

4.2. International Perspective

The international perspective on review and discharge of those placed under civil commitment can be understood by looking at the existing international human rights documents (CRPD, ICCPR, Arbitrary Working Group and the MI Principles) including Regional human rights instruments. Some of these documents such as the MI Principles that specifically provide for civil commitment procedures may not be considered politically correct since the CRPD presumably supersedes them. Nonetheless, they are explored because it is considered that they are in a position to offer applicable guidance. The following proceeds with the analyses.

4.2.1. CRPD

The Convention in itself makes no direct mention of the processes of review and discharge of those placed under compulsory measures for treatment purposes. As mentioned earlier in the thesis, it is because during the CRPD creation the very issue of involuntary detention for treatment was never dealt with head on. Even at present, there is no clear agreement on the matter with both the Committee and States engaging in different interpretation and practices.¹³⁹² For example in its recent “Guide to the Implementation of Article 14” the Committee continues to maintain its prohibitory stand as it has done previously in General Comment one, Statement on Article 14, and Concluding Observations, whereas State practice keeps promoting and maintaining the practice of involuntary commitment.¹³⁹³

However, even though the CRPD makes no reference on involuntary commitment or the processes of review and discharge, it could be argued that it does by inferring from three things. The first is drawn from the CRPD general principles, section 16 and 33. To expatiate, the CRPD itself calls upon member States to guarantee the rights of those with disabilities through, legislative and administrative action, including ensuring equal access and equality in the services (such as application for review of detention before relevant authorities).¹³⁹⁴ Services must therefore be provided through proper means, within a safe and appropriate environment.¹³⁹⁵ To balance rights and duties, a system of checks and balances must consequently be in place to guarantee a functioning and remedying system required under section 16.¹³⁹⁶ This section is supplemented by article 33 that directly re-

¹³⁹² See, CRPD Committee, Guidelines on Article 14 of the CRPD, Supra note 40, para 6.

¹³⁹³ See, Ibid, para 10.

¹³⁹⁴ See, CRPD (2008), Preamble & Articles 3, 4, 5 & 12.

¹³⁹⁵ See, Ibid, Article 15 (Freedom from torture or cruel, inhuman or degrading treatment or punishment) & Art. 16(Freedom from exploitation, violence and abuse).

¹³⁹⁶ See, Ibid, Article 3. It states that “In order to prevent the occurrence of all forms of exploitation, violence and abuse, States Parties shall ensure that all facilities and programmes designed to serve persons with disabilities are effectively monitored by independent authorities.”

quires State parties to set up national independent monitoring mechanisms including allowing civil society participation in the investigating, monitoring and reporting.¹³⁹⁷

The second inference involves article 14- right to liberty clause that guarantees any limitation on the right should not amount to being unlawful or arbitrary. This is the substance of the inference because, leaving aside the fact that the CRPD Committee has interpreted that involuntary commitment for those with mental disability in mental health facilities is arbitrary including the laws that sanction such action, the Convention requires that those who have been deprived of their liberty “through any process”, must be in accordance with the law, must be on an equal basis with others, are entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of the Convention, including by provision of reasonable accommodation”.¹³⁹⁸ Any process in this instance as is understood in the international human rights documents, national legislations and practice is/can be via review, discharge and compensation where a breach is pronounced.

The third reference being suggested comes from the CRPD guideline on Article 14. It is observed that at least the Committee emphasizes that for those deprived of their liberty under article 14 have the guarantee to a review of their detention, including conditions of stay to ensure that it is not arbitrary, does not continue to be so and are released from such detentions through the process of deinstitutionalisation.¹³⁹⁹ Meanwhile while the thesis discerns as such and agrees that many institutions need to be closed due to the deplorable conditions therein, it supplements that for those in being used their conditions must be improved and constantly monitored in view of the dreadful circumstance many are in. That’s why the author inversely finds the CRPDs position contradictory and

¹³⁹⁷ See, Ibid.

¹³⁹⁸ See, Ibid, Article 14 (1&2).

¹³⁹⁹ See, CRPD Committee, Guidelines on Article 14 of CRPD, Supra Note 40.

unrealistic considering State practice and because while it provides that review is important it goes forth to condition that this acknowledgement does not preclude the fact that it has maintained detention in mental health institutions for such treatment is contrary to CRPD as follows:

The Committee has stressed the necessity to implement monitoring and review mechanisms in relation to persons with disabilities deprived of their liberty. Monitoring existing institutions and review of detentions do not entail the acceptance of the practice of forced institutionalization. Article 16(3) of the Convention explicitly requires monitoring of all facilities and programmes that serve persons with disabilities in order to prevent all forms of exploitation, violence and abuse, and article 33 requires that States parties establish a national independent monitoring mechanism and ensure civil society participation in monitoring (paras. 2 and 3). Review of detentions must have the purpose of challenging the arbitrary detention and obtain immediate release, in no case it should allow for the extension of the arbitrary detention.¹⁴⁰⁰

In addition to the above, one of the other reasons besides State practice that makes the Committees opinion difficult is that it becomes politically incorrect to discourse about review of those detained under civil commitment because it is contrary to the principles enshrined in the CRPD.¹⁴⁰¹ It raises contemplations on what the Committee's position would be regarding those who voluntarily accept civil commitment through advance decisions or wishes given to their substitute decision makers and supporters. It is important to ask how this features in this pro-against jurisprudence. All the same, the important issue here is that review is central in any form of deprivation of liberty and even though, review of civil commitment is a thorny issue and not directly provided, it is essential that safeguards are given in law.

The following considers review and discharge as provided by the UN Working Group on Arbitrary Detention and its documents as it provides significant and expansive standpoints on arbitrary detention and the role of review.

¹⁴⁰⁰ See, *Ibid*, para 19.

¹⁴⁰¹ See, CRPD Committee, General Comment No 1, *Supra* Note 40, para 40.

4.2.2. UN Working Group on Arbitrary Detention

The UN Working Group on Arbitrary Detention was introduced in chapter one (UNWGAD), as an organ established by the Human Rights Council to oversee matters on detention. The UNWGAD jurisprudence has always been clear on the issue of reviewing detention. Currently its position is in the recently adopted Basic Principles.¹⁴⁰² The given position is that according to international law, States have the duty to ensure that every person enjoys the right to liberty and that those deprived have the right to have a determination of whether the deprivation is lawful. Comparable to the CRPD, UNWAGD position based on the Basic Principles evidently asserts this right as follows:

The right of anyone deprived of his or her liberty to bring proceedings before a court, in order that the court may decide without delay on the lawfulness of his or her detention and obtain appropriate remedies upon a successful challenge, [as it is] widely recognized in international and regional human rights instruments, the jurisprudence of the International Court of Justice and of international human rights mechanisms, including in the reports and country visits of treaty bodies and special procedure mandate holders, regional human rights mechanisms, in the domestic law of States and the jurisprudence of national courts.¹⁴⁰³

The group conditions that the “right to challenge the lawfulness of detention before a court is a self-standing human right, the absence of which constitutes a human rights violation.”¹⁴⁰⁴ And by asserting as such it constitutes review as “a judicial remedy designed to protect personal freedom and physical integrity against arbitrary arrest, detention, including secret detention, exile, forced disappearance or risk of torture and other cruel, inhuman or degrading treatment or punishment.”¹⁴⁰⁵ In addition it ensures that the determination of the “whereabouts and state of health of detainees and of identifying the authority ordering or carrying out the deprivation of liberty.”¹⁴⁰⁶ This is very crucial especially as it guarantees that those with mental illness are placed in proper facilities and given the best care that is available and acceptable. This falls squarely on the principle of reasonable accommodation enounced in the CRPD and right to health by the ICESCR. It furthermore assures

¹⁴⁰² See, Report of the Working Group on Arbitrary Detention, Basic Principles, Supra Note 273.

¹⁴⁰³ See, Ibid, para, 1.

¹⁴⁰⁴ See, Ibid, para, 2.

¹⁴⁰⁵ See, Ibid.

¹⁴⁰⁶ See, Ibid.

the monitoring and review of place of detention in terms of guaranteeing favourable and conducive environment for the provision of treatment.

In continuation to the above, and in emphasizing the importance of this right, the Basic Principles maintains that while the right to liberty is not absolute, the “right to be free from arbitrary or unlawful deprivation of liberty is an internationally recognized right”¹⁴⁰⁷ and it is not derogable under international law.¹⁴⁰⁸ Therefore the deprivation and detention shall not be unlawful.¹⁴⁰⁹ It is a guarantee available to everyone including persons with disabilities without discrimination.¹⁴¹⁰ It consequently places responsibility upon States to “guarantee the right to take proceedings before a court to challenge the arbitrariness and lawfulness of detention and to receive without delay appropriate and accessible remedies” within its national legal system.¹⁴¹¹ The Basic Principles recommend that this right should where possible be imbedded at “the highest possible level, where applicable, in the constitution”.¹⁴¹² As shall be determined further on in the text many jurisdictions indeed do guarantee this right within their constitutions.

As implied above, the right is exercisable by persons with disabilities. Alike the CRPD, the Basic Principle further segment on persons with disabilities, maintains that all “deprivation of liberty of any persons with physical, mental, intellectual or sensory impairments, is required to be in conformity with the law, including international law, offering the same substantive and procedural

¹⁴⁰⁷ See, Ibid, Principle 1.

¹⁴⁰⁸ See, Ibid, Principle 4.

¹⁴⁰⁹ See, Ibid Para 12 states that: “For the purposes of the present Basic Principles and Guidelines, deprivation of liberty is regarded as “unlawful” when it is not on such grounds and in accordance with procedures established by law. It refers to both detention that violates domestic law and detention that is incompatible with the Universal Declaration of Human Rights, general principles of international law, customary international law, international humanitarian law, as well as with the relevant international human rights instruments accepted by the States concerned. It also includes detention that may have been lawful at its inception but has become unlawful because the individual has served the entire sentence of imprisonment, following the expiry of the period for which the person was remanded into custody or because the circumstances that initially justified the detention have changed.”

¹⁴¹⁰ See, Ibid, Principle 8.

¹⁴¹¹ See, Ibid, Principle 1&2.

¹⁴¹² See, Ibid, Principle 2.

guarantees available to others and consistent with the right to humane treatment and the inherent dignity of the person”.¹⁴¹³ It is also comparable to the CRPD as far as prohibiting deprivation of liberty for involuntary committal or internment on grounds of the existence of a disability.¹⁴¹⁴ In connection to review, it calls for the review of arbitrariness and lawfulness of those detained, including possibility of the right to appeal, with the sole recommendation that this review goes hand in hand with States “obligation to design and implement de-institutionalization strategies based on the human rights model of disability”.¹⁴¹⁵ As mentioned before, just like the CRPD, it does not take into account the current State practice of civil committal and also the possibility that there are certain individuals that may opt for compulsory treatment. Therefore, by excluding civil committal it leaves a lacuna, one that presents a danger of arbitrariness, the very thing it is trying to prevent

Finally, it is imperative as the Basic Principles emphasizes that the right to review should be guaranteed to everybody deprived of their liberty, it should not be derogated from and that it should actually be implemented so that it does not remain only on paper. This right comes with its other guarantees such as the right to legal representation, legal aid, right to information, remedies and reparations and equality before the courts among others that are fundamental in the determination of the lawfulness of detention.¹⁴¹⁶ The following presents the ICCPR and its position on review and discharge.

4.2.3. ICCPR

The ICCPR comparative to the CRPD and UNWAGD jurisprudence provides for the right to liberty and the principle that any deprivation shall be in accordance with the prescribed law and interna-

¹⁴¹³ See, *Ibid*, Principle 20(39).

¹⁴¹⁴ See, *Ibid*, Principle 20(38) & Guideline 20.

¹⁴¹⁵ See, *Ibid*, Principle 20 (38) & Guidelines 20.

¹⁴¹⁶ See, *Ibid*, Principles 7-15.

tional standards. Though, unlike the CRPD, the ICCPR proceeds to further enunciate the rights of those deprived of their liberty. For example it requires those detained to be promptly given information as to the reasons of the restriction and their rights.¹⁴¹⁷ In addition, it conditions as a right that “anyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings before a court, in order that a court may decide without delay on the lawfulness of his detention and order his release if the detention is not lawful.”¹⁴¹⁸ As it is, the ICCPR and the Basic Principles impart related message- the necessity of review of any form of detention before a court of law or empowered authority, so as to determine the lawfulness of such restriction. Similarly they both provide other rights that match hand in hand in the process of review. According to the interpretation given in General Comment 35 on article 9, it is apparent that the right to review is non-derogable under international law, that State parties have a duty to ensure its proper implementation which also includes governmental actions and private actions that involve restricting the right to liberty.¹⁴¹⁹ This is very important especially when mental health services are being offered by both government mental health institutions and private institutions.

The right to review is also a guarantee to persons with disabilities. General Comment 35 discusses this right in light of persons with mental disabilities placed under involuntary care.¹⁴²⁰ Akin to the two international documents above, the Human Rights Committee cognizance of the inherent harm of involuntary hospitalization and challenges faced by persons with disability also asserts that “the existence of a disability shall not in itself justify a deprivation of liberty.”¹⁴²¹ It however does not outlaw involuntary commitment or call for the abolition of mental health legislations; instead, it calls member states to revise out dated mental health legislation in order to avoid arbitrary deten-

¹⁴¹⁷ See, ICCPR (1976), Art. 9 (1&2).

¹⁴¹⁸ See, ICCPR (1976), Art.9 (4).

¹⁴¹⁹ See, Human Rights Committee, General Comment 35, Supra Note 163, para 2 & 7.

¹⁴²⁰ See, Ibid, para 2 & 7.

¹⁴²¹ See, Ibid, para 19.

tion. Meanwhile, “any deprivation of liberty must be necessary and proportionate, for the purpose of protecting the individual in question from serious harm or preventing injury to others” and that any limitation “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.”¹⁴²²

Review is presented as one of those substantive and procedural protections necessary to prevent and to check unlawfulness and arbitrariness. The Human Rights Committee unlike the CRPD has maintained firmly that “deprivation of liberty must be re-evaluated at appropriate intervals with regard to its continuing necessity.”¹⁴²³ And to this end, “the individuals must be assisted in obtaining access to effective remedies for the vindication of their rights, including initial and periodic judicial review of the lawfulness of the detention, and to prevent conditions of detention incompatible with the Covenant.”¹⁴²⁴ Note that, the Committee imputes certain rights and obligations that go hand in hand with review procedures such as, “respect for the views of the individual and ensure that any representative genuinely represents and defends the wishes and interests of the individual.”¹⁴²⁵ These are words reflected in article 12 of the CRPD, respect of wishes and interests of the individual.

4.2.4. The MI Principles

The MI Principles are currently subject to strong criticism due to their acceptance of civil commitment and as such has been held to be weak and must be read in light of the CRPD. Paradoxically, it is the only international soft human rights instrument paralleled to the analysed that specifically and

¹⁴²² See, *Ibid*, para 19.

¹⁴²³ See, *Ibid*, para 19.

¹⁴²⁴ see, *Ibid*.

¹⁴²⁵ See, *Ibid*.

precisely sets out substantive and procedural safeguards for those placed under civil commitment. Moreover, despite the acceptance through its guiding principle, it strictly considers it as a last resort and not for all as it in tandem promotes access to community mental health services and facilities.¹⁴²⁶

Accordingly, as far as review and discharge is concerned, the MI Principles offers more spelt out guidelines some similar to the other Conventions while others very analogous to the domestic mental legislations. Thus, the MI Principles requires that individual's initial detention has to be for a short period pending the review of admission and retention and in this initial period, the reasons for the admission must be given to the individual, the representatives and promptly to the review body.¹⁴²⁷ As it follows there is an expectation of a review body which must be judicial, independent and impartial with relevant expert individuals.¹⁴²⁸ This body is then required to accept applications for review and dispense with them in a simple and expeditious manner and in accordance with the periodic intervals designated in the domestic law.¹⁴²⁹ The right of review works best with other protections such as the right to information, to retain counsel and right to appear individually or through representatives in the hearing¹⁴³⁰

Review must be done with simple and expeditiously procedures as specified by law, must periodically review cases of involuntary patients at reasonable intervals as specified by domestic law. According to the MI Principe's, the review must concern itself with whether the criteria for involuntary admission have been met and are continuously satisfied.¹⁴³¹ If not, then the patient must be

¹⁴²⁶ See, MI Principles, Supra Note 153, principle 7(1&2) & 15(1&2)

¹⁴²⁷ See, Ibid, principle 16 (2).

¹⁴²⁸ See, Ibid, principle 17 (1).

¹⁴²⁹ See, Ibid, principle 17 (2, 3 &4).

¹⁴³⁰ See, Ibid, principles 18 & 19.

¹⁴³¹ See, Ibid, principles 17 (2, 3 & 4).

discharged accordingly.¹⁴³² Discharge can also be effected when a relevant mental health practitioner responsible for the patient is satisfied that the conditions for holding the individual as an involuntary patient have ceased to exist or no longer justify further detention.¹⁴³³

A patient subjected to involuntary admission and detention or the representative or family have a further right of review through the use of appeal mechanism to a higher court against the decision of the review body or any decision that the individual be subjected to involuntary admission and detention in a mental health facility.¹⁴³⁴ In addition to appeals mechanism, it is a right for a patient present and past to make a complaint through procedures outlined in law.¹⁴³⁵ In addition to the mentioned, and despite the differences with the CRPD, it is arguable to state that the Principles can be featured within the CRPD jurisprudence by the very fact of its purpose to offer protections to persons with mental disability subjected to civil commitment. Its principle on the establishment of national monitoring and remedying system is important to the review of those admitted and detained under civil commitment and can be likened to article 33 of the CRPD.¹⁴³⁶

All these protections and more not cited above, are reflected in the domestic legislations of many countries party to the CRPD and even referenced in jurisprudence as shall be examined further below. Before this, the Regional Human Rights system is also evaluated to ascertain the position of review and discharge in civil commitment.

¹⁴³² See, *Ibid*, principle 17 (5).

¹⁴³³ See, *Ibid*, principle 17 (6).

¹⁴³⁴ See, *Ibid*, principle 17 (7).

¹⁴³⁵ See, *Ibid*, principle 21.

¹⁴³⁶ See, *Ibid*, principle 22.

4.3. Review and Discharge in the Regional Systems (ECHR, ACHR & ACHPR)

Parallel to the international standards set by international conventions, the regional human rights systems provides similar approach. However differences can be noted in terms of words in the text and interpretations. Some of them such as the ECHR as shall be seen have given expansive interpretations to the right of review unlike its counterparts, including that given by the CRPD. Nevertheless, the principle in law is the same. Hence, the regional systems demand that persons detained including those with mental disabilities admitted involuntarily to a psychiatric facility or mental health institution must have the right to take proceedings before a competent court so that without delay the lawfulness of their arrest or detention may be determined and an order of release given if the arrest or detention is unlawful.¹⁴³⁷ The American convention extends this right to possibilities when a threat of deprivation of liberty is made.¹⁴³⁸ It is the thesis view that the American approach may be an applicable course of action to persons with mental disability threatened to be involuntarily deprived of their liberty on a discriminatory basis. As presented, recourse to review is to be conducted at any time when a deprivation of liberty has occurred through arrest or detention. This ensures that procedural assessments on the admission process, stays and discharge are effected appropriately. In so doing, it averts any form of forced remain in psychiatric or mental health institution if they no longer meet the criteria for compulsory detention for assessment or treatment. These procedures have already been presented in the previous chapters.

¹⁴³⁷ See, ECHR (1950), Art. 5 (4), It states that: “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”.

See, ACHR (1978), Article 7(6). It states that: “Anyone who is deprived of his liberty shall be entitled to recourse to a competent court, in order that the court may decide without delay on the lawfulness of his arrest or detention and order his release if the arrest or detention is unlawful. In States Parties whose laws provide that anyone who believes himself to be threatened with deprivation of his liberty is entitled to recourse to a competent court in order that it may decide on the lawfulness of such threat, this remedy may not be restricted or abolished. The interested party or another person in his behalf is entitled to seek these remedies.”

See also, ACHPR (1986), Art. 7 (1- a & d). It states that: “(1) every individual shall have the right to have his cause heard. This comprises: (a) The right to an appeal to competent national organs against acts of violating his fundamental rights as recognized and guaranteed by conventions, laws, regulations and customs in force; (d) The right to be tried within a reasonable time by an impartial court or tribunal.”

¹⁴³⁸ See, ACHR (1978), Article 7(6).

The ECHR has laid down these principles in its vast jurisprudence dealing with claims of unlawful and arbitrary detention in mental health institutions. In its locus classicus case of *Winterwerp v Netherlands (1979)*, the court set out its principle that to be in line with the object and spirit of the Convention and particularly article 5 on detention of those with a mental illness, the following requirements must be observed: (a) it must be reliably established by way of objective medical expertise that the patient in question has true mental disorder (b) that the mental disorder in question must be of a certain degree that warrants compulsory confinement and (c) that the validity of continued confinement depends upon the persistence of such a disorder.¹⁴³⁹ Continued confinement according to the ECHR jurisprudence goes together with review of detention and reasons of detention. In *Winterwerp*, the court found a violation of the right to challenge the lawfulness of the applicant's detention because the applicants continued detention was not constituted by a proper court in the sense but by a prosecutor who rejected to determine some of the applicant's subsequent application for review and release.¹⁴⁴⁰ In reaching this conclusion the court highlighted that:

As is indicated earlier in this present judgment, reasons initially warranting confinement of this kind may cease, consequently it would be contrary to the object and purpose of article 5 to interpret paragraph 4 thereof (art. 5-4), read in its context as making this category of confinement immune from subsequent review of lawfulness to be available at reasonable intervals. That, the very nature of deprivation of liberty under consideration would appear to require a review of lawfulness of to be available at reasonable intervals.¹⁴⁴¹

For this right to be effective, the individual concerned must be personally heard or heard through a representative. Again, the ECHR in *Winterwerp* emphasized this point by underscoring that the right to personal challenge or through representation is to be read into article 5(4). The reasoning here is that “the failure to which he will not have been afforded “the fundamental guarantees of procedures applied in matters of deprivation of liberty”, that “mental illness may entail restricting or modifying

¹⁴³⁹ See, *Winterwerp V The Netherlands (1979)*, Supra Note 203.

¹⁴⁴⁰ See, *Ibid*, para 64

¹⁴⁴¹ See, *Ibid*, para 55.

the manner of exercise of such a right, but it cannot justify impairing the very essence of the right”.

¹⁴⁴² “Indeed special procedural safeguards may prove called for in order to protect the interests of those persons who in account of their mental illness, are not fully capable of acting for themselves.”¹⁴⁴³ This was a very stern, important and appropriate response to the Dutch government who postulated that as long as there is substantial medical evidence confirming an individual is suffering from a mental illness, it is not necessary for the person to be heard personally.¹⁴⁴⁴ These principles currently appear in the courts jurisprudence.

In the American region, the IACHR has had no jurisprudence on article 7 on persons with mental disability. However, through the case of *Victor Rosario Congo v. Ecuador (1998)*, the IACHR validated its readiness to apply the Convention and also in tandem applied the precedents of the ECHR and the guidance of the MI Principles to the protection of persons with mental disabilities.¹⁴⁴⁵ In the mentioned case, the State of Ecuador was found to have violated the right to life, right to physical integrity and to judicial protection of Victor Rosario who suffered from mental illness and while being a detainee was assaulted with his ensuing death. The State was found to have failed to investigate and provide judicial protection envisaged in the American convention under article 25.¹⁴⁴⁶ This position by the Inter-American court has had scholars proposing that it be used to “strengthen the human rights framework by compelling States to modernize their mental health laws to incorporate these human rights norms and principles.”¹⁴⁴⁷ The thesis coincides with these scholars with the insight of abuses happening against persons with mental illness in institu-

¹⁴⁴² See, *Ibid*, para 60.

¹⁴⁴³ See, *Ibid*.

¹⁴⁴⁴ See, *Ibid*.

¹⁴⁴⁵ See, *Victor Rosario Congo v. Ecuador*, (1998), *Supra* Note 265, para 53, 54 & 57.

¹⁴⁴⁶ See, *Ibid*, para 90-97.

¹⁴⁴⁷ See, Lance Gable et al, *Mental Health and Due Process in the Americas: Protecting the Human Rights of Persons Involuntarily Admitted to and Detained in Psychiatric Institutions*, 18 *Public Health* 370 (2005).

tions and other places, who are denied their substantive and procedural right to safeguard their rights.

In the case of the African Court, the court has had one but significant jurisprudence which has tackled the issue of review of those with mental illness compulsorily placed in psychiatric and mental health institutions. The court in *Purohit and Moore v. The Gambia*, did not find violation of article 6 (right to liberty) since the right is not absolute but warned that “any domestic law may not justify the deprivation of such persons freedom and neither can a State Party to the African Charter avoid its responsibilities by recourse to the limitations and claw back clauses in the charter”.¹⁴⁴⁸ Hence even though it was of the view that civil commitment “does not violate the provisions of Article 6 of the African Charter because Article 6 of the African Charter was not intended to cater for situations where persons in need of medical assistance or help are institutionalised, there was a violation of Article 7(Right to fair trial).¹⁴⁴⁹ This is because the then Gambian mental health legislation the “Lunatic Detention Act” did not contain protective provisions on the “right to review or appeal against an order or any remedy for detention made in error or wrong diagnosis or treatment. Neither do [did] the patients have the legal right to challenge the two separate Medical Certificates, which constitute the legal basis of their detention.”¹⁴⁵⁰

Analogous to the ECHR or Inter-American Court, the African Court’s reasoning relied on the MI Principles to find that the “omissions in the LDA clearly violate Articles 7(1)(a) and (c) of the African Charter.¹⁴⁵¹ It emphasized that:

The guarantees in Article 7 (1) extend beyond hearings in the normal context of judicial determinations or proceedings. Thus Article 7(1) necessitates that in circumstances where persons are to be detained, such persons should at the very least be presented with the opportunity to challenge the matter of their detention before the competent jurisdictions that should have ruled on their detention.²⁴ The entitlement of persons with mental illness or

¹⁴⁴⁸ See, *Purohit and Moore v. The Gambia*, (2001), Supra Note 237, para 64.

¹⁴⁴⁹ See, *Ibid*, para 64.

¹⁴⁵⁰ See, *Ibid*, para 27.

¹⁴⁵¹ See, *Ibid*, para 71.

persons being treated as such to be heard and to be represented by Counsel in determinations affecting their lives, livelihood, liberty, property or status, is particularly recognised in Principles 16, 17 and 18 of the UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Care.¹⁴⁵²

The decision is significant but has had little impact in many African States, since majority still utilize archaic mental health legislation and newly enacted statutes such as the Ghanaian lack regulations to regulate the compulsory treatment of those detained in spiritual and traditional mental health centers which continue to be a bed of abuse and arbitrary detention for those with mental health disabilities. In addition, mental health care continues to be the least funded and provided for in the health sector. This lack has resulted in poor provision of mental health care in uncondusive facilities and environment including increased challenge to many families in caring for their loved ones with mental illness with this care depicted with neglect and arbitrary detentions at home or in this unorthodox care centres. Perhaps the proposed African Convention mentioned in chapter one for persons with disabilities may bring more changes.

The above gives a synopsis of how review and discharge is presented and implemented within the regional systems. In sum, the final analysis that can be drawn is that review of detention serves as a substantive and procedural right that must be enforced in all situations of detention. Review has the consequential effect of release and discharge where the reasons for detention cease to exist or where detention is not the best or least restrictive alternative of providing mental health care. As noted, these right interlinks with other rights such as right to information, to a hearing in person or through representative, including the right to other special procedures such as interpreters when required. The positions in the regional system reflect some of those set out in the international human rights documents and also in many jurisdictional mental health legislation as discussed below.

¹⁴⁵² See, *Ibid*, para 72.

4.4. Jurisdictional Perspectives

Under this part the analysis delves into the national systems to comprehend how review and discharge are presented in protecting the rights of persons receiving mental health care. It shall begin with the England & Wales (UK), South Africa then followed by Ontario (Canada) and Ghana.

4.4.1. England & Wales (UK)

For consideration of review of and discharge from detention in any jurisdiction starts from the constitution that stipulates the right to liberty and fair trials. In UK, the right is embedded in the UKHRA (1998) that essentially contains the ECHR provisions. The jurisprudence thus follows much that is set out in the ECHR decisions as shall be seen in the upcoming discourse on review and discharge of civil commitment patients under the UK mental legislative scheme. The following examines review.

4.4.1.1. Review

4.4.1.1.1. By Tribunal & Country Court arising from: Individual, Representatives & Nearest Relatives Applications, Hospital manager's referrals & Secretary of State Referrals.

Patients detained for assessment (s.2), detained for treatment (s.3) and placed under CTO (s. 17 & 64) under the Act have a right to review of their detention through normal procedures of review in the Act as well as the use of judicial review mechanisms such as habeas corpus.¹⁴⁵³ As shall be discussed below, review can be undertaken by the Mental Health Review Tribunal, an institution

¹⁴⁵³ See, UKMHA (1983) as amended, s. 66. See also, R (MH) v Secretary of State for the Department of Health (2005) UKHL 60, para 12 / MH v UK, (2013), Supra Note 614, para 32.

charged with such responsibilities under the UKMHA, the County court (administrative court) and other judicial institutions with powers to hear judicial review cases, including appeal procedures. Before commencing the discourse it is important to highlight that as of 2008, the Mental Health Review Tribunal in England became the first-Tier Tribunal,¹⁴⁵⁴ “an independent judicial body established under the Tribunals, Courts and Enforcement Act 2007 [and] among its many functions, the Health, Education and Social Care (HESC) Chamber of the First-tier Tribunal exercises powers under the Mental Health Act 1983.”¹⁴⁵⁵ Its functions is to determine whether patients under the Act are liable to be detained, should continue to be detained, be subject of a CTO or guardianship as the case may be and not reviewing other people’s decisions to detain or enforce other compulsory measures.¹⁴⁵⁶ There is an Upper Tribunal established under the same Act as the First-Tier and whose function as far as mental health cases are concerned is to decide appeals against decisions of the First-tier Tribunal, including those appeals emanating from the MHRT for Wales.¹⁴⁵⁷ In Wales, the Mental Health Review Tribunal continues to carry the same functions as specifically designated in the UKMHA.¹⁴⁵⁸ Hence I refer to both of them as Tribunals.

Therefore, to commence illustrating the right of review, the case of *R (MH) v Secretary of State for the Department of Health (2005)/ MH v UK (2013) ECHR 1008*, provides an extensive overview of review of patients detained for compulsory assessment and treatment under the UKMHA.

¹⁴⁵⁹This is a case involving a young woman severely mentally disabled as a result of Down's syndrome, and formally admitted to hospital under section 2 complaining that her article 5(4) ECHR/UKHRA was violated, as an incapacitated person she was not able to challenge the lawful-

¹⁴⁵⁴ See, UK Tribunals, Courts and Enforcement Act(2007), section 3 & See, Transfer of Tribunal Functions Order (2008-SI/2833) , Article 3 & Schedule 1

¹⁴⁵⁵ See, UK Department of Health, Mental Health Act 1983: Code of Practice, Supra Note 458, p. 49, para 6.2.

¹⁴⁵⁶ See, Ibid, p. 49, para 6.2. & p. 6.4.

¹⁴⁵⁷ See, Ibid, p.50, para 6.7.

¹⁴⁵⁸ See, UKMHA (1983) as amended, s. 65.

¹⁴⁵⁹ See, *R (MH) v Secretary of State for the Department of Health (2005)*, Supra Note 1453.

ness of her detention through review even though her mum as a nearest relative could make an application on her behalf.¹⁴⁶⁰ Baroness Hale of Richmond responded by emphasizing that the patients subjected under the UKMHA are not left without the right to review and judicial review/habeas corpus mechanisms.¹⁴⁶¹ She underscored that the system under the UKMHA was designed in a manner to respect the rights of patients compatible with the UKHRA. This is through giving “patients and their relatives easy access to the tribunal which is designed to meet their needs” of review and discharge.¹⁴⁶²

Accordingly, powers of review and discharge are vested in the MHRTs instituted in the UKMHA (1959[now 1983 as amended]) Act to “provide an independent body entitled to review the detention of a patient under the Act”.¹⁴⁶³ For this reason, “their existence and jurisdiction satisfies, broadly speaking the requirements of article 5, particularly Article 5 (4), of the European Convention of Human Rights”.¹⁴⁶⁴ Thus, a patient, the representative or nearest relative must make the application for review depending on the scheme they fall into.¹⁴⁶⁵ For those under section 2, it is 14 days upon admission for assessment, those under section 3, six months beginning with the day on which the patient is admitted for treatment, six months beginning when a guardianship order is made, the same goes for community treatment order.¹⁴⁶⁶

The approach above is one among other ways that the Act was designed to ensure effective challenges as to the lawfulness of detention. The other is through the statutory duties of hospital man-

¹⁴⁶⁰ See, *Ibid.*

¹⁴⁶¹ See, *Ibid.*, para 31 & 32.

¹⁴⁶² See, *Ibid.*, para 25 & 26.

¹⁴⁶³ See, Jean McHale & Marie Fox, *Health Care Law: Text and Materials*, (2007), *Supra* Note 612, p. 549.

¹⁴⁶⁴ See, *Ibid.*

¹⁴⁶⁵ See, UKMHA (1983) as amended, s. 66 (1, 1(h)).

¹⁴⁶⁶ See, *Ibid.*, s. 66.

agers.¹⁴⁶⁷ This is a similar method that comes across in the other jurisdictions with the only difference situated in the person in charge of making the referral. This method was also highlighted in the above case by Lady Baroness Hale who affirmed that the UKMHA does not essentially expect that a patient commence the process since in some situations there will be an automatic referral of the patient's case to an MHRT.¹⁴⁶⁸ Current legislative procedure provides for an automatic referral for review to the tribunal by hospital managers.¹⁴⁶⁹ The time for referral is similar to the individual applications described a prior. However, they do not have a duty to apply if the application has already been made by the individual or representatives, or if the patient says otherwise.¹⁴⁷⁰ This aspect is again similarly comparative to the Ontario and South African legislation. The Legislative scheme also ensures that longer detentions are prevented by obliging hospital managers to refer cases where patients have been detained for more than three years without review, irrespective of an individual application having been made or not.¹⁴⁷¹ For those under CTOS, applications shall be made where there has been a revocation of the order.¹⁴⁷²

It is imperative to note that this right of review as mentioned a prior and in the international framework, works collectively with other rights such as right to information, counsel, representative and to be heard in person. Hence, this right is positively provided for in the UKMHA by requiring that the first fundamental statutory duty of managers, is that of informing patient subjected to the act (under section 2, 33 and CTO placed) in a manner they can understand how the Act applies to them and their rights, which also includes the right to apply to the tribunal for a review of their deten-

¹⁴⁶⁷ See, *Ibid*, s. 68 (1-9).

¹⁴⁶⁸ See, *R (MH) v Secretary of State for the Department of Health* (2005), *Supra* Note 1453, para 25 & 26.

¹⁴⁶⁹ See, UKMHA (1993) as amended, s. 68 (1, 2, & 3). See also, UK Department of Health, *Mental Health Act 1983: Code of Practice*, (2015), *Supra* Note 458, p. 88, para 12.10 & p. 381, para 37.39

¹⁴⁷⁰ See, *Ibid*, s. 68 (3)

¹⁴⁷¹ See, *Ibid*, s. 68 (6).

¹⁴⁷² See, *Ibid*, s. 68 (7).

tion.¹⁴⁷³ This right to information also extends to caretakers or and nearest relatives, unless the patient wishes otherwise.¹⁴⁷⁴ It is guided that information should not be generalized, and patients “should be told the essential legal and factual grounds for their detention or CTO.”¹⁴⁷⁵ The purpose is “for the patient to be able to adequately and effectively challenge the grounds for their detention or their CTO, [hence] should they wish, they should be given the full facts rather than simply the broad reasons.”¹⁴⁷⁶ Therefore, “this should be done promptly and clearly [and] they should be told they may seek legal advice, and assisted to do so if required.”¹⁴⁷⁷ Generally, as it was put in *R (MH) v Secretary of State for the Department of Health (2005)* “the hospital managers have to do the best they can to make the patient’s rights practical and effective” which ensures a balanced approach to provision of mental health treatment and securing of rights.¹⁴⁷⁸

In addition to the aforementioned scheme of review, the UKMHA has two additional substantive and procedural aspects of guaranteeing that detentions for admission and treatment are lawful. These are through the power of the Secretary of State and use of County court. The analysis begins with the duties of the Secretary of State and once again uses the aforementioned case *R (MH) v Secretary of State for the Department of Health (2005)*. In this case the reason why a violation was not found and section 2 found compatible with article 5(4) ECHR in the appeal stage is because the Court noted that the applicant in addition to the possibilities already discussed, she had the opportunity of using the statutory duties of the Secretary of State through the mother to seek a review of her detention.¹⁴⁷⁹ Therefore, the statutory obligation of secretary of State is stipulated in

¹⁴⁷³ See, *Ibid*, s. 130, 132A & 133. See Also, UK Department of Health, Mental Health Act 1983: Code of Practice, (2015), *Supra Note*, p. 37, para 4.9.

¹⁴⁷⁴ See, *Ibid*, s. 133.

¹⁴⁷⁵ See UK Department of Health, Mental Health Act 1983: Code of Practice, (2015), *Supra Note* 458, p. 38, para 4.15.

¹⁴⁷⁶ See, *Ibid*, p. 38, para 4.15.

¹⁴⁷⁷ See, *Ibid*.

¹⁴⁷⁸ See, *R (MH) v Secretary of State for the Department of Health (2005)*, *Supra Note* 1453, para 25.

¹⁴⁷⁹ See, *Ibid*, para 25& 27. At paragraph 27 it was held: “The history of this case is a good illustration. The patient's mother was able to challenge every important decision affecting her daughter. Most helpfully, she stimulated the Secretary of State's reference to the tribunal very quickly after it became clear that her daughter was to be kept in hospital

section 67 UKMHA and they are required to make a reference to the tribunal at any time of any person subjected to the Act. In addition, he or she may receive and consider any such requests on their merits.¹⁴⁸⁰

The Guide to the UKMHA emphasizes that Hospital managers should contemplate requesting the Secretary of State to refer cases particularly for children and young people under the age of 18.¹⁴⁸¹ Furthermore, consideration should be done in cases where it is in “respect of any patients whose rights under article 5(4) of the ECHR might otherwise be at risk of being violated because they are unable (for whatever reason) to have their cases considered by the Tribunal speedily following their initial detention or at reasonable intervals afterwards.”¹⁴⁸² This procedural aspect was followed in the *MH V UK (2013)* case and was one of the reasons that the court partially found that the applicant had available “special procedural guarantee” – ‘a duty to refer rather than goodwill of Secretary of State’- which guaranteed a speedy judicial review of her detention in terms of article 5(4), therefore she could not claim otherwise.¹⁴⁸³ The court compared this procedure to other cases such as *Stanev V Bulgaria (2012) ECHR* where violations were found due to the fact that third parties were not allowed to intervene.¹⁴⁸⁴

longer than 28 days. Had MH been discharged once the 28 days were up there would, in my view, have been no violation of her rights under article 5(4). It follows that section 2 of the Act is not incompatible with article 5(4).”

¹⁴⁸⁰ See, UK Department of Health, Mental Health Act 1983: Code of Practice, (2015), Supra Note 458, p.383, para 37.44.

¹⁴⁸¹ See, Ibid, p.383, para 37.45.

¹⁴⁸² See, Ibid, p.383, para 37.44 & 37.45. See also, *MH v UK*, (2013), Supra Note 614, para 94. The court held, “As concerns the legislative scheme at issue in the present case, the House of Lords pointed out that the Secretary of State was required under the Human Rights Act to exercise any power compatibly with the rights enjoyed by individuals under the Convention. This means that once a request is made for a referral, rather than enjoying a discretionary power to refer the case to the Tribunal, he is under a duty to do so if not to do so would involve an infringement of the patient’s rights under Article 5 § 4 of the Convention to obtain speedy judicial review of the detention. In such circumstances, the referral to a judicial body cannot be said to be dependent on the goodwill or initiative of the Secretary of State, but rather is a legal consequence flowing from his statutory obligation to act compatibly with the patient’s rights under Article 5 § 4 of the Convention. In this regard the present case can be distinguished from those of *Stanev* and *Rakevich* (cited above), where the third parties were not under any duty to intervene on the applicants’ behalf.”

¹⁴⁸³ See, Ibid.

¹⁴⁸⁴ See, Ibid.

As a final point on referral, it is moreover directed that referral should be done in cases that involve patients whose admission under section 2 (admission for assessment) has been extended under section 29 (appointment by court of acting nearest relative) pending the outcome of the application to the county court for the displacement of the nearest relative.¹⁴⁸⁵ It can similarly be exercised in situations where, “the patient lacks the capacity to request a reference due to mental illness, or either the patient’s case has never been considered by the Tribunal, or a significant period has passed since it was last considered”.¹⁴⁸⁶

The above given case demonstrates the procedural guarantees available even to those who lack the capacity to bring proceedings. Note however that the European Court of Human Rights despite all this procedures exercised in the case, found a violation of article 5 (4), because the mothers attempt at discharging or seeking review was prevented by a “barring order” and as a result, her right to order and the order had no effect thus being prevented from making any other further discharge order for a period of six months.¹⁴⁸⁷ In similar respect, it reasoned that since the applicants liberty was deprived by a social worker, the applicant or nearest relative could not use the normal 14 day procedural guarantees in article 2 and before the clarification of the other legal avenues discussed above by the court, the applicant or mother could not “have the benefit of effective access to a mechanism enabling her to “take proceedings” of the kind guaranteed to her by Article 5 § 4 of the Convention [and therefore] the special safeguards required under Article 5 § 4 for incompetent mental patients in a position such as hers were lacking in relation to the means available to her to challenge the lawfulness of her “assessment detention” in hospital for a period of up to twenty-eight days.”¹⁴⁸⁸

¹⁴⁸⁵ See, UKMHA (1983) as amended, s. 29 (1-5). See also, UK Department of Health, Mental health Act 1983: Code of Practice, (2015), Supra Note 458, p.383, para 37.46.

¹⁴⁸⁶ See, Ibid, s. 29 (3-b). See also, Ibid, p.384, para 37.46.

¹⁴⁸⁷ See, MH v UK, (2013), Supra Note 614, para 84.

¹⁴⁸⁸ See, Ibid, para 86.

The County court authority under the UKMHA legislative scheme akin to the other mechanisms provides substantive and procedural safeguards as regards review of detention and discharge.¹⁴⁸⁹ Any person may apply to the court with discharge requests or requests for barring orders. Barring orders have the consequences of displacing the nearest relative for a court appointed decision maker if reasonable cause is shown and also preventing any orders from being carried by the nearest relative in question.¹⁴⁹⁰ Orders may too have the effect involving a prolongation of detention from a section two to a section three.¹⁴⁹¹ On the other hand, a displacement order may be refused and if this is made, then the discharge request applied for shall be granted.¹⁴⁹²

In terms of review, the court in *R (MH) v Secretary of State for the Department of Health (2005)*, explained that when applications are made to the county court they avail the applicant a chance for his or her case of discharge from detention and/or against orders of displacement to be determined which inevitably involves the determination of the reasons for detention and why it should be shortened or prolonged.¹⁴⁹³ Equally, when an order is made by the county court, particularly when there is a resulting detention under section 3, the applicant gets a “fresh right to appeal to the tribunal”.¹⁴⁹⁴ Caution is given however that those proceedings in the county court may take a long time and that is why the legislative scheme has the Mental Health Review Tribunals located in hospitals close to patients in order to avail ready, quick and continuous access to patients subjected to the Act.¹⁴⁹⁵ Hence, the applicants right to judicial determination under article 5 (4) may be guaranteed

¹⁴⁸⁹ See, UKMHA (1983) as amended, s.29, 30 & 31.

¹⁴⁹⁰ See, Ibid, s 29 & 30.

¹⁴⁹¹ See, Ibid, s.29 (4). See also, *R (MH) v Secretary of State for the Department of Health (2005)* Supra Note 1453, para 28.

¹⁴⁹² See, Ibid, s. 30.

¹⁴⁹³ See, *R (MH) v Secretary of State for the Department of Health (2005)*, Supra Note 1453, para 28-30.

¹⁴⁹⁴ See, Ibid, para 28&29.

¹⁴⁹⁵ see, Ibid , para 30 . See also, *MH v UK, (2013)*, Supra Note 614, para 33 & 90-98.

in a speedy manner by the Tribunal and not the county court if the applicant pursues this mechanism for review of detention. The following examines review through habeas corpus.

4.4.1.1.2. Review via Habeas Corpus & UKHRA (Compatibility of Legislative Schemes and Governmental Body Actions).

Judicial review/ and or habeas corpus are considered optional judicial mechanisms for persons detained under the UKMHA legislative scheme and can be drawn on to guarantee judicial determination of their detention.¹⁴⁹⁶ As shall be determined further in the chapter, these mechanisms are analogous in the legislation in the research jurisdictions like habeas corpus Acts. The only difference is in the empowering document, in case of the UK it is directly spelt out including in the self-standing UKHRA, while the others research countries compatibility must be with the constitution as a whole including the respective Bill of Rights or Charter of fundamental freedoms therein. Nevertheless, the aftereffects bestow an advantage to the rights claimants which can be maintained to be very crucial in protection of rights. Back to the UK, on Habeas corpus and briefly on its history it can be summarized that the writ of *habeas corpus ad subjiciendum* has had a long history in English law as means of expediting the legality of detention by being scrutinized by a judge.¹⁴⁹⁷ As a discretionary writ, it's issued to a person holding the detained individual directing him or her to produce that individual before the court and show lawful cause for the detention.¹⁴⁹⁸ If the return to the writ shows a lack of lawful authority to detain, then the court is obliged to order the release of the individual.¹⁴⁹⁹ The burden of alleging lawful authority lies with the detainer, but once this lawfulness is

¹⁴⁹⁶ See, *R (MH) v Secretary of State for the Department of Health* (2005), *Supra* Note 1453, para 32. The Court summarized that- "Hence, while judicial review and/or habeas corpus may be one way of securing compliance with the patient's article 5(4) rights, this would be much more satisfactorily achieved either by a speedy determination of the county court proceedings or by a Secretary of State's reference under section 67. Either way, however, the means exist of operating section 29(4) in a way which is compatible with the patient's rights. It follows that the section itself cannot be incompatible, although the action or inaction of the authorities under it may be so."

¹⁴⁹⁷ See, United Kingdom, Habeas Corpus Act (1816).

¹⁴⁹⁸ See, *Ibid* s. 1.

¹⁴⁹⁹ See, *Ibid*, s. 3.

established, the burden to prove otherwise is set upon the detained to point out the flaw in that decision.

Judicial review on the other hand is the conventional mechanism of reviewing acts of public bodies arising originally from prerogatives such as mandamus, certiorari and prohibition. The claimant must seek permission to review a decision of an administrative body and must establish reasonable grounds why (public law grounds) mostly to show cause that the decision made by an administrative body is unlawful and not merely disagreeing with the merits of the decision. The grounds for review vary and may entail illegality, irrationality and procedure impropriety. Judicial review comes useful in cases where there is a decision to detain or to refuse discharge of those with mental disability. Judicial review of administrative decisions and the consistent application of legislation in concurrence with individual's rights as alluded to at the beginning are exercised in the UK by way of the Human Rights Act 1998. The Act unlike the other jurisdictions constitutions explicates that all 'primary and subordinate legislations must as far as possible be read and given effect in a way which is compatible with the Convention rights.¹⁵⁰⁰ If not compatible, a declaration of incompatibility must be given, even though it takes time for these to take effect.¹⁵⁰¹ Hence, this requires all "public authority to act in a way which is incompatible with a Convention right"- which in the case of this thesis the right to liberty as it applies to persons with mental disability.¹⁵⁰² These requirements confer positive corollaries to claimants who believe an authority has acted unlawfully for they can make claims in that respect, as a right before a court or tribunal or/and relying on a conventional right to bring proceedings.¹⁵⁰³ If successful in the challenge, they also get the right to a

¹⁵⁰⁰ See, UKHRA (1998), s.3.

¹⁵⁰¹ See, Ibid, s.4

¹⁵⁰² See, Ibid, s.6.

¹⁵⁰³ See, Ibid, s.7.

judicial remedy that may include compensation or order for release/discharge in case of unlawful deprivation of liberty.¹⁵⁰⁴

Jurisprudentially, it has been indicated that despite the fact that this mode can be invoked by persons with sufficient standing, it has its shortcomings. One of these shortcomings already mentioned is the reverting of burden of proof and that reviews of this nature are normally “not sufficiently rigorous review of merits as opposed to the formal legality of the patients detention to comply with article 5 (4).”¹⁵⁰⁵ In addition, there is the fact that if it is a discretionary administrative decision there is always a presumption that it is lawful unless challenged and set aside. The case of *R (MH) v Secretary of State for the Department of Health (2005)* illuminates on this factors as follows:

Administrative Court must now itself act compatibly with the patient's rights, it would be obliged to conduct a sufficient review of the merits to satisfy itself that the requirements of article 5(1)(e) were indeed made out. But it is not well equipped to do so. First, it is not used to hearing oral evidence and cross examination. It will therefore take some persuading that this is necessary: cf *R (Wilkinson) v Broadmoor Special Hospital Authority* [2002] 1 WLR 419 and *R (N) v M* [2003] 1 WLR 562. Second, it is not readily accessible to the patient, who is the one person whose participation in the proceedings must be assured. It sits in London, whereas tribunals sit in the hospital. How would the patient's transport to London be arranged? Third, it is not itself an expert tribunal and will therefore need more argument and evidence than a mental health review tribunal will need to decide exactly the same case.

¹⁵⁰⁴ See, *Ibid*, s. 8.

¹⁵⁰⁵ See, *X v United Kingdom* (1981) 4 EHRR 188. This case involved a case of an brought on behalf of the applicant who passed away by his next of kin, contending that his recall back for re-detention after conditional discharge from Broadmoor Hospital, a special secure mental hospital for the criminally insane after three years was unjustified, that he was not given sufficient reason for the re-detention and had no access to judicial review. The re-detention was effected by the wife who claimed due to his mental illness, he had not been doing well and feared his situation may escalate. He filed a writ of habeas corpus through his solicitor to a Divisional Court of the Queen’s Bench Division, a right available to those subjected under the Mental Health Act of 1959 now -1983. The issue in this case was “whether the habeas corpus proceedings did fully investigate the merits of the decision to recall him, or whether it merely examined if the recall had been ordered in accordance with the relevant provisions of the 1959 Act. He relied on Article 3 and Article 5 par. 1, 2 and 4 of the Convention (art. 3, art. 5-1, art. 5-2, art. 5-4)?” The Court found a violation of 5(4) and not 5 (1), because he was indeed unable to have the substantive and procedural merits of his case determined for two reasons. One, he could not rely on the Mental Health Review Tribunal at that time, since it did not have the power to review the lawfulness of detention decisions and order release if detention was unlawful, because it only had advisory functions. Second is the inadequacy of the Habeas corpus proceedings which the Court emphasized habeas corpus proceedings do not allow wide “judicial determination of both the substantive and the formal lawfulness of his detention required by article 5 (4). This is because it is only limited “in examining an administrative decision to detain, the court’s task is to inquire whether the detention is in compliance with the requirements stated in the relevant legislation and with the applicable principles of the common law.” Hence, a violation of art 5 (4) even though the applicant had access to a court which ruled that his recall and detention were lawful as per statute in terms of English law, since this cannot of itself be decisive as to whether there was a sufficient review of "lawfulness".

All of this takes time, thus increasing the risk that the determination will not be as speedy as article 5(4) requires.¹⁵⁰⁶

Insufficiency of the given methods and a violation of article 5 (4) were also noted in the famous case of *H. L V UK (2004) ECHR* concerning the detention and compulsory treatment without consent of an incapacitated man who could not refuse or accept treatment under the doctrine of medical necessity.¹⁵⁰⁷ This violation of article 5 (4) was given by the ECHR because there were no procedures and protections availed under the doctrine of medical necessity to informal incapacitated patients who were under the UKMHA and therefore those detained could not avail themselves to the substantive and procedural guarantees therein.¹⁵⁰⁸ These included H.L. getting a speedy judicial determination or periodic interval review on merits of the legality of his detention through judicial review using (the super-Wednesbury test) even if it included a proportionality test and/or a habeas corpus proceeding.¹⁵⁰⁹ The court used its jurisprudence in *X V UK (1981) ECHR* claiming it is the starting point on judicial review “where the Court found that the review conducted in *habeas corpus* proceedings was insufficient for the purposes of article 5 (4) as not being wide enough to bear on those conditions which were essential for the “lawful” detention of a person on the basis of unsoundness of mind since it did not allow a determination of the merits of the questions as to whether the mental disorder persisted.”¹⁵¹⁰

Nonetheless, it is noteworthy to emphasize that despite the limitations, the use of judicial review mechanisms and habeas corpus proceedings may be used to ensure the judicial control and review of detention. Thus constituting them as essential elements of guaranteeing that an individual’s liberty is not arbitrarily deprived and is attuned to the patients’ rights under article 5 (4)

¹⁵⁰⁶ See, *R (MH) v Secretary of State for the Department of Health (2005)*, Supra Note 1453, para 30.

¹⁵⁰⁷ See, *H.L. v. The United Kingdom (2004)* Supra Note 451, para 125

¹⁵⁰⁸ See, *Ibid.*

¹⁵⁰⁹ See, *Ibid.*, para 125, 13 & 140.

¹⁵¹⁰ See, *Ibid.*, para 137.

ECHR/UKHRA. For example, it is judicially recommended that the remedy of habeas corpus irrespective of its limitation “can constitute an effective check against arbitrariness in this sphere [and] may be regarded as adequate, for the purposes of article 5 par. 4, for emergency measures for the detention of persons on the ground of unsoundness of mind., [particularly for short measures] even though not attended by usual guarantees such as a thorough medical examination.”¹⁵¹¹ It is not supported for continued or long detention because it does not embody wide judicial control and importantly a thorough periodic examination of whether the reason for detention (presence of mental disorder, need for treatment, availability of treatment) are persistent and whether it justifies or not a release or discharge.¹⁵¹²

4.4.1.2. Discharge

Review of detention as illustrated above ensures that the detention is not arbitrary and that also guarantees that where the reasons for detention no longer exist the person detained must be released or discharged according to proper procedures. This is what was laid out in the case of *Johnson V UK (1997) ECHR*,¹⁵¹³ where the court held that it is a right for patients to be discharged when they no longer suffer from mental illness, the reason for their confinement, but it does not guarantee an immediate and absolute discharge because flexibility has to be given to the relevant authorities to ensure that the course of action serves the interest of the individuals and communities.¹⁵¹⁴ A breach of the ECHR article 5(1) was found against the UK in this case because of a lack of a scheme for discharging mental patients whose treatment was no longer required like Johnsons whose release kept being unreasonably delayed with deferrals.¹⁵¹⁵ Johnson’s case though concerns individuals who

¹⁵¹¹ See, X v United Kingdom (1981), Supra Note 1505, para 58, MH v UK, (2013), Supra Note 614, para 83 & R (MH) v Secretary of State for the Department of Health (2005), Supra Note 1453, para 31&32.

¹⁵¹² See, Ibid.

¹⁵¹³ See, Johnson V The United Kingdom (1997), Supra Note 208, para 61-64.

¹⁵¹⁴ See, Ibid, para 61.

¹⁵¹⁵ See, Ibid, para 67.

have committed crimes due to mental illness and have a different system applied to them in terms of discharge, it illustrates two significant concerns for all persons civilly committed. One is that there must be proper discharge mechanisms to ensure that individuals who no longer meet the criteria for detention for treatment are properly discharged. Two is that, discharge must be timely done (recognizing that aftercare services may be difficult to arrange) to prevent arbitrary detentions that keeps happening in many jurisdictions.

Now, review of detention as a means of effecting discharge can be used as aforementioned. In addition self-standing application can be made to the Mental Health Review Tribunal by or in respect of a patient detained under sections 2, 3 and those placed under guardianship and community placement orders asking the Tribunal to direct discharge.¹⁵¹⁶ Individuals who can make the request in respect of the patient include, the nearest relative, hospital managers and responsible clinicians as discussed subsequently.

Accordingly, nearest relatives may exercise their statutory duty of discharge in respect of a detained, under guardianship or CTO.¹⁵¹⁷ They must be given full information regarding the assessment, and treatment of their patient concern in order to carry out their obligations, including discharge.¹⁵¹⁸ The process of executing discharge is by writing a standard letter which they may be given or guided on how to apply by the hospital managers. The letter should bear the names of the person intended to be released, the intention and the order to discharge the person. This letter acts as a notice and an actual order since, it does not result in an automatic discharge of the individual, but gives the hospital managers 72 hours as per the law to effect the discharge.¹⁵¹⁹ The discharge

¹⁵¹⁶ See, UKMHA (1983) as amended, s. 72.

¹⁵¹⁷ See, Ibid, s.23 (2) & 26.

¹⁵¹⁸ See, UK Department of Health, Mental health Act 1983: Code of Practice (2015), Supra note 458, p. 355, para 32. 20.

¹⁵¹⁹ See, UKMHA (1983) as amended, s. 23 (2) & 25.

according to the law may be effected after the responsible clinician has given a report to the hospital manager indicating that the individual concerned if discharged, would not likely act in a manner dangerous to other persons or to himself.¹⁵²⁰ If it is in the contrary however, the order shall not be effected and the nearest relative shall be barred from making another order until after six months¹⁵²¹ meanwhile, discharge can also be done by the responsible clinician.

Thus, akin to nearest relatives, Responsible clinicians are allowed to discharge patients subjected to the Act under part 2 (assessment, treatment & CTO) and unrestricted patients under part 3.¹⁵²² The Code of Practice provides further parameters as regards this power of clinicians, by elucidating that with this powers, “they must keep under review the appropriateness of using that power, [that] if, at any time, responsible clinicians conclude that the criteria which would justify renewing a patient’s detention or extending the patient’s CTO (as the case may be) are not met, they should exercise their power of discharge.¹⁵²³ Hence, “they should not wait until the patient’s detention or CTO is due to expire”, but effect discharge in its merits.¹⁵²⁴ Conducting release in this manner is more appropriate and prevents any unlawful and unnecessary detention.

In addition to the two groups, Hospital Managers,¹⁵²⁵ atop their other statutory duties have the duty to make discharge themselves or consider through any other means.¹⁵²⁶ The managers seat in a constituted panel of three or more people who should know the workings of the Act, equality issues and general law relating to the subject and have had trainings on the same.¹⁵²⁷ The panelists are

¹⁵²⁰ See, *Ibid*, s. 25 (1).

¹⁵²¹ See, *Ibid*, s. 25 (1-a&b).

¹⁵²² See, *Ibid*, s. 23 (2b).

¹⁵²³ See, UK Department of Health, Mental health Act 1983: Code of Practice, (2015), *Supra* Note 458, p. 355, para 32.18.

¹⁵²⁴ See, *Ibid*.

¹⁵²⁵ See, *Ibid*, p. 385, para 38.3.

¹⁵²⁶ See, UKMHA (1983) as amended, s. 23& 25.

¹⁵²⁷ See, UK Department of Health, Mental health Act 1983: Code of Practice, (2015), *Supra* Note 458, p. 386, para 38.4-38.10.

expected to be “independent hospital managers who do not include staff members or a person among having a financial interest”.¹⁵²⁸ Discharge is based upon assessment of the patient’s treatment history of mental illness current and past. The UKMHA does not specify the criteria for assessing whether discharge is viable. This being said however, direction is given by the Code of Practice that, “the essential consideration is whether the grounds for continued detention or CTO under the Act is justified”.¹⁵²⁹ Hence, the assessment should be based on the criteria’s provided for compulsory detention for assessment or treatment,¹⁵³⁰ and CTO have ceased to exist.¹⁵³¹ The same applies to those detained in the other sections of the legislation.¹⁵³²

Finally, as was mentioned, applications can be made to the Tribunal. The Tribunal taking into account the section upon which the applicant or patient is detained (for this thesis section 2, 3&17) can effectively direct the discharge if it is satisfied that the requirements in section 72 resulting in the compulsory confinement and have not been satisfied.¹⁵³³ The Tribunal has the statutory powers

¹⁵²⁸ See, Ibid, p. 385, para 38.5.

¹⁵²⁹ See, Ibid, p. 387, para 38.15.

¹⁵³⁰ See, Ibid, p. 387, para 38.16.

¹⁵³¹ See, Ibid, p. 387, para 38.18.

¹⁵³² See, Ibid, p. 387, para 38.17.

¹⁵³³ See, UKMHA (1983) as amended, s. 72(1, 2&3). It states that: “Where application is made to [F2the appropriate tribunal] by or in respect of a patient who is liable to be detained under this Act [F3or is a community patient] , the tribunal may in any case direct that the patient be discharged, and— **(a)**the tribunal shall direct the discharge of a patient liable to be detained under section 2 above if [F4it is] not satisfied—(i)that he is then suffering from mental disorder or from mental disorder of a nature or degree which warrants his detention in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; or (ii)that his detention as aforesaid is justified in the interests of his own health or safety or with a view to the protection of other persons; **(b)**the tribunal shall direct the discharge of a patient liable to be detained otherwise than under section 2 above if [F4it is] not satisfied—(i)that he is then suffering from [F5 mental disorder or from mental disorder]of a nature or degree which makes it appropriate for him to be liable to be detained in a hospital for medical treatment; or (ii)that it is necessary for the health of safety of the patient or for the protection of other persons that he should receive such treatment; or(iia)that appropriate medical treatment is available for him; or](iii)in the case of an application by virtue of paragraph (g) of section 66(1) above, that the patient, if released, would be likely to act in a manner dangerous to other persons or to himself. **(c)**the tribunal shall direct the discharge of a community patient if [F4it is] not satisfied— (i)that he is then suffering from mental disorder or mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment; or (ii)that it is necessary for his health or safety or for the protection of other persons that he should receive such treatment; or (iii)that it is necessary that the responsible clinician should be able to exercise the power under section 17E(1) above to recall the patient to hospital; or (iv)that appropriate medical treatment is available for him; or (v)in the case of an application by virtue of paragraph (g) of section 66(1) above, that the patient, if discharged, would be likely to act in a manner dangerous to other persons or to himself.]]”

to make immediate absolute discharge, “discharge at a future date” deferred or conditional(in terms of restricted patients) depending with the circumstances of each case, particularly where after care services are to be arranged or it concerns restricted patients under the Act.¹⁵³⁴ In certain circumstances the Tribunal may decide not to discharge a patient from detention or CTO but may “recommend that the patient be granted leave of absence or be transferred to another hospital or into guardianship, with a view to facilitating the patient’s discharge on a future occasion”.¹⁵³⁵ Note however, the powers of the Tribunal are only limited to the mentioned and it cannot therefore “discharge patients from detention onto a CTO, nor can it order the release of a CTO patients who is detained temporarily as a result of being recalled to hospital (without at the same time discharging then from the CTO itself)”.¹⁵³⁶

4.4.1.3. Sum Up

The above is how UK- England and Wales exercise the right to review and discharge. The time frame for review as shall be seen differs slightly from that of the other research jurisdiction. Differences also can be noted in the vigilance of courts in protecting rights of those detained, much of which has been reinforced by the judgements from the ECHR and that has positively led to substantial changes in law. However, similarities are plenty as afar as exercising the right, prompt consideration when applications are made by the patient or in respect of, right to use habeas corpus and other judicial review mechanisms. In this regard the following looks at South Africa’s perspective on the rights in question

¹⁵³⁴ See, *Ibid*, s.72 (1A &3). See also, UK Department of Health, Mental health Act 1983: Code of Practice, (2015), *Supra* Note 458, p. 81, para 6.71 & 6.72.

¹⁵³⁵ See, *Ibid* s. 72 (3). See also, *Ibid*, p. 81, para 6.72.

¹⁵³⁶ See, UK Department of Health, Mental health Act 1983: Code of Practice, (2015), *Supra* Note 458, p. 82, para 6.77.

4.4.2. South Africa

Analogous to the UK, Ghana and Ontario, observing substantial and procedural rights in deprivation of liberty is a constitutional right that guarantees that unfair deprivation of liberty by State, those acting under States direction or private individuals does not take place. In interpreting the right to freedom and security of persons as provided in the constitution, the South African courts have emphatically provided that:

[there are] two different aspects of freedom: the first is concerned particularly with the reasons for which the State may deprive someone of freedom; and the second is concerned with the manner whereby a person is deprived of freedom. As I stated in [*Bernstein*], our Constitution recognises that both aspects are important in a democracy: the State may not deprive its citizens of liberty for reasons that are not acceptable, nor, when it deprives citizens of freedom for acceptable reasons, may it do so in a manner which is procedurally unfair. The two issues are related, but a constitutional finding that the reason for which the State wishes to deprive a person of his or her freedom is acceptable, does not dispense with the question of whether the procedure followed to deprive a person of liberty is fair.¹⁵³⁷

Thus, the paragraph highlighted makes a case for the necessity of proper procedures for review of any detention including civil commitment. Furthermore and as accentuated in the already discussed case of *De Vos N.O. and Others v Minister of Justice and Constitutional Development and Others (2015)* in chapter three, the right as it is “is aimed at protecting against the deprivation of a person’s physical liberty without appropriate procedure (procedural aspect of the right) and for reasons that are not acceptable (substantive aspect of the right), as to what reasons are acceptable, depends on the circumstances of each case.”¹⁵³⁸ Deprivation of liberty for treatment of mental illness is acceptable circumstances as also underscored in this constitutional case.¹⁵³⁹ Thus as it is, review and discharge procedures are carried out by an independent “Mental Health Review Board” also re-

¹⁵³⁷ See, *S v Coetzee and Others* [1997] ZACC 2, para 159.

¹⁵³⁸ See, *De Vos N.O. and Others v Minister of Justice and Constitutional Development and Others (2015)*, Supra Note 1124, para 25.

¹⁵³⁹ See, *Ibid*, para 65.

ferred to as the Review Board in the law and as presented in the subsequent description of its duties herein.¹⁵⁴⁰

South Africa's Review Boards are established by the executive council responsible for health services after consultation with head of provincial department in every province where there is a health establishment providing mental health care, treatment and rehabilitation or it can be one encompassing a cluster of all health establishments in the province.¹⁵⁴¹ This echoes the practices in the UK where the Tribunals sit in every hospital where there is a mental healthcare unit. Similarly, it must have some professionals in its sittings at least as the law puts it, it must be composed by at least three and not more than five South African individuals who are "mental practitioner, a magistrate, an attorney or an advocate admitted in terms of the law of the republic and a member of the community concerned".¹⁵⁴² These members are appointed through a call of nominations placed in the Provincial gazette and any other means of circulation before undergoing a vetting process to be carried by the Executive Council, who also determine their term limits and remuneration.¹⁵⁴³ This process ensures the independence and impartiality of the Review Board as a judicial entity as required by the Constitution and international law already discussed above.

Accordingly, once appointed and vetted, the constituted Review Board has the mandatory powers of speedily determining "(a) appeals brought against decisions of head of establishment, (b) make decisions regarding assisted or involuntary mental health care (c) consider reviews and make decisions on assisted or involuntary mental health care (d) consider 72-hour assessment made by the heads of the health establishment and make decisions to provide further involuntary care, treatment and rehabilitation; (e) consider applications for transfer of mental health care users to maximum

¹⁵⁴⁰ See, SMHCA (2002) as amended, s.1 (XXXIV).

¹⁵⁴¹ See, *Ibid*, s. 18.

¹⁵⁴² See, *Ibid*, s. 20 (2).

¹⁵⁴³ See, *Ibid*, s. 20 (3&4).

security facilities; and (f) consider periodic reports the mental health status of mentally ill prisoners.”¹⁵⁴⁴ In exercising these duties, it is permissible under the law for the Board to consultant with a body or person with relevant expertise on the relevant issue in concern.¹⁵⁴⁵ It may also “determine its own procedures for conducting business”.¹⁵⁴⁶ These highlighted powers resonate with those given in the rest of the research jurisdictions. To get an in-depth look, the following looks at the process of review and then followed by discharge procedures with a final sum up at the end.

4.4.2.1. Review

As noted above, one of the responsibilities bestowed upon the Review Board is to conduct reviews and make decisions on matters where applications for assisted care or involuntary mental health care. This function works in three ways: (a) head of establishment sending a copy for initial review, (b) through an appeal lodged by user or representative against decision of head of establishment (c) through periodic review. I shall add in between review through other judicial review mechanisms such habeas corpus before the periodic review. Thus, they are discussed in the same chronological order.

4.4.2.1.1. Review by Review Board

This function together with the role bestowed upon the Head of establishment, of sending a copy of an accepted application of admission for assisted or involuntary care within the seven days of the decision for an initial review.¹⁵⁴⁷ Upon receipt of the copy and within thirty days, the Review Board is then expected to undertake an investigation into the nature of incapacity of the concerned assisted user, the circumstances under which the user shall be receiving treatment and thereafter and

¹⁵⁴⁴ See, Ibid, s. 19. (1).

¹⁵⁴⁵ See, Ibid, s. 19(2).

¹⁵⁴⁶ See, Ibid, s. 24 (1).

¹⁵⁴⁷ See, Ibid, s. 28 (1).

within the given time give a response.¹⁵⁴⁸ According to the law, there are two responses that can be given to the head of establishment and on notice to the mental health care user - “(a) continue providing the mental health care user with the appropriate care, treatment and rehabilitation services or (b) discharge the mental health care user according to accepted clinical practice”.¹⁵⁴⁹ However, where an appeal is lodged against the decision of the head of establishment to the Board, it must stay the investigations into the initial review and consider the appeal.¹⁵⁵⁰

In case of an involuntary mental health user, and when an application has been accepted, there is an assessment period of 72 hours, upon which if assessed by the head of establishment that the involuntary user does not warrant further compulsory care, he or she must discharge the user.¹⁵⁵¹ If involuntary care is warranted but through an outpatient basis, then the user must be discharged with conditions attached to the method of care and the review board must be informed.¹⁵⁵² Like the assisted user initial review, the same sending of an approved copy of inpatient involuntary mental health care to the Review Board must be done within seven days after the expiration of the assessment time.¹⁵⁵³ Relevant notices and documents must be given to the involuntary mental care user, the head of establishment and independent mental health care practitioner if any for the purpose of the hearing.¹⁵⁵⁴ The Review Board has equal thirty days upon which to conduct the review and give an answer as to the relevant parties whether it affirms or rejects the continuation of compulsory inpatient care and treatment.¹⁵⁵⁵ If it affirms, the procedures below must be followed.

¹⁵⁴⁸ See, Ibid, s. 28(2).

¹⁵⁴⁹ See, Ibid, s. 28(2 & 3).

¹⁵⁵⁰ See, Ibid, s. 28(4) & s. 29.

¹⁵⁵¹ See, Ibid, s. 34(1, 2&3).

¹⁵⁵² See, Ibid, s. 34 (3a&b).

¹⁵⁵³ See, Ibid, s. 34(3c).

¹⁵⁵⁴ See, Ibid, s. 34(7 a&b).

¹⁵⁵⁵ See, Ibid, s. 34 (7c).

4.4.2.1.2. Judicial Review by High Court of Involuntary Care, Treatment and Rehabilitation

Unlike decisions made for assisted care users that end with the Review Board, the decision to continue compulsory care and treatment if made by the Review Board must receive a further ‘Judicial review’ by a High Court. In this regard, the Review Board’s decision must be submitted to the Registrar of the High Court with relevant documents.¹⁵⁵⁶ Submission of decision also includes instances where an appeal has not been upheld.¹⁵⁵⁷ Judicial review is undertaken when there is further need of inpatient involuntary care, treatment and rehabilitation. Thus, when the High court receives the forwarded documents from the Review Board, it also has thirty days in which it must carry the proceedings and give its decision.¹⁵⁵⁸ The proceedings must also involve hearing submissions from all the relevant parties.¹⁵⁵⁹ The High court can make two decisions according to the law; the first can be to order further hospitalization of the mental health care user, including orders on managing of his financial affairs according to the law.¹⁵⁶⁰ The second order is “immediate discharge of the mental health care user”.¹⁵⁶¹ This aspect of review is noteworthy to mention is not available in the other jurisdictions, but through review by a higher tribunal or court can be made through a challenge of the decision to detain for treatment, like explained in the subsequent process.

4.4.2.1.3. Review and Discharge through Appeal procedures

This brings us to the second approach to review. An appeal with facts and grounds upon which it is based against the decision of the head of establishment can be made by the user, spouse, next of kin, representative, associate or/and guardian to the Review Board within thirty days of receiving a

¹⁵⁵⁶ See, *Ibid*, s. 34 (7c) & 36.

¹⁵⁵⁷ See, *Ibid*, s. 35 (4).

¹⁵⁵⁸ See, *Ibid*, s.36.

¹⁵⁵⁹ See, *Ibid*, s.36 (a&b).

¹⁵⁶⁰ See, *Ibid* s. 36 (c-i).

¹⁵⁶¹ See, *Ibid*, s. 36 (c-ii).

written notice of decision to give assisted or involuntary care treatment and rehabilitation from the head of establishment.¹⁵⁶²The Review Board has the standard thirty days upon which to hear the submission of either the independent mental health practitioner or head of establishment on the merits of the appeal and give a decision.¹⁵⁶³Here again the Board can either uphold the appeal and order immediate discharge according to clinical practice or reject the appeal and order the continuation of inpatient compulsory care, treatment and rehabilitation.¹⁵⁶⁴As aforementioned, if it upholds the decision for the case of inpatient compulsory care and treatment, it must forward the documents to the High Court for Judicial Review.¹⁵⁶⁵ It is imperative to mention that the whole process of review or discharge in South Africa, akin to UK, Ontario and Ghana, can be delayed if the users assisted or involuntary opt to continue with their expressed consent.

4.4.2.1.4. Periodic Review and Annual Reports

The third method of review is the periodic review of assisted and involuntary mental health care user.¹⁵⁶⁶ Analogous to the Ghanaian or Ontario (6 months) specification, it is carried out six months after the commencement of care, treatment and rehabilitation services and every twelve months thereafter.¹⁵⁶⁷This review is carried out in two stages for assisted and three for involuntary mental health user. The first involves a review with a report being undertaken by the head of the health establishment and the second is review done by the Review Board based on the report given by the Head of health establishment. The Review Board gives a final order as shall be discussed down below. But first, it is important to highlight what the review must entail. According to the law, the head of establishment in conduct-

¹⁵⁶² See, Ibid, s. 29 (1a&b) & s. 35 (1).

¹⁵⁶³ See, Ibid, s. 29 (2) & 35 (2).

¹⁵⁶⁴ See, Ibid, s. 29 (3) & 35 (3).

¹⁵⁶⁵ See, Ibid, s. 35 (4).

¹⁵⁶⁶ See, Ibid, s. 30 & 37.

¹⁵⁶⁷ See, Ibid, s. 30 (1) & 37(1).

ing the review must ensure that he or she determines the “capacity of the mental health user to express him or herself on the need of the care, treatment and rehabilitation services, whether there is an availability of least restrictive and intrusive measures than the currently administered or used particularly on the rights of movement, privacy and dignity of the user, and a recommendation regarding further care, treatment and rehabilitation services”.¹⁵⁶⁸ For involuntary mental health care user, the review must take one additional aspect into account “whether the mental health care user is likely to inflict serious harm on himself or herself or other people”.¹⁵⁶⁹ This is a recurring aspect in the UK, Ontario and Ghana legislation. The interesting difference is the particular attention given to the three rights in the SMHCA.

Thus, back to the two stages, it follows that the summary of the findings must be sent to the Review Board which must again deliberate over the report within thirty days of receipt, including delivering a response.¹⁵⁷⁰ Now, as is the norm, the Review Board must hear all persons involved from the user concerned or the representative to consulting any other person who has any information about the status of the user.¹⁵⁷¹ Subsequently, it must give its final orders on the review to the user, head of establishment and relevant head of provincial department.¹⁵⁷² The findings here again may involve an order for discharge which bear the consequences of stopping all care, treatment and rehabilitation services according to accepted clinical practice and for hospitalized users, must be realized or discharged from the relevant health mental establishment.¹⁵⁷³ As for an involuntary mental health care user, a discharge report must be given to the Registrar of the High court.¹⁵⁷⁴ Off course, if the user consents to further treatment, then it continues as governed under voluntary care, treat-

¹⁵⁶⁸ See, *Ibid*, s. 30(2a, b & c) & 37 (2a, c & d).

¹⁵⁶⁹ See, *Ibid*, s. 37 (2b).

¹⁵⁷⁰ See, *Ibid*, s. 30 (4b) & 37 (3).

¹⁵⁷¹ See, *Ibid*, s. 30 (4a&b) & 37 (4a&b).

¹⁵⁷² See, *Ibid*, s. 30 (4c) & 37 (4b).

¹⁵⁷³ See, *Ibid*, s. 30 (5a-i&ii) & 37 (a-i&ii).

¹⁵⁷⁴ See, *Ibid*, s. 37 (6).

ment and rehabilitation services section.¹⁵⁷⁵ Compliance of the order by the head of establishment is not an option but mandatory.¹⁵⁷⁶

4.4.2.1.5. Review through Other Mechanisms such as Habeas Corpus.

The use of habeas corpus in challenging civil commitment in South Africa is possible and analogous to the UK and Ontario.¹⁵⁷⁷ Conversely, there is no legislative enactment such as the Habeas Corpus Acts in the UK and Ontario or in the Constitution Bill of Rights.¹⁵⁷⁸ Review through Habeas corpus according to the jurisprudence of the South African can be exercised through “the common law remedy known as the interdictum de libero homine exhibendo well established in [their] law.”¹⁵⁷⁹ As such, “the order or writ de libero homine exhibendo, which may be applied for whenever a person has been unlawfully deprived of his freedom, is directed at the custodian of the prisoner, and is analogous to the writ of habeas corpus ad subjiciendum (commonly known as habeas corpus) of the English law.”¹⁵⁸⁰ Hence, while it may not be the strongest way of guaranteeing review and subsequent discharge, equivalent to UK jurisprudence, it is a door open nonetheless.

4.4.2.2. Discharge

From the discussion afore, its apparent that discharge must be executed when there is no longer cause for further care, treatment and rehabilitation after the assessment duration and in the aftermath of review with an order of discharge. This order as mentioned again can be made by the Review Board or the High Court after review or a successful appeal on the part of the mental health

¹⁵⁷⁵ See, *Ibid*, s. 30 (5a-i&ii) , 37 (5a-ii) & 38.

¹⁵⁷⁶ See, *Ibid*, s. 30 (5b) & 37 (5b).

¹⁵⁷⁷ See, *Nkwentsha v Minister of Law and Order, Republic of South Africa and Another (554/86) [1988] ZASCA 33*, para 30.

¹⁵⁷⁸ See, *Ibid*, para 27 & 29.

¹⁵⁷⁹ See, *Ibid*, para 30.

¹⁵⁸⁰ See, *Ibid*.

care user. Discharge must be executed by the head of health establishment for assisted and involuntary users who upon recovery of capacity make an informed decision of not wanting to proceed with the mental care and hence want a discharge.¹⁵⁸¹ However, for involuntary mental care users, discharge is pegged on the satisfaction of the criteria that he or she is no longer suffering from a mental illness of a nature that is likely to inflict serious harm to herself, himself or others or the care, treatment and rehabilitation is necessary for the protection of the financial interest or reputation of the user”.¹⁵⁸² If not satisfied, then the mentioned procedures of review and discharge must be made.

Off course discharge everywhere including South Africa is not automatic as it may be taken to be because as the law puts it clinical practices have to be followed. It means therefore like the UK that a certain reasonable time must be given to enforce it. It might be delayed if the user consents to continue with the care voluntarily through consent. Even with this change, the most important thing is that, it must be done by the head of the health establishment who “must in a prescribed form issue a discharge report to the user who was admitted for the purposes of receiving care, treatment and rehabilitation services”.¹⁵⁸³

4.4.2.3. Sum Up

South African legislation and jurisprudence as illustrated guarantees that deprivation of liberty is met with proper protections that is comparably acceptable within various national jurisdictions and international standards. However, minor differences in terms of review and discharge requirements can be detected for example duration for referrals, use of relatives, whereas in UK their roles are

¹⁵⁸¹ See, SMHCA (2002) as amended, s. 2 & 38.

¹⁵⁸² See, Ibid, s. 38 (3) & 32 (b).

¹⁵⁸³ See, Ibid, s. 16.

more defined while in South Africa they are not or Ontario where the use of Habeas corpus is directly provided for in the constitution or UK in a statute and in South Africa its only applicable through common law. The following analyses the Ontario way of review and discharge.

4.4.3. Ontario (Canada)

Comparable to the other three jurisdictions, it is a constitutional right not to be arbitrary deprived of liberty or detained without just cause.¹⁵⁸⁴ Then, since the right to liberty and security is not absolute, its limitation must be in accordance with the principles of fundamental justice.¹⁵⁸⁵ The principle of fundamental justice requires that those detained must be “(a) informed promptly of the reasons therefor, (b) retain and instruct counsel without delay and to be informed of that right and (c) to have the validity of the detention determined by way of habeas corpus and to be released if the detention is not lawful”.¹⁵⁸⁶ Remember that South Africa and UK do not provide habeas corpus as a right within their constitutions like Canada. Accordingly, judicial review of legislation, action or omissions as a safety measure is guaranteed in the constitution to all individuals including those subjected to civil commitment. This aspect was buttressed in the leading case of *Fleming V Reid (1991)* where the Ontario Court of Appeal found violation by asserting that the then:

The impugned scheme under the Mental Health Act fails to meet the requirement of s. 7 that the principles of fundamental justice be observed with respect to involuntary incompetent patients. Those patients are arbitrarily deprived of their right to security of the person insofar as they are denied any hearing in which they may assert, through their substitute consent-givers, their competent wishes with respect to treatment and, thus, their right to be free of unwanted medical treatment. Such a violation of the principles of fundamental justice, in my opinion, can be neither "reasonable" nor "demonstrably justified in a free and democratic society".¹⁵⁸⁷

¹⁵⁸⁴ See, The Constitution Act of Canada (1982), s. 9.

¹⁵⁸⁵ See, Ibid, s. 7.

¹⁵⁸⁶ See, Ibid, s. 10.

¹⁵⁸⁷ See, Fleming v. Reid, (1991), Supra Note 529, para (VII).

Similar findings are also reiterated in the recent case of PS given further below where the OMHA statutory scheme was found incompatible with the constitution as far as review powers of the Consent and Capacity Board (CCB) and access of review goes for long term involuntary detainees. The following looks at the CCB, statutory power of review, then followed by review under the mental health legislations.

4.4.3.1. Review through the Jurisdiction of the CCB

Thus, the Consent and Capacity Board (CCB) is an autonomous adjudicative Board established under the “Health Care Consent Act with jurisdiction under that Act, the Mental Health Act, the Substitute Decisions Act, the Personal Health Information Protection Act and the Mandatory Blood Testing Act”.¹⁵⁸⁸ It is the equivalent to the Tribunal and Review Board of UK, South Africa and Ghana. As an independent tribunal it carries the mandate to adjudicate on matters of capacity, consent, and civil committal, substitute decision making, disclosure of personal health information and mandatory blood testing.¹⁵⁸⁹ Its aims are to “provide fair, timely, effective and respectful hearings that balance legal, medical and healthcare considerations while protecting individual rights and ensuring the safety of the community”.¹⁵⁹⁰ These are re-echoing functions that the Tribunal and Review Boards in the other research jurisdictions are mandated to do. It is equally constituted as an expert (members appointed by a Lieutenant Governor in Council) with a three member panel or five consisting of a lawyer, a psychiatrist and a member of the public sitting appointed by the in a given inquiry, including those cases involving deprivation of a person’s liberty.¹⁵⁹¹

¹⁵⁸⁸ See, OHCCA (1996) as amended, part V (s.70-81).

¹⁵⁸⁹ See, Ontario Consent and Capacity Board, Annual Report 2014-2015: (Fiscal Period – April 1, 2014 to March 31, 2015), p.2. Available at: <http://www.ccboard.on.ca/english/publications/documents/annualreport20142015.pdf>.

¹⁵⁹⁰ See, Ibid.

¹⁵⁹¹ See, OHCCA (1996) as amended s, 70(2)& 73 & OMHA (1990) as amended, s. 39.13 & 39.14.

See also, See, Ontario Consent and Capacity Board, Annual Report 2014-2015, Supra Note 1589, p.5.

However, unlike the other tribunals that can deal with matters of fact and law, the Ontario Tribunal powers of review in matters of involuntary admission and continuation is “limited to determine whether or not the prerequisites set out in this Act for admission as an involuntary patient continue to be met at the time of the hearing of the application”.¹⁵⁹² It can rescind or confirm a certificate of involuntary admission or continuation in any hearing including those brought under community treatment orders.¹⁵⁹³ This limitedness in its powers was brought out in the case of *P.S. v. Ontario (2014)* where legislative review of OMHA and its guarantees of review and discharge of those under long stay detentions.¹⁵⁹⁴

The case concerned PS a deaf man who was found guilty of assaulting a minor, completed a 45-month prison sentence after which he was detained through involuntary admission for 19 years after being diagnosed with paedophilia-paraphilia in a security mental institution.¹⁵⁹⁵ According to the OMHA, his detention was repeatedly renewed for additional three years as long as it was determined that his illness was likely to result in serious bodily harm to himself or other persons. He challenged the constitutionality of the OMHA for lacking proper procedures of reviewing his long term stay since the CCB had limited powers of confirming, rescinding or transfer from one facility to the other (transfer being a new power under s.39.2 as a remedy to long stay patients).¹⁵⁹⁶ PS was not successful in his appeal to the Superior Court of Justice but successful in the Court of Appeal.

The Court of Appeal strongly responded that the OMHA legislative scheme as far as long stay patients (those detained for six months and above) are concerned lacked “to ensure that the conditions of a person’s long-term detention are tailored to reflect the person’s actual level of risk, moving

¹⁵⁹² See, OMHA (1990) as amended, s. 41.1.

¹⁵⁹³ See, Ibid, s. 41.2, 3 & 4.

¹⁵⁹⁴ See, *P.S. v. Ontario*, (2014) ONCA 900 (CanLII).

¹⁵⁹⁵ See, Ibid.

¹⁵⁹⁶ See, Ibid, para 127.

towards their ultimate integration”¹⁵⁹⁷ This lack was associated with the CCB powers of review. In this regard, the court emphasized that:

At this stage, we are tasked with assessing the constitutional adequacy of the CCB’s powers, including s. 39.2. In my view, the limited authority conferred by s. 39.2 fails to bring the MHA up to the applicable constitutional standard. Section 39.2 is a blunt tool. It only deals with transferring a long-term patient from one psychiatric facility to another. This falls well short of a general authority to ensure that the liberty interest of the patient is adequately protected. The CCB lacks the jurisdiction to order a long-term patient to be transferred to a different security level within a psychiatric facility, to transfer him or her to another hospital with conditions, or to increase privileges regarding community access. There is nothing in s. 39.2 of the MHA to give the CCB the authority to ensure that the long-term patient is moved towards reintegration into the community. There is no power to order conditions for gradual release or ongoing supervision.¹⁵⁹⁸

The Court further analysed that by the mere fact that the CCB powers were inadequate to “make orders regarding security, privileges, therapy and treatment, or access to and discharge into the community”, including basic questions as to where and how a person is detained and how they are discharged into the community, it “fails to ensure adequate protection of liberty interest of those detained as long term involuntary patients under the MHA” and consequently a breach of section 7 of the constitution.¹⁵⁹⁹

In the aftermath of this decision, the Ontario legislator made amendments to the concerned section by introducing involuntary admission and certificate of continuation slashing out renewals and giving the CCB extended powers that it can make when confirming a patients certificate of continuation.¹⁶⁰⁰ It does not mention verbatim that it can determine matters of fact and law, but these orders may touch on the subjects concerning transferring orders, placing patient on leave of absence, supervised or unsupervised access to the community, provision of different level of security level inside or outside a psychiatric facility or providing patients with vocational, interpretation or reha-

¹⁵⁹⁷ See, *Ibid*, para 127.

¹⁵⁹⁸ See, *Ibid*, para 126 & 127.

¹⁵⁹⁹ See, *Ibid*, para 127, 129 & 132.

¹⁶⁰⁰ See, OMHA (1990) as amended, s. 39 & 41.1- 41.14.

bilitative services.”¹⁶⁰¹The CCB is required to make these orders whilst taking into account factors such as ‘public safety, capability and ability of psychiatric hospitals to take and care for patients, mental condition of the patient, re-integration of the patient into the society including other needs of the patient and the implementation of the least restrictive factors on the individuals liberty vis a vis the circumstances requiring the patients involuntary detention’.¹⁶⁰² It is significant to articulate that like in South Africa and the UK, constitutional challenges and review of legislations bring forth impactful changes in legislations which are beneficial for persons with mental disabilities. The afore court case brings a couple of important issues relating to review and use of involuntary detention and treatment such as appeal, use of habeas corpus as analysed below.

4.4.3. 2. Review under Mental Health Legislations

The right to apply for review is a safety measure in the mental health statutes in Ontario. It is governed by the OMHA and OHCCA respectively. It is conducted by the CCB as already discussed above. It can be exercised in form of review by the CCB, appeal by higher court, through the use of habeas corpus and or judicial review of other courts decision and legislative scheme as discussed respectively further below.

¹⁶⁰¹ See, Ibid, s. 41.2. It states that: “(2) The Board is limited to making only one or more of the following orders when it confirms a patient’s certificate of continuation: 1. Transfer the patient to another psychiatric facility, subject to subsections (10), (11) and (12), but only if the patient does not object. 2. Place the patient on a leave of absence for a designated period on the advice of a physician, subject to subsection (13). 3. Direct the officer in charge of the psychiatric facility to provide the patient with a different security level or different privileges within or outside the psychiatric facility. 4. Direct the officer in charge of the psychiatric facility to allow the patient to be provided with supervised or unsupervised access to the community.5. Direct the officer in charge of the psychiatric facility to provide the patient with vocational, interpretation or rehabilitative services. 2015, c. 36, s. 10.”

¹⁶⁰² See, Ibid, 41.3. It states that: “(3) In making an order under this section, the Board shall take into account the following factors: 1. The safety of the public. 2. The ability of the psychiatric facility or facilities to manage and provide care for the patient and others. 3. The mental condition of the patient. 4. The re-integration of the patient into society. 5. The other needs of the patient. 6. Any limitations on the patient’s liberty should be the least restrictive limitations that are commensurate with the circumstances requiring the patient’s involuntary detention. 2015, c. 36, s. 10”.

4.4.3.2.1. Review by CCB

This section does not repeat what has been discoursed but examines the procedural aspects. Therefore as considered above on CCB jurisdiction, the CCB generally accepts review applications from an involuntary patient and CTO patient, his or her representative inquiring whether the fundamentals of the Act have been made.¹⁶⁰³ These fundamentals also include findings of incapacity, decisions of substitute decision maker and evaluators made under the OHCCA.¹⁶⁰⁴ The burden of proving that the statutory requirements in the legislation are met in an involuntary detention hearing is placed on the attending physician who must show ‘cogent and compelling reasons’.¹⁶⁰⁵ Similar imposition is placed in UK, South Africa and Ghana legislation.

The right of review applies every time when a certificate of involuntary admission or continuation of detention certificate and CTO are issued or reissued.¹⁶⁰⁶ For example In *P (Re), 2011* the CCB revoked a CTO issued outside the 72 hour statute required time.¹⁶⁰⁷ The physician in this case failed to fulfil the prerequisite that he had examined the patient within the stated duration before issuing a CTO.¹⁶⁰⁸ The evidence presented before the CCB confirmed that the physician had examined the patient 1.5 hours outside the 72 hour duration prescribed under section 33. 1(4-c) of the OMHA.¹⁶⁰⁹ In a strong response to the physician’s claim that the time difference was of no consequence, the CCB held-

¹⁶⁰³ See, Ibid, s. 39 (1).

¹⁶⁰⁴ See, OHCCA (1996) as amended, s. 32, 60 & 65.

¹⁶⁰⁵ See, AG (Re), (2014), Supra Note 817, p.6. See also, Ibid, s. 20 (5).

¹⁶⁰⁶ See, OMHA (1990) as amended, s.39.

¹⁶⁰⁷ See, This case involves a review of a finding of capacity and reissuance of CTO of “Ms. P, who has been found incapable of consenting to treatment, suffers from chronic paranoid schizophrenia, symptoms of which she began to exhibit in 1996. He was hospitalized many times between 1997 and 2007 but has been subject to five previous CTOs since January of 2008.”

¹⁶⁰⁸ See, P (Re), (2011), Supra Note 828, p.7.

¹⁶⁰⁹ See, Ibid. In p. 5, the facts are presented that “The second contested criterion is the timeline requirement regarding the examination of the applicant. The community treatment plan was entered into at 3:00 p.m. on December 20, 2010, and it so happens that the date and time of the examination of the applicant (required by s.33.1(4)(c) to take place within the 72-hour period before entering into the community treatment plan) was 1:30 p.m. on December 17.”

The *MHA* provides timelines that must be adhered to for various purposes, some being expressed in days and others in hours and the significance of expressing the requirement in hours cannot be overlooked. That the examination must take place “within 72 hours” does not mean “within 3 days”, and it does not mean “within 72 hours more or less” or “within about 72 hours”. Just as the authority under s. 15(5)(b) of the *MHA* to detain a person for psychiatric assessment “for not more than 72 hour” is strictly construed, so too is the time requirement here in question to be strictly construed.¹⁶¹⁰

In addition to the above, when a CTO beneficiary does not apply, “there is an automatic, mandatory review of the CTO by the CCB when it is renewed for the second time and upon every second renewal thereafter; and appeal to the Superior Court of Justice”.¹⁶¹¹ The right to review by the Board extends to incapacity decisions, and all other complaints relating to capacity, consent and treatment under the OHCCA.¹⁶¹² This right is distinctively illustrated by the case of *Fleming V Reid (1991)*, where a violation of the Charter was found because the appellant wishes not to consent to treatment was overridden by the Board according to the law without affording hearing or review of any kind to the appellant or his substitute decision maker as well as the incompatibility of the provision in the MHA to the charter.¹⁶¹³ Fleming and the Ps decisions are comparable in as far as review of legislations and protections are concerned, all of which have borne positive results in terms of legislative changes that ensure proper safeguards for those civilly detained under the mental health legislations in Ontario.

¹⁶¹⁰ See, Ibid, p.7.

¹⁶¹¹ See, Thompson and Empowerment Council v. Ontario, (2013), Supra Note 534, para 100. See also, OMHA (1990) as amended, s.39.1 (3).

¹⁶¹² See, OHCCA (1996) as amended, s.65.

¹⁶¹³ See, Fleming v. Reid,(1991), Supra Note 529, part VIII. The court stated that: “The right to personal security is guaranteed as fundamental in our society. Manifestly, it should not be infringed any more than is clearly necessary. In my view, although the right to be free from non-consensual psychiatric treatment is not an absolute one, the state has not demonstrated any compelling reason for entirely eliminating this right, without any hearing or review, in order to further the best interests of involuntary incompetent patients in contravention of their competent wishes. To completely strip these patients of the freedom to determine for themselves what shall be done with their bodies cannot be considered a minimal impairment of their [Charter](#) right. Safeguards can obviously be formulated to balance their wishes against their needs and ensure that their security of the person will not be infringed any more than is necessary. Recognizing the important objective of state intervention for the benefit of mentally disabled patients, nonetheless, the overriding of a fundamental constitutional right by the means chosen in this Act to attain the objective cannot be justified under [s. 1](#) of the [Charter](#).”

4.4.3.2.2. Judicial Review through Habeas Corpus

Another method of review is the use of Habeas corpus. Comparable to the principle in the UK case of *HL v. UK (2013)*, or common law approach in South Africa, habeas corpus can be used to bring a person detained before a court of law in Ontario to show cause why the detention is justified. In *S. V Her Majesty the Queen (2013)*, the court emphasized that “as a general rule, habeas corpus is available to challenge unlawful deprivations of liberty and operates to protect individuals against wrongful restraints of liberty.”¹⁶¹⁴ The courts in Ontario have the power to award a writ of Habeas Corpus as codified in the Habeas Corpus Act (1990).¹⁶¹⁵

According to the court’s ruling in the successive appeal of the above case in *P.S. V. Ontario (2014)*, it was given that habeas corpus “can also be used to challenge the constitutionality of legislation authorizing detention”.¹⁶¹⁶ In this case the legislation in question was the OMHA as far as involuntary detention of long stay patients was concerned. The Court of Appeal, in holding as such was reacting to the superior courts judge refusal to exercise his jurisdiction to grant habeas corpus to P.S, by claiming that “courts have declined to exercise their habeas corpus jurisdiction in circumstances where there exists a comprehensive scheme providing for broad rights of review and appeal” such as that given in the OMHA and available to the applicant.¹⁶¹⁷ The Court of Appeal thus rejected this proposition by maintaining that the judge erred in rejecting to award habeas corpus as an available remedy to the appellant P.S. since the OMHA was not a comprehensive scheme as the CCB lacked constitutionally adequate code for review for individuals in long stay involun-

¹⁶¹⁴ See, *S. v. Her Majesty the Queen*, (2013), Supra Note 528, para 33.

¹⁶¹⁵ See, Habeas Corpus Act (1990)., R.S.O. 1990, c. H..

¹⁶¹⁶ See, *P.S. v. Ontario*, (2014), Supra Note 1594, para 186.

¹⁶¹⁷ See, *S. v. Her Majesty the Queen*, (2013), Supra Note 528, para 34& 35.

tary detentions.¹⁶¹⁸ One would agree with the Court of Appeal position considering that the right to habeas corpus is ingrained in the constitution. The following examines appeal.

4.4.3.2.3. Judicial review through appeal

The right of review also includes the right to appeal to a higher court of law. This right also is present in the four jurisdictions as stated in their various sections. In Ontario, right of appeal is to the Superior Court of Justice on question of fact and law.¹⁶¹⁹ The right also extends to those under a CTO, and can be exercised every time a CTO is issued or renewed in order to determine whether the criterions of the CTO are met.¹⁶²⁰ The case of P.S. significantly explains the right of an individual to have his or her involuntary admission, certificate of continuation, community treatment orders, including findings of incapacity to consent to treatment to be subjected through further scrutiny via judicial review mechanisms such as appeal.¹⁶²¹ In **L.C. v. Dr. Duff (2013)** it was held that:

A party before the Board has a statutory right of appeal to this court. On appeal, the standard of review for questions of law is correctness, for questions of mixed fact and law, or questions of fact alone, the standard of review is reasonableness. "An unreasonable decision is one that 'is not supported by any reasons that can stand up to a somewhat probing examination'" (*Starson v. Swayze*, 2003 SCC 32, [2003] S.C.J. No. 33 (S.C.C.) at para. 88.) Absent such demonstrated unreasonableness, there is no basis for judicial interference with the findings or inferences of fact made by the Board.¹⁶²²

As it follows, the procedural requirements under the law require that any person in a proceeding under the OMHA or OHCCA may bring an appeal claim on grounds of fact and law¹⁶²³ The

¹⁶¹⁸ See, P.S. v. Ontario, (2014), Supra Note 1594, para 186. The Court of Appeal maintained verbatim: "The application judge declined to exercise his jurisdiction to grant *habeas corpus*. That ruling was grounded in the conclusion that the MHA contains a complete code for the review of decisions made under that statute. I have found that the application judge erred in finding that the review powers of the CCB were constitutionally adequate. *Habeas corpus* is an appropriate remedy to challenge the constitutionality of legislation authorizing detention: see *Charkaoui*, at para. 90; *Steele v. Mountain Institution (Warden)*, [1990] 2 S.C.R. 1385. It follows that the application judge's rejection of *habeas corpus* as an available remedy cannot stand".

¹⁶¹⁹ See, OMHA (1990) as amended, s. 48 (1) & OHCCA (1996) as amended, s. 80 (1).

¹⁶²⁰ See, OMHA (1990) as amended s. 39 & 48.

¹⁶²¹ See, OMHA (1990) as amended, s. 48 & OHCCA (1996) as amended, s. 80.

¹⁶²² See, L.C. v. Dr. Duff, 2013 ONSC 2974, para 9.

¹⁶²³ See, OMHA (1990) as amended, s. 48 & OHCCA (1996) as amended, s. 80.

OMHA does not lay down the procedures but the OHCCA provides that the first procedural step is the lodging of an appeal with the higher court within seven days of receiving the Boards decision and also serving notice of appeal on to the other parties including the Board.¹⁶²⁴ The next step is for the Board to execute upon receiving notice of appeal by providing the parties with the record of proceedings before it including transcript of any oral evidence given before it and immediately file proof of service with the court.¹⁶²⁵ This step is naturally followed by both parties appellants and respondents submitting their factums within 14 days after being served with the record of transcript on part of the appellants and 14 days after for the respondents after being served the appellants factums, with proof of service from both parties filed with the court.¹⁶²⁶ The Court upon receiving the required documents must promptly set a hearing date compatible with its just disposition.¹⁶²⁷ This is different from the other jurisdictions that have thirty day duration to determine the appeal. The court has the discretion to accept late appeal applications through extending time which is advantageous to those who might miss the duration window.¹⁶²⁸ It may also use its discretion to accept new or additional evidence which may prove advantageous to the appellant.¹⁶²⁹

On appeal, the courts have the statutory power of exercising the Boards mandates, substitute decisions of health practitioners, substitute decision maker or any other representative and refer any matter back to the Board, or court (such as in the Ps case) with “directions, for rehearing in whole or in part”.¹⁶³⁰ It might also find provision of law to be unconstitutional or applied erroneously as in the seminal case of P.S which may have the effect of changing the legislation for the better for all. In finding that section of the law unconstitutional, one of the remedies it gave was an order of sev-

¹⁶²⁴ See, OHCCA (1996) as amended, s. 80.2 & 80.3.

¹⁶²⁵ See, Ibid, s. 80. 4.

¹⁶²⁶ See, Ibid, s. 80.5 & 80.6.

¹⁶²⁷ See, Ibid, s. 80. 8.

¹⁶²⁸ See, Ibid, s. 80. 7.

¹⁶²⁹ See, Ibid, s. 80. 9.

¹⁶³⁰ See, Ibid, s. 80.10.

erance of the OMHA provision that permitted indefinite detention of long stay involuntary patients such as P.S., giving six months.¹⁶³¹ It used the remedial powers embedded in section 52 of the Charter to this conclusion, but suspended the order for 12 months so that the Ontario legislator could find appropriate way of responding.¹⁶³² As mentioned earlier, the legislators responded by adding more powers to the tribunal under section 41.2 OMHA.

4.4.3.2.4. Review through reviewing CCB decisions and other Courts decision

Judicial review as shown is not limited to the decision of the CCB but also extends to challenge of the mental health legislative scheme and their constitutionality.¹⁶³³ It is also extended to the review of Superior Courts decisions including legal actions and omissions. To illustrate this point the thesis reuses the *P.S. V Ontario* decision, where the Ontario Court of Appeal found a violation of the appellants section 15(1) of the charter (right to equal recognition before the law) because he was not given enough accommodation in regards to his deafness, “the inadequacy of the level of interpretation services provided to the appellant” which contributed heavily to his long term involuntary stay due to miscommunication.¹⁶³⁴ The Court of Appeal found that application judge erred for not reaching to this conclusion despite the extensive material evidence provided to him by the appellant and available in the CCB transcript. It held:

¹⁶³¹ See, *P.S. v. Ontario*, (2014), *Supra* Note 1594, para 200 & 201. They stated that: “... In such a case, as was explained in *R. v. Morales*, [1992] 3 S.C.R. 711, at pp. 741-742: Severance does not usurp Parliament’s role, but rather is the approach which best fulfils the terms of s. 52(1) of the *Constitution Act, 1982*, which provides that a law which is inconsistent with the Constitution is of no force and effect “to the extent of the inconsistency”. Severance is also least intrusive to the overall statutory scheme.” Hence, “In my view, severance is the appropriate remedy in this case. Section 20(4) prescribes the duration of the initial and subsequent certificates of involuntary admission”.

¹⁶³² See, *Ibid*, para 199. It states that, “Section 52(1) of the *Constitution Act, 1982*, provides that “any law that is inconsistent with the provisions of the Constitution is, to the extent of the inconsistency, of no force or effect.” The phrase “to the extent of the inconsistency” leaves courts with considerable flexibility in crafting the appropriate remedy.” In para 206, the court held: “...In such a situation, temporarily suspending the declaration is appropriate. Accordingly, while I would grant a declaration of invalidity, I would temporarily suspend that declaration for a period of twelve months from the date of these reasons to afford the legislature the opportunity to consider how best to deal with the issue of long-term involuntary committals and the powers of the CCB.”

¹⁶³³ See, *Ibid*, para 186.

¹⁶³⁴ See, *Ibid*, para 138.

While I fully accept that the application judge's factual findings are entitled to deference on appeal, I have concluded that his findings in relation to s. 15(1) are vulnerable to appellate review for two reasons. First, he erred in law with respect to the nature and extent of the application of s. 15(1). Second, he failed to address or explain a significant volume of evidence indicating that the failure to provide the appellant with adequate interpretation services was more prevalent than the specific occasions he listed. As a result of these errors, it is my respectful view that he mischaracterized the extent and nature of the violations of the appellant's s. 15(1) rights.¹⁶³⁵

The courts holding above brings into light the fact that in the provision of mental health care and services, care must be provided in a non-discriminatory manner and in a way that the patient concerned may be able to understand. As such, this pins on the right to information and the way the information is accessed and as seen in the international framework and the other jurisdictions, as a right that must be effectively observed. In the instant case, the court upheld this right by affirming the principle the laid out in **Eldridge v. British Columbia (Attorney General) [1997]**, that non-discriminatory health care practices require the “regular provision of communication through deaf appropriate services”,¹⁶³⁶ which in this case was not met by lack of using expert interpreters, the use of written communication and gestures that were not sufficiently accommodative and a lack of a English proficiency test to determine the appellants English reading comprehension.¹⁶³⁷ Hence a violation of P.S. section 7 and 15 rights respectively. These are those omissions that are offensively arbitrary in nature and could easily be avoided. Instead they are perpetuated leading to poor quality of mental health care and arbitrary detention and treatment.

¹⁶³⁵ See, *Ibid*, para 138

¹⁶³⁶ See, *Ibid*, Para 134 where the court held: “Deafness is a physical disability that triggers the protection of s. 15(1): *Eldridge v. British Columbia (Attorney General)*, [1997] 3 S.C.R. 624, at para. 55. The guarantee of equal protection and equal benefit of the law gives a deaf person, such as the appellant, the right to adequate interpretation services in order to access governmental services. In *Eldridge*, the Supreme Court held, at para. 78, that “discrimination can accrue from a failure to take positive steps to ensure that disadvantaged groups benefit equally from services offered to the general public.” The court also held, at para. 77, that to fulfil its s. 15(1) obligation to ensure equal benefit of the law, an entity acting in a governmental role “will be required to take special measures to ensure that disadvantaged groups are able to benefit equally from government services.”

¹⁶³⁷ See, *Ibid*, para 157-178.

4.4.3.2.5. Other Avenues for Review

Finally and in addition to the full right of appeal to Superior courts and other high courts, it's been reiterated in a number of judicial decisions that there are other means that a complainant patient can rely upon to make a complaint such as the "right to apply to the Ontario Human Rights Tribunal or to make a complaint to the Royal College of Physicians and Surgeons".¹⁶³⁸ The complaint could provide a way of reviewing the civil commitment and an ensuing discharge where applicable.

The above was a substantial analysis on how review and in some instances discharge is enforced. The following section connects properly how discharge is made in Ontario as a procedural and substantive right.

4.4.3.3. Discharge

Discharge in Ontario is no different from the other areas of research. Thus, a patient under the Ontario legislations has the right to be discharged if that individual does not meet the required assessment or admission criteria, if necessary checks are not conducted and when duration for involuntary admission, treatment or CTO terminates. Termination can be done through withdrawal of consent and rescinding of involuntary certificates of admission or revoking of CTO due to a failure to meet statutory criteria for both involuntary and CTO processes.¹⁶³⁹ Discharge or release can be effected by officer in charge or /and by the CCB after review of an individual's detention in a psychi-

¹⁶³⁸ See, *S. v. Her Majesty the Queen*, (2013), Supra Note 528, para 37.

¹⁶³⁹ See, *S.E.* (2010), Supra Note 842. The Board maintained that—"The *MHA* states that a panel, charged with hearing the issues relating to involuntary detention, "may confirm the patient's status as an involuntary patient if the Board determines that the prerequisites set out in this *Act* for admission as an involuntary patient were met at the time of the hearing" ([s.41\(2\) MHA](#), emphasis added). If a panel determines that the prerequisites for involuntary status are not met, it "shall rescind the certificate" ([s.41\(3\) MHA](#), emphasis added). The permissive wording in [s.41\(2\)](#), particularly in contrast to the language in [s.41\(3\)](#), has led some panels to hold that there is discretion to refuse to confirm a certificate in certain circumstances, particularly where there are findings that actions by the hospital have the effect of depriving the applicant of legal rights. Typically, panels have only exercised the discretion where there has been "egregious" conduct on the part of the attending physician or the treatment team."

atric facility or CTO placement if they do not comply with the legal stipulations including the fact that the patient is ‘no longer in need of the observation, care and treatment provided in’.¹⁶⁴⁰ The case of *P (Re) (2011)* illustrates that reviews are crucial in ensuring that an individual is not detained arbitrarily and can exercise the right to be discharged either from a CTO or involuntary detention where statutory stipulations are not met.¹⁶⁴¹ It is important to note that alike the UK, South Africa or Ghana, discharge of a mental health patient in Ontario is not immediate as a discharge plan must be effected depending with each case.

Nevertheless, discharge of those involuntarily committed in Ontario is statistically reported to be “consistent with what appears to be a dominant theme of modern mental health policy –minimizing hospitalization and maximizing rapid return to community living”.¹⁶⁴² The numbers, indicate that “34%of patients involuntarily committed under the MHA were in hospital for less than a week, 80% for less than a month and 98% for less than six months”.¹⁶⁴³ These are good numbers and as it held, is attributed to the protective provisions in the OMHA “tailored to deal with urgent situations where an individual requires immediate treatment to avoid harm to him or herself or harm to others [and] certifications typically have a short life, [which] form a statutory pattern that indicates an expectation that the risk of harm can ordinarily be resolved by treatment and that the patient can typically be returned to the community within days or weeks”.¹⁶⁴⁴ These numbers, predisposes one to make the argument that where respect of law is made and in conjunction with proper provision of mental health care and services, there is respect of individuals rights which minimizes the occur-

¹⁶⁴⁰ See, OMHA (1990) as amended, s. 20 (3, &8), s.33.2(1&2), s. 33.4(1) & s.34.1

¹⁶⁴¹ See, Ibid, s. 33.2-33.4 & 39.1(6&7).

¹⁶⁴² See, P.S. v. Ontario, (2014), Supra Note 1594, para 195.

¹⁶⁴³ See, Ibid, para 194.

¹⁶⁴⁴ See, Ibid, para 195. It is explained: “The short periods of certification – 72 hours for the first certification, two weeks for the second, an additional one month for the third and then an additional three months for each successive certification”.

rence of abuse and arbitrariness. It also gives concerned individuals their liberty to live within the community and the confidence to access mental healthcare as it should be.

4.4.3.4. Sum Up.

The Ontario approach to review, discharge and civil commitment as seen, is not very dissimilar from the other research jurisdiction as regards requirements of review and detention. Review is conducted by CCB and other courts in the hierarchy which is similar to the rest of the jurisdictions. The right to judicial review mechanisms such as habeas corpus, appeals and judicial review of decisions of the CCB other courts including legislative scheme is exercisable as is in the UK and South Africa. It is correspondingly exercisable through automatic sending of application to the CCB, application by substitute decision makers and representatives. The differences reside in the no-treatment before without consent which does not come up in review unless that is the challenge, and duration of making review applications and their determination. The other was the function of the CCB which was limited to determining whether the criteria's of civil commitment have been met. However after the ruling in P.S. case, the OMHA was revised to give the CCB powers to review detention and any issue relating to therapeutic concerns of those long time involuntary detainees such as PS, since the OMHA lacked enough protections such as access to review.

Finally, as it emerges in the Ontario jurisprudence, is that the right to review is a fundamental substantial and procedural protection to those subjected to short or long term involuntary detention including those under community treatment orders. Thus the disrespect of it, fails to meet the constitutional guiding principles and parity. It also continues to indicate that the use of civil commitment is constitutionally acceptable, it is for short duration, not for all individuals with mental disa-

bility and that the use of community mental health care services must work hand in hand to ensure proper delivery of mental health to those in Ontario.

4.4.4. Ghana's Approach

4.4.4.1. Review & Discharge in the Basic Document

Comparable to the other three jurisdictions, the right to review and discharge also begins from the basic document of the land, the constitution. In chapter two, it was introduced that the right to liberty as provided in the constitution is a fundamental human right but as it stands it is not absolute and is subject to acceptable limitation such as for the purpose of providing mental health care to those in need and satisfy the criteria established by the mental health Act.¹⁶⁴⁵ What was not presented in the introduction, but nevertheless discussed as part of the substantive and procedural safeguard in the GMHA, is the right to review and discharge of those compulsorily deprived of their liberty for the sole purpose of receiving mental health treatment and care.

Accordingly, it is presupposed that by accepting a limitation of such an important right in the constitution, there is also a guarantee that there are substantive and procedural safeguards to ensure that the limitation is not abused and that those subjected to such measures are effectively protected. Hence, in the same constitutional article that permits the restriction, it correspondingly guarantees that for “a person who is arrested, restricted or detained shall be informed immediately; in a language that he understands, of the reasons for his arrest, restriction or detention and of his right to a lawyer of his choice.”¹⁶⁴⁶ It also provides that “a person who is unlawfully arrested, restricted or detained by any other person shall be entitled to compensation from that order person.”¹⁶⁴⁷ This

¹⁶⁴⁵ See, The constitution of the Republic of Ghana (1992), Article 14 (1-e).

¹⁶⁴⁶ See, Ibid, Article 14 (2).

¹⁶⁴⁷ See, Ibid, Article 14 (5).

means therefore that the individual has the right to bring a challenge, contending the lawfulness of the restriction. These guarantees in the constitution have already been discussed in the previous chapter, as they have been similarly set out by the Mental Health Act. In essence, persons subjected to compulsory treatment and care get to exercise these constitutional protections directly from the specific mental health statute.

Nevertheless, besides these guarantees one other imperative issue article the Ghanaian constitution akin to the Canadian sets out for everyone, whose right to liberty has been restricted, is the right of review through an application of a writ of habeas corpus. The constitution protects the fundamental human rights and freedoms set therein by empowering those aggrieved or whose rights and freedoms have been contravened, and ‘without prejudice to any other action that is lawfully available’, to apply to the High Court for redress.¹⁶⁴⁸ The constitution does not stop there but proceeds to direct what type of relief that may be given by the High Court when dealing with fundamental rights and freedoms, by empowering it to “issue such directions or orders or writs including writs or orders in the nature of habeas corpus, certiorari, mandamus, prohibition and quo warranto as it may consider appropriate for the purposes of enforcing or securing the enforcement of any the fundamental human rights and freedoms to the protection of which the person concerned is entitled.”¹⁶⁴⁹

These types of review applications and relief are very relevant to persons with mental disability subjected to detention for compulsory treatment and care. It may happen that an individual has been wrongly or unlawfully detained or seeks to challenge a decision to detain for treatment as it goes with the involuntary treatment decisions under the GMHA, thus in those circumstances the individual or personal representative may rely on this relief to seek a review of the case, locate and pro-

¹⁶⁴⁸ See, Ibid, Article 33(1).

¹⁶⁴⁹ See, Ibid, Article 33 (2).

duce the detained individual, or get prohibitory or and injunctive relief against future detentions. These processes help to review the orders of detention made for involuntary treatment.

Finally, the constitution guarantees that if the individual or personal representative is aggrieved by the decision of the High Court, then he or she has the right to proceed to seek further relief in the Court of Appeal and lastly the Supreme Court through an appeal process.¹⁶⁵⁰ Hence, the individual has the right to exercise his right to appeal. All this guarantees are appropriate as it appears in law. The interesting question to ask however is whether thus far they have been utilized and have been effective to persons detained?

The following looks at review and discharge as provided under the GMHA.

4.4.4.2. Review & Discharge under the GMHA

As presented in the section above, it is presumably clear what the constitution requires of those implementing the law and holders of rights. This also includes the way the legislature makes the law. All the laws according to the constitution must be compatible with it lest it falls short of being unconstitutional. In this regard, the law that regulates the detention and treatment of those detained under section 14 (right to liberty) for the sole purpose of mental health treatment is the current GMHA. This Act has not been rendered unconstitutional. It actually extends the constitution exception under section 14 by guaranteeing effective access to mental health treatment and care via voluntary and involuntary types of treatment. It also ensures that the user's rights are protected through various substantive and procedural guarantees that are more extended than those offered in the constitution. In the preceding chapters different sets of safeguards were highlighted including the requirements of those in authority to provide treatment and care. It also involves the responsibility of

¹⁶⁵⁰ See, Ibid, Article 33(3).

ensuring proper compulsory treatment through investigations, review and discharge by the Tribunal or court.

Accordingly, one of those requirements and also as a right for those subjected to the Act is the duty to review and have review done of their detention. In the GMHA, the organ responsible for reviewing voluntary and involuntary treatment is the Mental Health Review Tribunal (Review Tribunal) analogous to UK, South Africa and Ontario.¹⁶⁵¹ According to the Act the Review Tribunal has the power and the responsibility of (a) receiving, hearing and investigating any complaints of persons subjected to the Act, (b) reviewing and monitoring cases of involuntary admissions and treatments process and long term stay voluntary admissions and (c) the authority to approve requests for intrusive or irreversible treatments.¹⁶⁵²

In conducting its business, the Act like its counterparts, empowers the Review Tribunal to determine its own procedures, compels it to consult with the respective mental health and other experts when exercising its duties and provide guidance on minimizing intrusive and irreversible treatments, seclusion or restraint. It also has a compulsory duty to keep record of all its functions. This is crucial particular when further review of its functions or decisions are required.¹⁶⁵³ Hence, there are two things for reviewing in the Act. That is the detention and the treatment plan. The discourse starts with the latter because it intrinsically forms the basis for the first.

4.4.4.2.1. Review of Treatment Plan

In the other jurisdictions this type of review distinction was not specifically made as in the Ghanaian statute. This is because it is not specifically provided but according to the powers bestowed to

¹⁶⁵¹ See, GMHA (2002), s. 24.

¹⁶⁵² See, Ibid, s. 26 (1-3).

¹⁶⁵³ See, Ibid, s. 26 (4-6).

the reviewing organs, it can be inferred that it is included when for example Ontario determines all therapeutic matters relating to care or the UK requiring that all criteria have been met including availability of appropriate care. It can also be likened when looking at the duration in which the various legislations have set out on how long a person can be detained. Accordingly, the GMHA conditions that review is not limited to the basis of the detention, but involves extending it to reviewing of the treatment plan.¹⁶⁵⁴ Hence, for a “treatment plan for a patient on involuntary admission, it shall be for one month after which it shall be reviewed.”¹⁶⁵⁵ This review time varies in instances where there is a prolonged treatment order.¹⁶⁵⁶

As it is, the legislation anticipates that for some patients, a month may not be time enough for treatment and recovery and therefore a treatment may extend beyond a month. In this case it sets out that the time frame of such ‘a prolonged treatment order shall not exceed twelve months’ and within these twelve months a review shall be conducted at six months by the Tribunal [compare this to the 28 days, 3,6and 12 months permissible detention and renewal durations in the UK, Ontario and South Africa].¹⁶⁵⁷ Notice here that it is possible to prolong the detention for treatment and this may pose a risk of arbitrary detention and abuse.

However, there are embedded safeguards in the GMHA akin its counterparts that optimistically may counter the risks. These protections include that any request or recommendation for treatment prolongation be made as an application to the tribunal which has the power to determine any extension after hearing all the relevant information, and determining that prolongation of the treatment in a psychiatric hospital or place of treatment meets the criteria of an involuntary patient including

¹⁶⁵⁴ See, *Ibid*, s. 45 (3).

¹⁶⁵⁵ See, *Ibid*, s. 43 (5).

¹⁶⁵⁶ See, *Ibid*, s. 47 (1).

¹⁶⁵⁷ See, *Ibid*, s. 47 (1&2).

that the treatment is the ‘least restrictive treatment available’.¹⁶⁵⁸ The application must be substantiated with reasons for the recommendation, which can be made by the psychiatrist or head of facility concerned if he or she is of the ‘opinion that the severity of the condition warrants it’.¹⁶⁵⁹ In addition to these, the concerned patient and the respective representative or both have the right to be present before the tribunal to be heard and the right to appeal against a prolongation order.¹⁶⁶⁰

4.4.4.2.2. Review by Court

The above is about a treatment plan and its review. The other review mentioned is the review of the detention made through the temporary treatment order by the court.¹⁶⁶¹ It should be made clear from the onset that this order is connected with the treatment plan mentioned above because on balance the reason for the order is treatment itself. In this regard, once the one month duration expires, the law requires that the individual be discharged unless in the review of the treatment plan, there is substantial evidence calling for a prolongation of the treatment.¹⁶⁶² The burden is placed on the one calling for an extension and if there are reasonable grounds then the Review Tribunal can make an extension which is subject to review every six months. Besides this function of making an extension order, the Review Tribunal has the powers of review at any time, including its own orders of the detention of an individual under the GMHA by itself or through an application.¹⁶⁶³ Thus, it need not wait for six months to carry a review. The concerned individual or representative equally, need not wait for lapse of a month or six months to seek a review of the compulsory detention for treatment because they have the right to seek a review from the Review Tribunal including the

¹⁶⁵⁸ See, *Ibid*, s. 46 (1, 5, 6 & 7).

¹⁶⁵⁹ See, *Ibid*, 46 (1 & 5).

¹⁶⁶⁰ See, *Ibid*, s. 46 (3).

¹⁶⁶¹ See, *Ibid*, s. 42.

¹⁶⁶² See, *Ibid*, s. 42, 46 & 53.

¹⁶⁶³ See, *Ibid*, s. 26, 31 & 32.

right to appeal against any decision made.¹⁶⁶⁴ This brings the discussion to review through appeal below.

4.4.4.2.3. Review through Appeal

As already stated, the patient or the respective representatives have the right to make an appeal against an admission decision or prolongation of treatment order to the Review Tribunal.¹⁶⁶⁵ For an effective appeal process, they have the statutory rights of seeking counsel representation, independent medical opinion and access to their medical information.¹⁶⁶⁶ In the appeal, they have the right to seek a discharge or revocation of treatment order.¹⁶⁶⁷ The Review Tribunal has twenty one days to respond to the application and unless it is for a new admission then it must respond within three days.¹⁶⁶⁸

Hence, review has to be followed by effective discharge when appropriate, depending with the circumstance of each individual case. For individual's receiving voluntary treatment, it is not a difficult question because they can opt to discharge themselves but those under compulsory treatment it becomes a little bit trickier and with this the risk of long unwarranted detention which resultantly become a violation of their right. For this reason is the importance of having constant review of the individual's compulsory care to ascertain that detentions are executed according to orders, are not extended without proper substantiation and authorization and that they come to an end through discharge of the individual

¹⁶⁶⁴ See, Ibid, s. 32 &44.

¹⁶⁶⁵ See, Ibid, s. 44 (1 &2) & 46 (3).

¹⁶⁶⁶ See, Ibid, s.44 (3,4&5).

¹⁶⁶⁷ See, Ibid, s. 32 (4).

¹⁶⁶⁸ See, Ibid, s. 32 (4).

4.4.4.3. Discharge by the Tribunal

In this regard, when the criteria for admission for treatment cease to apply then discharge has to be effected. The Ghanaian Act stipulates that upon the expiry of the specified period by a court or this Act the involuntary patient shall be discharged. The court mandated time as given in the Act is one month while the other as stipulated by the GMHA refers to temporary detentions when a patient is admitted under emergency situations.¹⁶⁶⁹ In emergency situations, a patient has to be discharged before seventy two hours by the psychiatrist or head of the facility.¹⁶⁷⁰ A court order has to be obtained within this specified duration and if not, then the person has to be discharged.¹⁶⁷¹ However, a patient has the option of choosing voluntary care over discharge when the time expires.¹⁶⁷² Discharge of a person detained in the GMHA for compulsory care as stated must be effected at the end of the scheduled time by a court order or as given in the Act.¹⁶⁷³ The relevant psychiatrist or head of facility has the duty to effect the release.¹⁶⁷⁴ Release may also be executed earlier than the stipulated time by a court or in the Act “where the psychiatrist or head of a facility is satisfied that the involuntary patient warrants earlier discharge, the involuntary patient shall be discharged and information given to the court or Tribunal accordingly.”¹⁶⁷⁵ Similarly, a patient on involuntary treatment and is facing trial when fully treated and ready to be discharged to continue with the trial, the psychiatrist or head of health establishment must report to the nearest police authority for him to be fetched within thirty days of the report of wellbeing. If the person is not fetched within the thirty days, the head of facility must report the issue to the Tribunal which has the authority to discharge him. Hence, the individual does not continue to be detained.

¹⁶⁶⁹ See, *Ibid*, s. 43 (3). It states that; “(3) Where the court is satisfied that that person is suffering from severe mental disorder and meets the requirements of section 42, the court may order placement of that person under care, observation or treatment in a psychiatric hospital for a period not exceeding one month as determined by the court.”

¹⁶⁷⁰ See, *Ibid*, s. 49 (2).

¹⁶⁷¹ See, *Ibid*, s. 49 (3).

¹⁶⁷² See, *Ibid*, s. 49 (2&3).

¹⁶⁷³ See, *Ibid*, s. 53 (1).

¹⁶⁷⁴ See, *Ibid*, s. 53 (1).

¹⁶⁷⁵ See, *Ibid*, s. 53 (2).

The Review Tribunal plays an important part in the discharge process as it does in the review process. First of all, upon any detention or admissions of an individual for involuntary care or emergency care, it must be informed by the psychiatrist or head of facility. From above, it should also be given information of any early releases done by the psychiatrist.¹⁶⁷⁶ In addition to this duty of receiving information, it has the power to “direct the discharge of a person detained under this Act despite a previous order of a court or Tribunal except in the case of a serious offence and may make the recommendations that it considers necessary to the head of the facility.”¹⁶⁷⁷ Remember that the direction to discharge is pegged upon the satisfaction that the grounds upon which the detention was based no longer exist.¹⁶⁷⁸

4.4.4.4. Sum Up.

The Ghanaian experience is likened to the other jurisdictions. However, in practice, persons receiving mental health care in Ghana’s health institutions or spiritual and traditional centres of healing are not exercising this right due to its inaccessibility associated with infrastructure and lack of knowledge. The recent GMHA needs to be implemented to ensure that civil commitment is not arbitrary, including regulating these unorthodox mental health centres making them accountable.

4.5. Conclusion

This chapter was intended to illustrate the importance of the substantive and procedural right of review and discharge in civil commitment. It was also meant to indicate that the use of civil com-

¹⁶⁷⁶ See, *Ibid*, s. 53.

¹⁶⁷⁷ See, *Ibid*, s. 30 (1).

¹⁶⁷⁸ See, *Ibid*, s. 30. It states that: “(2) The Tribunal shall direct the discharge of a patient where it is satisfied (a) that the patient is no longer suffering from mental disorder, or (b) that it is not necessary in the interest of the health or safety of the patient or for the protection of other persons that the patient should continue to be detained, or (c) that the patient if released is not likely to act in a manner dangerous to the patient or to others, and (d) that admission is no longer the least restrictive form of treatment for the patient.”

mitment by many jurisdictions is not without proper legislative framework to guarantee the protection of those subjected therein. As discoursed in the international and regional human rights framework, the right to review which is considered an international norm applies to all forms of detention including compulsory detention for the purpose of providing mental health treatment and care. The right even though it is a self-standing right, it was shown that it co-functions with other rights such as the right to information, right to a counsel or representative, right to a hearing before an impartial and independent judicial body, the right to a speedy and prompt determination of the matter and the right to a decision that may include orders of discharge and the right to compensation where there was harm done.

All these findings in the international human framework can be seen to be in or have been transposed into the legal frameworks in many domestic jurisdictions including those being researched. However, when it comes to specific procedures for civil commitment, the domestic jurisdictions legal frameworks compare to those provided by the MI Principles. The MI Principles in addition to what the international human rights document require, directs more on assessments before detention, prompt reviews during admissions and thereafter, short term detention durations and discharge, use of alternatives such as community treatment rather than hospitalization or institutionalization where not necessary, it guides on safe appropriate environment and informed staff, the rights of relatives and representatives patients and review of mental health facilities. It can thus be argued that with the current continued trend of using involuntary detention and treatment including community treatment orders in many jurisdictions, the MI Principles provides more guidelines than those offered by the CRPD article 14 or the Guidelines on article 14 that basically outlaw civil commitment. Since, there is the trend of civil commitment and abuse in institutions, community facilities and at home, the core issue that should or ought to be addressed is how to protect rights. As proposed by this thesis, one way is through a guaranteeing in practice the enforcement of proper

legal framework. A framework that also incorporates in totality the right to review and discharge of those compulsorily detained. This additionally includes effective access to various mechanisms of review and judicial structures. This is what the CRPD Committee, activists and scholars ought to reconsider to position within article 14, the right to liberty.

At least from the research jurisdictions even with differences in certain provisions as exemplified by the legislations and court jurisprudence, review of detention is a constitutional right and must include the right to a subsequent discharge where appropriate. Other important protective aspects coming across include:

- (a) Automatic referral of cases of admission for review
- (b) The right of the patient and respective representatives to seek review and discharge. This means they have the right to access and use various review mechanisms such as appeals, habeas corpus and judicial review (of legislation, administrative decisions and actions)
- (c) The right to review every time a prolongation of treatment is sought or enforced
- (d) Discharge can be enforced by the individual, or a representative, substitute decision maker or nearest relative, medical practitioner and the Tribunals.
- (e) Discharge must be enforced when treatment is no longer necessary to be given in a hospital or institution and when it is generally not necessary
- (f) The burden of proving continued detention lies with the medical practitioner.
- (g) The right to review, is a duty also on the responsible State institution to review the conditions of detention.
- (h) The right to review as mentioned works together with other rights such as the right to information, to counsel, to fair hearing, to speedy and prompt determination, to orders of release, order and right of compensation here there has been arbitrary deprivation of liberty including harm.
- (i) Presence of reviewing independent institutions near mental health facilities (at least UK, partly South Africa and Ontario mental health tribunals).

Finally, it is important to highlight that the time for review or making an application for review is very important because early applications lead to early reviews that prevent subsequent or continued arbitrary detentions. From the jurisdictions, the time for making reviews do not differ substantially as the first review are typically within a 14 to 30 day duration, putting in mind that there is

the assessment period of 72 hours and discharge thereof if treatment is not necessary and can be considered reasonable. The key issue is the subsequent detention and review which varies from three months to six months then a year. Borrowing from the Ontario jurisprudence, six months should be the longest term for detention with constant review, the rest of the jurisdictions could follow. Off course to avoid arbitrariness in detention access to review and conducting of review depends with the enforcement of the law and by the availability of proper judicial infrastructure. This differs greatly from one jurisdiction to the other, with the UK having its Tribunals near hospitals and South Africa, though not all provinces and Ghana none which is dire for those being detained in spiritual and traditional mental health centres and mental health hospitals and facilities.

CHAPTER 5: CONCLUSION: IMPERATIVENESS OF RETHINKING

5.1. Lessons Learnt

Presently, civil commitment is not an easy topic to approach. It has become a daunting endeavour to support its practice as well as a difficult process to implement successfully without undermining certain human rights. Honourable Justice Edward Belobaba, from the Ontario jurisdiction in the case of *Thompson and Empowerment V Ontario (2013)*, perfectly expresses these challenges connected with involuntary commitment by articulating that “involuntary civil commitment and forced psychiatric treatment will always be enormously difficult issues for modern governments [For] Incarcerating people who have committed no crime and forcing them to take medication that may have devastating side-effects tests the legitimacy of coercive psychiatry, the justifiable limits of State intervention and the meaning of individual freedom.”¹⁶⁷⁹ The reluctance of States to do away with civil commitment as aforementioned in chapter one is engrained in their public policies that impose the duty to protect and the duty to provide. In context, the duty to provide access to mental and physical health services is sanctioned by public health policies and in this manner it justifies States intervention through various measures in the prevention and treatment of illness. This is not uncommon when viewed from quarantine practices of infectious diseases or prevention of harm. The duty to protect from self-harm and others is also embedded in the same public policies. States interventions can also be viewed from a human rights perspective. This infers to their obligation of promoting and implementing positive rights, responsibilities set out in international conventions, domestic constitutions and subsidiary legislation. When understood from this perspective it shows just cause for States intervention through civil commitment in order to restore mental health which is generally important for an individual’s health, wellbeing and general social participation in the community.

¹⁶⁷⁹See, *Thompson and Empowerment Council v. Ontario*, 2013 ONSC 5392, para 129.

Even then, while as mentioned States intervention to promote mental health wellbeing may somehow provide a justifiable rationale for the use of civil commitment, it does not. The passing of the CRPD and the strong advocacy taking place to address the challenges articulated by Justice Edward above and many others inclusively makes it exceedingly daunting to substantiate the use of civil commitment. Why, because among the advocacy strategies being used to realize the shifts required by the CRPD include the calls to State Parties to eradicate legislative measures that sanctions its application, the continuing deinstitutionalization campaigns and the promotion of community centered mental health or psychiatric care and services as replacement. However, despite all these and as illustrated throughout the thesis is that post-CRPD, civil commitment continues to be strongly exercised as evidenced by State practice through their domestic policies, legislations and regulations. Moreover, its application is conspicuously reinforced by judicial decisions that reflect the constitutionality of the process and individuals choice of the process. Most importantly is the fact that the judicial decisions emphasis on the use of substantive and procedural guarantees to make certain that abuse and arbitrary detentions are impeded during the process.

This analysis is timely when there is need to evaluate the position of civil commitment within the CRPD jurisprudence taking into account the contra perspective. It is an expectation that this thesis through the comparative analysis and highlights of substantive and procedural standards found within this four jurisdiction with the purposive intent that they be used to curb abuse and arbitrariness, attempts to establish a balance in this impasse by joining the conversation of making mental health law reforms that uphold the rights of persons with disabilities subjected to coercive measures. The thesis acknowledges the use of civil commitment as long as it is within a well-defined protective legal framework coupled with other aspects that are presented later on. It equally supports the shift the CRPD has brought requiring a holistic look into the rights and protections of persons with disabilities and it continues to uphold these momentum particularly strengthening the

respect of personal autonomy without the intent of undermining it. As argued in this thesis, individuals with mental health concerns are different, some may need medication and some may not. Some may opt for voluntary mental health services while some may opt for compulsory mental health services for example through the use of prior made wishes or may be subjected nevertheless through parental authorization ,court orders etc. The preference for civil commitment must be addressed and at the very least this diversity must be correctly acknowledged. Civil commitment is not for all and it should not be imposed to all. This is why its application should be recognized in a protective and effective regulatory framework with substantive and procedural grounds. In the same way, it is important to ensure that our governments, care providers, family members and other supporters respect individual rights of those subjected to coercive powers. To be involuntarily committed should not mean that an individual has lost all human rights or has ceased to be a human being deserving respect and humane care. Civil commitment in institutions should not be taken as a dumping site for persons with mental illness, but a recovering area that consist of all that is needed for the purpose. Individuals and families must be encouraged through various advocacy measures to access care through inpatient and within their communities.

Therefore, in chapter one civil commitment was placed under the right to liberty and security of persons and other interconnected rights such as the right to health and equal representation before the law It was also discussed in light of the current position of its use as represented in the CRPD and the interpretation by the CRPD Committee in its guidelines on Article 14 on the right to liberty, General Comments and Concluding Observations. A discussion on reasons for and against civil commitment as represented by various social actors such as scholars, activists and States were highlighted and the consequent result indicated a divergence in their reasons. Those with contra positions such as the CRPD Committee represented a more libertarian approach while those in support took a more *parens patirie* approach, the duty to protect life and to assist for positive health

and social outcomes. However, despite the polarity in opinions the imperativeness of combating abuse and arbitrariness through guaranteeing standards when accessing mental health services was emphasized. Therefore, since addressing this concern is the main objective of the thesis, the chapter, presented an analysis of how civil commitment is juxtaposed within the right to liberty and other interconnecting rights such as the right to health, freedom from torture etc. From the jurisprudence of the international and regional human rights systems, it was found that the right to liberty is not absolute and civil commitment is considered one exception under that right. It is an exception that has to be guaranteed by a set of standards that equally ensures that those subjected to it are not abused or arbitrarily detained. This analysis also presented a similar approach to the MI Principles instrument that can be seen to be followed by various member States but an absolute separation from the CRPD position which completely rules out compulsory interventions and treatment. This first chapter even though it did not extensively address the historical aspects of civil commitment, it provided a theoretical perspective on the current understanding of civil commitment within international and national human rights debate. This incursion was necessary as it provided and provides the basis of how national mental health legislation have been and are made as regards civil commitment. For instance, the general permissibility of civil commitment, the criteria and special safeguards within the national legislations. The chapter provided those standards that were presented as important to guarantee respect of rights, prevention of and punishment of abuse and arbitrariness.

Having established a foundation, **chapter two** continued to pursue a justification of the present research by comparatively examining different mechanisms and approaches being used in the four research jurisdictions. Two things were accomplished here- the introduction of key legislation and the analysis of the initial process of civil commitment titled ‘Civil Commitment: Admissions and Treatments’. Hence, in the introduction of the key legislative frameworks which involved a comparative outlook, it emerged that domestic legislation of England and Ontario provide more stand-

ards and options covering majority of areas including guiding texts on the meaning of their legislations and how to implement them than those of South Africa and Ghana. South Africa legislation emerged to have more safeguards for example in matters of capacity and civil commitment than the Ghanaian. The Ghanaian also had peculiar provisions that do not appear in the counterpart jurisdictions such as the requirement to provide proper care in hygienic environment and use of traditional and spiritual centers of healing. This provision can be termed as progressive for the Ghanaians in view of the fact that it is or may be a reaction to the existing poor and unhygienic conditions and a realization of abuse in the mental health facilities. Moreover it may be reasoned that the proviso interpretatively calls upon the State to effectively invest in mental health services and the general infrastructure. Thus, it can be supposed that the absence in other jurisdiction is due to their continuous investment in the provision of services or is articulated in a different law. Be it as it may, this provision is significant in that it makes it straightforward to hold the State and private institutions accountable for providing proper mental health services. It equally presents an avenue for monitoring and review of institutions. Back to the findings, these legislations were correspondingly equated to the CRPD and other international documents such as the MI Principles. The findings indicated that in terms of the CRPD prohibitory standpoint, the four domestic legislations in providing a legal framework for the use of civil commitment, do not meet its standards. However, these legal frameworks not only satisfied those provided by the MI Principles but in the most part are paralleled. Furthermore they satisfied some of the Regional Human Rights systems standards such as those set by the European Court of Human Rights in view of its extensive jurisprudence on civil commitment under article 5 (1-e).

On the second part of the analysis concerning ‘admission and treatment process’, it came out clear that there were many similarities and minor differences in criteria and standards. On similarities for example, it is required that before compulsory measures are imposed, assessments to ascertain that

an individual fulfils the set out qualifying criteria's are accomplished. This is to ensure that compulsory measures are not automatic, that there are compelling reasons for admission and that other alternatives do not suffice. In this sense civil commitment is viewed and used as a last resort when nothing else is adequate. This supposedly means that outpatient mental health services and community treatment orders are given priority. Application for civil commitment across the jurisdictions are homogenous and can be made by the individual, the family, relatives, representatives, substitute decision maker, social worker and the hospital. However, some distinctness appear for example Ontario that presents a hierarchal list that must be followed while in England, South Africa and Ghana, there is a list though not hierarchical. In addition, in England an individual can contest decisions made by his or her representative. On similarities, key standards that repeatedly appeared included the requirement that information must be given from the moment assessments begin to the individual and representatives; that once the application satisfies the admission criteria it must be reviewed by the Boards or Tribunals and discharge must be made where admissions and treatments are not necessary. On treatments, across the jurisdictions certain types such as electroconvulsive therapy are prohibited without individual consent, that of their representative or the court.

Differences in criteria and procedures were equally found. For example in England in addition to the already mentioned criteria, there must be availability of treatment, in South Africa, Ontario and Ghana the element of an individual not being able to make informed decisions for care or is unwilling are included in the criteria. Also unlike the other three jurisdictions whereby treatment can be given without consent, in Ontario admissions do not go hand in hand with compulsory treatment because consent must be obtained before treatment and where the individual is unable to consent there are procedures to follow. In terms of supporting medical evidence, South Africa's legislation was the only one requiring two reports from two different mental health practitioners and if both differ/ed then a third practitioner must be consulted to examine the user concerned. Other differ-

ences emerged in requirements such as the holding times in assessments, admissions and discharge durations that ranged from 72 hours to twenty eight days and detentions renewable time up to three months, six months to a year. Materially, this chapter utilized judicial decisions specifically those found in the UK, Ontario and South Africa which revealed three things. First, that courts of law are very active in ensuring that standards set in the law are observed and therefore are ready to provide judgements that ensure that individuals rights are protected, where harm is found they order a compensation to the victim and where appropriate through decree initiate legislative or correct legislation. The second aspect is that from the apex courts jurisprudence, civil commitment has been legitimized by findings that affirm its application as constitutional. The third feature is that from the courts jurisprudence it is observed that legislative deficiency on protective substantive and procedures of law, misapplication of the law, abuse of rights and arbitrary detentions manifest as crucial concerning issues that are contested when it comes to civil commitment. In reaction to these cases, it is naturally conspicuous that the courts emphasize and reemphasize the observance of the law, the requirements of more special standards for those placed under civil commitment, provision of alternative least intrusive means such as outpatient and community, the provision of mental health services in proper hygienic environments and compensation where violations are found.

In **Chapter three** a further exploration of standards from the perspective of consent and capacity during civil commitment was pursued. The analysis like in chapter two took two approaches, by looking at the international human rights perspectives and the domestic statutory requirements with a keen attention to safeguards. The use of judicial jurisprudence was equally used relating to substantiate the aim of the thesis. Consent and capacity interlinks with civil commitment via the compulsory nature of civil treatment. The chapter limited itself to civil commitment and began looking at the right to equal recognition before the law that encompasses the right to self-determination as is presented by the CRPD and other international human rights treaties. From the exploration engag-

ing viewpoints emerged. First from the international perspective, it came out that the CRPD lays down the benchmark for consent and capacity which entails promotion of total autonomy in matters of treatment by prohibiting treatments without consent, the use of substitute decision makers for those incapable of making decisions by themselves and the use of guardianship systems. According to the CRPD Committee declarations, these systems are discriminatory. On account of this perspective, the replacement of these mechanisms as required by the CRPD and championed by the Committee is the use of supported decision making, which thus far has no specific articulated guidelines on what it consists of. To ensure exercise of autonomy, it further promotes the use of advance made wills that provide future authorization detailing what wishes and preferences that have to be respected in terms of treatment and are to be executed by mental health practitioners as regards their mental health care. Juxtaposed with the jurisprudence of other conventions such as the ICCPR, the CAT and regional instruments, these instruments from the outset concede that the right to informed consent is not absolute. Even then, these instruments support the exercise of autonomous decision making including the use of supported decision making, however, they do not oppose the use of either substituted decision making or guardianship systems as long as there are set within a legal framework containing protective standards to make certain that abuse and arbitrariness are prevented and punished. Equivalent outlook is reflected in the MI Principles. This was a slight riveting departure from the strong CRPD perspective, yet a more resounding approach that is seen being implemented in the research jurisdictions. It consequently raises questions as to the practicality in regards to implementation of the CRPD strong approach. Another attention-grabbing finding was that in the analyzation of the makings of the CRPD article 12 on equal recognition before the law and drafting of general comment one as it relates to autonomous decision making for some persons with disabilities incapable of such, It could be seen from the reservations of the article and the responses to the drafting of the comment that many States did not agree with the absolute position of the CRPD. While many accepted that it is paramount that supported decision making should be

legislated and implemented, they also remained adamant to abolish the system of substituted decision making or guardianship holding that there are situations where these mechanisms become important for persons with disabilities who simply are not able to make autonomous decisions even with the best support available. Therefore, what they emphasized is the availability of all these mechanisms together with substantial safeguards to ensure that individuals with disabilities rights are informed and protected from any abuse. Symmetrically important is that they have a regulatory framework which provides the basis for implementation and review. This division was equally evident in the scholarly works utilized. Majority of scholars championed the CRPDs viewpoint on absolute autonomous decision making approach while some sided with the States position that sometimes making decisions for those incapacitated for example to receive compulsory treatment is appropriate since it facilitates the individual to heal and thereafter be or become able to make their own choices. This is the same attitude that the thesis adopts in view of the reasons for its pursuit.

With the above, it was therefore not puzzling that from the findings the legislations in the chosen jurisdictions presented these prohibited mechanisms together with other workable procedures and applicable safeguards. The right to consent even though promoted constitutionally through the right of bodily security and prohibition of nonconsensual medical experiments, the right itself was held not to be absolute. In spite of that and to guarantee fairness, what is emphasized is the presence of substantive and procedural safeguards that set out standards and prohibition of certain psychiatric treatments without consent of the individual, representative, designated mental health tribunal and boards including courts of law. Like the other chapters, this chapter presented parallelisms in terms of procedures and standards. For instance, from the admissions to the treatment processes, it appeared that all the research countries mental health users are presumed capable of making decisions until proven otherwise. Criteria to prove otherwise are presented in the legislation. In addition, a mental health user or representative must be given adequate information that is necessary for him

or her to come to an informed decision and thereby giving an informed consent. While in the UK consent is not necessarily needed to ensure involuntary admission and treatment, the guiding principles nevertheless require that it be sought. In Ontario consent is a must before treatment and the procedures for consenting to treatments and those that provide authorization to substitute decision makers and guardian including the legally recognized representatives, are extensively provided in separate legislation that equally contain substantive and procedural safeguards as discussed in the chapter. This is a different approach contrasted with South Africa and Ghana that have one to two sections dedicated to consent within their mental health legal framework. An additional similarity that emerges across and is in accordance with the CRPD requirement is the respect of an individual's wishes and opinions. The exercise of this right is depicted through the authorized legal use of advance written directives, living wills or instructions given under power of attorney. UK, South Africa and Ontario specifically provide in their statutes while Ghana does not for which policy makers can be prompted to adopt. This feature appears to be promoted and implemented beyond the four jurisdictions and it is important because it specifically provides the clear wishes and preferences of the individual concerned. Thus if an individual opts for voluntary or involuntary treatment, it shall be provided as stipulated thereby preventing any unnecessary decisions, abuse or arbitrary detention. From the courts jurisprudence, once again the judicial system manifested to be very engaging in ensuring that the requirements set in the law are effected. The jurisprudence showed that the courts of law engaged with issues concerning the disregard of the law for example substitute decision makers arbitrarily overriding decisions made or given to them and mental health practitioners disregarding stipulated procedures as well as disregarding wishes and submission of applications for review as required.

Chapter Four as the last chapter of the thesis explored the theme of 'Review, Discharge and civil Commitment'. The discussion here is very important because throughout the whole thesis, the issue

regarding lack of timely reviews or discharge processes that result or resulted in lengthy detentions predisposing those detained involuntarily to abuse and arbitrary detentions emerged as a serious matter in question. According to the thesis this omission constitutes as one of the crucial rationale to the inquiry why the process of civil commitment process is being rejected. Hence, the chapter focused on examining how these concerns are tackled as well as explaining the importance of these processes by specifically reviewing the normative framework provided in international law including the requirements of the CRPD and the equivalents in the research jurisdiction. Accordingly, in the discourse that followed in international human rights law, what became evident particularly from the ICCPR, the UNWAGD and the regional human rights treaties ECHR, ACHR and ACHPR, is that the right to review is considered as an international norm and that it applies to all forms of detention including compulsory detention for the purpose of providing mental health treatment and care. Despite the fact that it is a self-standing right, it was shown that it co-functions with other rights. For instance, the right to information, right to a counsel or representative, the right to a hearing before an impartial and independent judicial body, the right to a speedy and prompt determination of the matter, the right to a decision that may include orders of discharge and the right to compensation where harm is/was done. The CRPD jurisprudence on article 14 (2) right to liberty does not enumerate this right however makes a reference that those who are deprived of their liberty must be accorded those guarantees in accordance with international human rights law together with the observing its objectives and principles that also include reasonable accommodation. Well, the understanding from these requirements comes down to the fact that the mentioned guarantees provided in the other international conventions jurisprudence get to be applied to those whose right to liberty is curtailed. The interesting feature from the CRPD jurisprudence such as the guidelines to article 14 right to liberty and as it relates to civil commitment is that, it does not guide on the review and discharge of those using the process or would use it. However, in view of the CRPD Committees interpretative opinion on absolute ban of compulsory measures, the guiding

principles only refers to review and discharge of those detained through the process of undertaking deinstitutionalization processes. Notwithstanding the CRPD absolute ban, and the fact that it may be difficult to accept or contradictory for the Committee to support review of a system it seeks to abolish, the thesis found it as an inadequacy on the part of the Committee for the lack of emphasis as to the use of review and discharge, especially taking into account States practice of non-compliance to its position on compulsory measures and the realities of abuses in institutions. The thesis extrapolates that encouraging the adoption of protective standards would be exceedingly ideal. Having an absolute ban in the face of continued use of civil commitment even post CRPD serves little to protect those in the system, those who would prefer it and those who may be subjected to compulsory mental health treatment and care. Rather, promoting such measures as difficult as it may be to its objectives, contributes much to human rights respect.

Nevertheless, the guarantees found in the international legal framework when juxtaposed to the national framework were found to be indistinguishable in as far as the emphasis on review and discharge and the attaching guarantees mentioned above were concerned. The domestic jurisprudence in the four countries presented paralleled mechanisms of review and institutions charged with the responsibility save for the titles, that is mental health tribunals and mental health review Boards. Mechanisms such as automatic review to the board or tribunal upon admissions by mental health practitioner or head of establishment, use of appeals procedures, habeas corpus and judicial review that encompasses legislative, administrative decisions and actions cut across the jurisdictions. External review of detention facilities was also available in their jurisprudence. Some of these mechanisms were not only provided within the mental health legislations but presented as constitutional rights. In this sense, persons with mental disability subjected to civil commitment could and can petition other institutions such as human rights commissions, ombudsmen and higher courts alleging a violation of their rights. From the case law of UK, Ontario and South Africa, the courts again

emerged to be very vigilant and strict in cases where review and discharge were not conducted as per the law or where inappropriately applied. Some judicial pronouncements such as Ontario led to the reform of legislations putting the detention under compulsory to a maximum of six months. There were differences which came out in terms of time for making application, the waiting time and duration when constant review should take place including conditions of discharge. A very important but missing aspect from this chapter was the lack of regulations as it relates to the general framework on the use of orthodox mental health services without review of any kind in the Ghanaian and the South African legislations. This lacuna continues to provide a bed of abuses and arbitrary detentions for those individuals seeking mental health services from these traditional and spiritual mental health centres. It however presents an opportunity to urge the respective government's policy makers to constitute a legal framework to that effect that may also include the guarantees found in the chapter. Thus by reviewing all these issues and right in this chapter, the analysis drew attention to the importance of review and discharge as it regards civil commitment. It equally makes apppoint of the imperatives of a protective legal framework that demands the implementation of review and discharge.

5.2. Additional Aspects for Contemplation (Economic, Cultural & Political)

Examining standards is the focus of this thesis in view of the fact the thesis premises that but for abuse and arbitrary detention, civil commitment is a necessary and adequate process in the provision of mental health care services. However examining safeguards alone cannot sufficiently provide a comprehensive solution to the multifaceted problems that face persons with mental disabilities especially those placed in civil commitment. To properly call it justice in accessing mental health care there are other factors that must equally be confronted. They include combating stigma, discrimination, inequalities, poverty, establishment of proper infrastructure and hiring competent

professionals. These issues are briefly discussed in light of economic challenges, cultural challenges and political aspects before finalizing with the way forward and a dialogue with the CRPD Committee.

5.2.1. The Economic Concern

The World Health Organization (WHO), express that “despite their vulnerability, people with mental health conditions – including schizophrenia, bipolar disorder, depression, epilepsy, alcohol and drug use disorders, child and adolescent mental health conditions, and intellectual impairments – have been largely overlooked as a target of development programmes and this is despite the high prevalence of mental health conditions, their economic impact on families and communities, and the associated stigmatization, discrimination, and exclusion”.¹⁶⁸⁰ The WHO brings two issues to bear; one is that mental illness has a cost in various forms that involves the personal, social and financial aspects of life. Therefore, it is important that individuals have the ability to bear the burden that comes with living and treating mental illness. Using civil commitment process has substantial effect to the individual and society. This is because for example, in every instance that an employed individual is compulsorily restrained to be treated be it shorter or longer durations it has an impact in personal autonomy sphere the social, cultural and economic sphere of life. Therefore it is important to have measures that try to provide balance. In the case of civil commitment, balance can be ensured through protections such protective standards on autonomy, proper treatment, shorter detentions, discharge and provision of care in community environment. The second issue regards the participation of the government in providing adequate financial budgets to the health sector. It is well published and acknowledged that poor access to mental health care and services is hugely contributed by meagre budgets spent or allocated to mental health services.¹⁶⁸¹ This presents a sig-

¹⁶⁸⁰ See, WHO, Mental Health and Development: Targeting People with Mental Health Conditions as a Vulnerable Group, World Health Organization publication (2010), p.2.

¹⁶⁸¹ See, Ibid.,. The WHO states that, “Mental health conditions affect millions of people in the world. The World Health Organization (WHO) estimates that 151 million people suffer from depression and 26 million people from schizophre-

nificant effect on the whole sector beginning from prevention, protection and sensitization measures on mental health, access to medical insurance and access to medicine, staffing, and infrastructure and its maintenance.

State Parties with willingness can address these issues particularly through implementing the CRPD requirements to ensure equality and non-discrimination practices in access to mental health care. Community mental health care should be encouraged so as to facilitate the participation of those with mental disability in their development in the community. Persons with mental disability should not be excluded discriminatory from participating fully in their communities. They should be empowered to change that which oppresses them through proper mental health care access and services and ‘development assistance that can help in improving their participation, resultantly leading to their improved psychological and material wellbeing’.¹⁶⁸²

5.2.2. The Cultural Challenge

According to the thesis, cultural challenge refers to two things. The first is the challenge presented by the use of traditional and spiritual healers to provide mental health care. This is off course associated with the way individuals perceive and understand mental illness from a cultural perspective. The concern for the thesis as regards access of mental health care through this method is the lack of solid protective legal framework that incorporates even the minimum standards against abuse and arbitrary detentions regarding involuntary detention and treatment. On the same subject, the vital concern involves the methods used in healing such as whipping, sexual abuse and chaining among others that become violations of the right to be free from inhumane treatment abuse and torture. This matter extends beyond the two African jurisdictions in view of the fact that practices like

nia; 125 million people are affected by alcohol use disorders. As many as 40 million people suffer from epilepsy and 24 million from Alzheimer and other dementias. Around 844 thousand people die by suicide every year.⁶In low-income countries, depression represents almost as large a problem as does malaria (3.2% versus 4.0% of the total disease burden), but the funds being invested to combat depression are only a very small fraction of those allotted to fight malaria
¹⁶⁸² See, Ibid.

chaining and sexual abuse occur in homes and mental health institutions in Asian and Western countries. In this regard there needs to be internal and external oversight of these centers as well as mechanisms to ensure that the practicing healers are qualified registered and uphold ethic in their fields. The Bottom line is that effective regulation must be in place that articulates standards, authorized entities and supervising mechanisms. Ghana has taken the first step of including these services in its mental health legislation, it must therefore go further and provide a guiding and protective framework.

The second meaning to cultural challenge refers to the aspect of stigma and discrimination of individuals with mental health problems embedded in our society that has become a cultured concern. Research on peoples experience with mental illness continuously reveals that “stigma surrounding mental health conditions is due mainly to widespread misconceptions about their causes and nature”.¹⁶⁸³ That “around the world, mental health conditions often are viewed as manifestations of personal weakness, or as being caused by supernatural forces. People with mental health conditions commonly are assumed to be lazy, weak, unintelligent, difficult and incapable of making decisions [and also] are thought to be violent, despite the fact that they are far more likely to be victims rather than perpetrators of violence”.¹⁶⁸⁴ This level of thinking and treatment must not be condoned. This thesis like many other advocacy and scholarly works joins the conversation that strongly supports advocacies aimed at stopping prejudices through sensitization and education of families, communities and countries. This is with a clear message that mental health concerns are not problems to be afraid, ashamed of or discriminated on, but concerns that can only be dealt with through togetherness, humility, kindness and knowledge akin any other health concern.

¹⁶⁸³ See, Ibid, p.8.

¹⁶⁸⁴ See, Ibid, p.9.

5.2.3. The Political Aspect

Addressing economic and cultural challenges must be addressed with political challenges. By this, the thesis is certain that in order to change prejudices that faces and experienced by individuals with mental illness, the task must not only begin at the grassroots level, but imperatively must be started and maintained from the leadership in the government and its institutions. Political leaders must have the will to undertake their lawmaking function and provide progressive adequate and functional laws or legal frameworks. This task includes revising obsolete legislations concerning mental health law. This aspect is very important for many African jurisdictions that still do not have or are still using their colonialist's legislations that lack substantive guarantees. Lawmakers must be ready to undertake the duty of incorporate progressive mental health policies for example the use of supported decision making and community mental health services and others as required by the CRPD. They must be educated legislators who conduct their research on current trends domestically and abroad and putting together legislations that are current and implementable. After all, the CRPD article 32 encourages States parties to take advantage of international cooperation in realizing the objectives of the convention through exchange of information, research, trainings, best practices and technologies among other measures such as development programmes in order to guarantee proper inclusion and provision of services to persons with disabilities in their jurisdictions. Leaders must correspondingly be in the lead in guaranteeing that they do not further reinforce prejudicing stereotypes in their communities and by minding the language they use when addressing mental health issues. In addition to the political aspect, judicial institutions must equally be ready to effectively apply mental health legislations and deliver timely and informed judgments. From the research analysis, their readiness and activism came out strongly and in view of this, the thesis maintains that this aspect should be capitalized on to ensure the respect and effective implementation of the rights of persons with mental disabilities accessing health care.

5.3. What Lies Ahead

This research has so far illustrated through State practice that States are not ready and willing to deal away with the practice of psychiatry, use of compulsory measures such as involuntary commitment, substituted decision making and guardianship systems. The thesis is certain that this trend shall keep on because evidentially many governments are either reinforcing these practices through additional guarantees in their existing mental health legislative frameworks or enacting new mental health legislations that still promote and enforce compulsory measures using different terminology with the same meanings and criteria. The recently passed into law India's Mental Healthcare Bill is just an example. This law while it introduces positive features such as community living, use of advance directives, role and powers of nominated representative among other rights akin to the research jurisdictions, the changes it introduces as regards involuntary treatment is the change in vocabulary -involuntary commitment to 'supported admission' but still retaining the same involuntary commitment procedures and standards.¹⁶⁸⁵ For this reasons, there is the underlining imperativeness of rethinking the promotion and use of protective protections. What should also lie ahead is the emphasis and implementation of these protective standards. The most natural and direct method that can and should be engaged to guarantee their enforcement and enjoyment is through education of all stake holders. For empowering mechanisms like the use of advance directives to be effective, persons with mental disabilities must be made aware or become aware of their rights to use such mechanisms, the various treatment alternatives available and articulate their preferred choices for the future.

¹⁶⁸⁵ See, The Mental Healthcare Bill, 2016, Bill No. LIV-C of 2013, As passed by the Rajya Sab on the 8th August 2016, into a Bill and Currently into Law by the Lok Sabha on the 27th March 2017. See, s.85, 89 & 90. Available at: <http://www.prsindia.org/uploads/media/Mental%20Health/Mental%20health%20care%20as%20passed%20by%20RS.pdf>.

5.4. A Dialogue with the CRPD Committee

The thesis would not be complete without making a few observations from the findings of the research directed towards the CRPD Committee and its role in the promotion of the rights of persons with disabilities. To begin, the thesis affirms that the CRPD is a much needed convention to secure the rights of persons with disabilities and that the Committees work is commendable. The author equally underscores that this thesis does not in any way question the legitimacy of the CRPD. Neither does it claim that State Parties are unwilling to or are not implementing the CRPD. States are open, are prepared, are willing and have proceeded in various ways since the coming in of the Convention to put measures in place to guarantee its implementation. However, like any other convention or legislation, there are always challenges that arise during the implementation phase. For the case of the CRPD, the challenge is not in the whole, but in the interpretation and implementation of certain provisions, such as those discussed in this thesis (articles 12, 14 & 25).

The findings of this research show States resilience in the continued use of civil commitment and substituted decision making mechanisms standing contrary to the interpretation of the convention given by the CRPD Committee. This resilience and continued poor treatment of persons with mental disabilities have been the key evidence substantiating the purpose of this research from a protectionist perspective. The research has also been driven by a couple of unanswered questions that arose, that may be brought out and be deemed proper to provoke a different research and CRPDs Committee engagement in this conversation. In view of this, one of the questions that keeps budging up is, why does the CRPD Committee continue to maintain an abolitionist position on mental health legislation proscribing civil commitment when States and certain individuals with mental disabilities continue to prefer the use as part of their enjoyment of the right to health? Similarly, with the awareness of the resilience and abuse and arbitrariness faced by individuals in mental

health centres why doesn't the Committee compromise its abolitionist position in lieu of protective Standards? Compromising does not mean defeat in its endeavour in the promotion of human rights for individuals with mental illness, but finding a pragmatic solution in the enforcement of these challenging provisions in the CRPD that is beneficial. Besides States are preaching the use of protective standards to guarantee the prevention of abuse and arbitrariness in access to mental health services, why not hold them accountable from this aspect?

To even further the conversation, it is the belief of the thesis that the Committee need to define what it entails to have voluntary access to mental health services. In this regard, the line of thought is that the CRPD Committee unquestionably supports the usage of empowering options such as supported decision making and advance decision making mechanisms, and on this basis if an individual makes an advance directive voluntarily that authorizes treatment through compulsory measures when compelling circumstances arise, would the Committee consider such advance made decisions for the use of civil commitment to be inline or contrary to the CRPD and in this case would they reconsider the importance of mental health legislation enabling the practice? In the event that the answer would be in the affirmative, would they be inclined to promote the use of safeguards to guarantee protection in such processes? At the end of it, this is the overriding purpose of this thesis. A proposal providing a rethinking perspective, an alternative to a rigid position, a balance or/ and an accommodating solution where the lines are not definitely cut.

Finally, a concern that was not dealt head on and remains an interesting query is how does the CRPD Committee harmonise its interpretation of civil commitment with the difference in approaches within the international and regional human rights conventions? Particularly in the interpretation provided by the Human Rights Committee in its recent General Comment 35 on the right to liberty that accept limitation on the right to liberty for the purpose of compulsory mental health

treatment with emphasis on safeguards. On the same point, instead of deeming inapplicable the MI Principles, the soft international instrument that contain provisions directly permitting the use of civil commitment with the safeguards articulated therein, why doesn't it adopt it as a guiding document, bearing in mind that national and regional courts recognize the instrument as guiding law and utilize its principles in their decision making? The author believes that accepting these instruments and Principles should not be taken as a defeat of its work or detraction from the objectives of the CRPD, but rather as realization in guaranteeing enjoyments of rights with protections. Moreover, the most relevant and interesting fact to weigh in is that, these international instruments whilst not opposed to the exercise of civil commitment and enabling mental health legislation, they equally promote the fulfilment of the CRPD objectives by requiring the establishment of and usage of community centred mental health services and using civil commitment and substitute decision making mechanism as a last resort within a regulated framework that guarantees protection of rights.

Having stated and raised the concerns above, the thesis points out that the CRPD Committee should and can be practical in the approach it uses in engaging States to make mental health reforms. They should take not only State practice into account but also the realities of the people subjecting themselves to involuntary commitment processes, those that greatly value the use of traditional and spiritual systems and those that may nevertheless be subjected to compulsory measures through emergency situations or court orders. In this regard they should consider promoting the use of substantive and procedural guarantees in mental health legislations. It is futile to have absolute prohibiting guiding principles and comments in an area where concerns are neither black and white resulting in those guidelines being disagreed, disregarded and remaining unimplemented. The CRPD Committee must find a way to address these concerns. Moreover the thesis once again considers that it is foreseeable that while States will endeavour to incorporate CRPD objectives they will also not

eliminate mental health legislations that sanction the practice of civil commitment or use of substituted decision making.

The CRPD Committee should have this foresight as well in view of the fact that it is visible in their monitoring and review of State practice and the reports submitted by States in which States justify the use of compulsory measures. Therefore, seeing that the CRPD Committee in the concluding observations has been calling for the elimination of these practices and enabling legislations, and since States are irrepressible and insist on protections as buffers against abuse and arbitrary detentions, then the CRPD Committee can and should start voicing a different calling that requires the formulation and implementation of protective safeguards in mental health legislation and be resilient as well in holding State parties accountable on this front. Hence there is still much work to be undertaken and new areas of research to pursue. In the meantime, protective substantive and procedural safeguards should be encouraged in order to guarantee protection to those subjected or subjecting themselves to civil commitment. Those standards that the research found to be currently supported are provided at the end of each chapter. They are not exhaustive taking into account that the research focused on a few jurisdiction. There may be other practical standards articulated in other jurisdictions that may be examined in a different research analysis. Notwithstanding, the standards revealed in the research can be considered as basics, starting point of considerations. These standards are not repeated here, but the thesis promotes them as current applicable protections that can and should be considered by State Parties including the CRPD Committee. State Parties can adopt them as a regulation supplement to their existing mental health frameworks. For those that do not have, they can transplant to be a part of their new mental health laws, however they must take into account the political, social, cultural and economic factors within their jurisdiction and responsibilities under international human rights laws.

BIBLIOGRAPHY

Text & Materials

1. Adam Samaha, What Good is the Social Model of Disability, 74 *The University of Chicago Law Review* (2007).
2. Amita Dhanda Legal Capacity in the in the Disability Rights Convention: Stranglehold of the Past or Lodestar for the Future, 34 *Syracuse Journal of International Law and Commerce* (2007).
3. Annegret Kampf, Involuntary treatment decisions: Using negotiated silence to facilitate change? In Bernadette Mcsherry & Penelope Weller (ed), *Rethinking rights based mental health laws* (2010).
4. Asbjorn Eide, Adequate Standard of Living in Daniel Moeckli, Sangeeta Shah & Sandesh Sivakumaran (ed.), *International Human Rights Law*, 2nd ed. Oxford University Press (2014).
5. Beauregard Tromp et al, One in Three South Africans Suffer from Mental Illness-Most Wont get any help, *Times Live* (published on 07 July 2014).
6. Benedict Carey, The Chains of Mental Illness in West Africa, *The New York Times* (11the October 2015).
7. Christopher Slobogin, Eliminating Mental Disability as a Legal Criterion in deprivation of Liberty Cases: The Impact of the Convention on the Rights of Persons with Disabilities on the Insanity Defense, Civil Commitment and Competency Law, 40 *International Journal of Psychiatry* (2015).
8. Christine Chinkin, *International Law Sources* in Daniel Moeckli, Sangeeta Shah & Sandesh Sivakumaran (eds.), *International Human Rights Law*, Oxford University Press (2014).
9. Claire Barcham, Understanding the Mental Health Act Changes- Challenges and Opportunities for Doctors, 1 *British Journal for Medical Practitioners* (2008)
10. Danny Sullivan & Paul Mullen, *Mental Health Rights in Secure Settings* in Michael Dudley, Derrick Silove & Fran Gale ed., *Mental Health and Human Rights: Vision Praxis and Courage*, Oxford University Press (2012).
11. Deborah Marks, *Models of Disability, Disability and Rehabilitation* (1997).
12. Dimitris Anatsiou & James Kauffman, The social Model of Disability: Dichotomy Between Impairment and Disability, 38 *Journal of Medicine and Philosophy* (2013).
13. Doku V., A Wasu-Takyi & J Awakame, Implementing the Mental Health Act in Ghana: Any Challenges Ahead? 46 *Ghana Medical Law Journals* (2012).
14. D.P. Madlala & F.B. Sokudela, The Care Treatment, Rehabilitation and legal Outcomes of Referrals to a Tertiary Psychiatric Hospital According to the Mental Health Care Act No.17 of 2002, 20 *South African Journal of Psychiatry* (2014).
15. Eric Rosenthal & Leonard Rubenstein, *International Human Rights advocacy under the Principles for the Protection of Persons with Mental illness*, 16 *International Journal of Law and Psychiatry* (1993).
16. Eriksson M. Sjöstrand et al, Paternalism in the Name of Autonomy, *Journal of Medicine and Philosophy* (2013).
17. Felicity Callard et al, *Mental Illness, Discrimination and the Law: Fighting for Social Justice*, Wiley Blackwell Publishers (2012).
18. FRA-European Union Agency for Fundamental Rights, *Involuntary Placement and Involuntary Treatment of Persons with Mental Health Problems*, publication office of the European Union-Luxemburg (2012)
19. Fiona Morrissey, The United Nations Convention on the Rights of Persons with Disabilities: A New Approach to Decision-Making in Mental Health Law, 19 *European Journal of Human Rights* (2012).

20. Gabel, S. L., & Peters, S., Presage of a paradigm shift? Beyond the Social Model of Disability toward a Resistance Theory of Disability 19 *Disability and Society* (2004).
21. Gareth Williams, *Theorizing Disability* in Gary Albrecht, Katherine Seelman & Michael Bury et al., *Handbook of Disability Studies*, Sage Publication London (2001)
22. Gerald Quinn, *A Short Guide to the United Nations Convention on the Rights of Persons with Disabilities*, in Gerald Quinn & Lisa Waddington (eds.), *European Year Book Of Disability Law*, 1 Intersentia Oxford-Portland (2009).
23. Hannah Roberts, *A Way Forward for Mental Health Care in Ghana?* 357 *The Lancet* (2001).
24. Han Magnus Solli & Antonio Barbosa Da Silva, *The Holistic Claims of the Biopsychosocial Conception of WHO' s International Classification of Functioning, Disability, and Health (ICF): A Conceptual Analysis on the Basis of a Pluralistic – Holistic Ontology and Multidimensional View of the Human being*, 37 *Journal of Medicine and Philosophy* (2012).
25. Human Rights Watch, *Like a Death Sentence: Abuse Against Persons with Mental Disability in Ghana*, Human Rights Watch (2012)
26. Isobel Booth (ed.), *The Fundamental Facts: Latest facts and Figures on Mental Health*, Mental Health foundation Publication (2007)
27. Javid Rehman, *International Human Rights Law*, 2nd Ed Pearson Education Limited (2010).
28. Javier Garcia Roca, *The Preamble, The Conventions Hermeneutic Context: A Constitutional Instrument of European Public Order* in Javier Garcia Roca & Pablo Santolaya (ed.), *Europe of Rights: A Compendium on The European Convention of Human Rights*, Martinus Nijhoff Publishers (2012).
29. Jean McHale & Marie Fox Ed., *Health Care Law: Text and Materials*, 2nd Ed. Sweet & Maxwell (2007)
30. Jocelyn Edwards, *Ghana's Mental Health Patients Confined to Prayer Camps*, 383 *The Lancet* (2014).
31. Joanna Moncrieff, *Psychiatric Diagnosis as a Political Device*, 8 *Social Theory of Health* (2010)
32. Joanna Moncrieff, *Is Psychiatry for Sale? An Examination of the Influence of the Pharmaceutical Industry on Academic and Practical Psychiatry*, Prepared as a MAUDSLEY DISCUSSION PAPER (Published June 2003).
33. John Dawson, *A Realistic Approach to Assessing Mental health Laws Compliance with the UNCRPD*, 40 *International Journal of Law and Psychiatry* (2015).
34. Kampf Annegret., *Involuntary Treatment Decisions: Using Negotiated Silence to Facilitate Change,* Bernadete McSherry & Penelope Weller ed., *Rethinking Rights- Based Mental Health Laws*, Oxford Hart Publishing (2010).
35. Krahn G and Campbell. VA, *"Evolving Views of Disability and Public Health: The Roles of Advocacy and Public Health,"* 4 *Disability and Health Journal* (2011).
36. Lance Gable et al, *Mental Health and Due Process in the Americas: Protecting the Human Rights of Persons Involuntarily Admitted to and Detained in Psychiatric Institutions*, 18 *Public Health* (2005).
37. Louis. Oyaro, *Africa at Crossroads: The United Nations Convention on the Rights of Persons with Disabilities*, 30 *American University International Law Review* (2015).
38. Manisuli Ssenyonjo, *Economic, Social and Cultural Rights in International Law* Hart Publishing (2009).
39. Mario Bunge, *Chasing Reality: Strife over Realism*, University of Toronto Press Canada (2006).

40. Martha Jackman, *The Implications of Section 7 of the Charter for Health Care Spending in Canada*, Saskatoon: Commission on the Future of Health Care in Canada, (October 1, 2002)
41. Mark Roberts, Caroline Mogan & Joseph Asare, *An overview of Ghana's mental health system: Results from an Assessment using the World Health Organization's Assessment Instrument for Mental Health Systems (WHO-AIMS)*, 8 *International Journal of Mental Health Systems* (2014).
42. Mary Donnelly, *From Autonomy to Dignity: Treatment for Mental Disorders and the Focus for Patients* 37 *Law in context* (2008).
43. Melvyn Freeman & Graham Thornicroft 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*, 2 *Lancet Psychiatry* (2015).
44. Michael Dudley, *Mental Health, Human rights, and Their Relationship: An Introduction*, in Derrick Silove & Fran Gale, (Eds.), in *Mental Health Human Rights: Vision, Praxis, and Courage*, Oxford University Press (2012).
45. Michael Palmer and David Harley, *Models and Measurements in Disability: An International Review*, Oxford University Press (2011).
46. Michael L. Perlin et al, *International Human Rights and Comparative Mental Disability Law*, Carolina Academic Press (2006).
47. Nenad Kostanjsek, *Use of The International Classification of Functioning, Disability and Health (ICF) as a Conceptual Framework and Common Language for Disability Statistics and Health Information Systems*, 11 *BMC Public Health* (2011).
48. Oliver Lewis, *The Expressive, Educational and Proactive Roles of Human Rights: An Analysis of the United Nations Convention on the Rights of Persons with Disabilities*, in Bernadette McSherry & Penelope Weller, (eds.), *Rethinking Rights Based Mental Health Laws*, Hart Publishing (2010).
49. Pablo A. Fernandez-Sanchez, *The Scope of obligations Under the European Convention on Human Rights (Art1.)* in Javier Garcia Roca & Pablo Santolaya (ed.), *Europe of Rights: A Compendium on The European Convention of Human Rights*, Martinus Nijhoff Publishers (2012).
50. Penelope Weller, *Lost in Translation: Human Rights and Mental Health Law* in Bernadette McSherry and Penelope Weller (eds.), *Rethinking Rights-Based Mental Health Law*, Hart Publishing (2010).
51. Peter W. Hogg, *Constitutional Law of Canada 2013 Student edition*, Carswell (2013).
52. Peter Bartlet, *Reforming the Deprivation of Liberty Safeguards (DOLS): What Is It Exactly that We Want?*, 20 *European Journal of Current Legal Issues*, Open Journal Systems (2014)
53. Peter Bartlet et al., *Mental Disability and the European Convention on Human Rights*, Martinus Nijhoff Publishers (2007).
54. Philip Mitchell, *Psychiatrists and the Pharmaceutical Industry: On the Ethics of a Complex Relationship* in Derrick Silove & Fran Gale, (Eds.), In *Mental Health Human Rights: Vision, Praxis, and Courage*, Oxford University Press (2012).
55. Phil Fennell, *Treatment Without Consent: Law, Psychiatry and the Treatment of Mentally Disordered People Since 1985*, Routledge Publishers (1996).
56. Ramlall S., *The Mental Health Care Act No 17 –South Africa. Trials and triumphs: 2002-2012*
57. Richard Bonnie & Svetlana Polubinskaya, *Unravelling Soviet Psychiatry*, 10 *Journal of contemporary Legal Issues*, (1999).
58. Robert Nikkel, *Reflections on Myth Machines, "Mental Illness," and the Perils of Good Intentions* (Published May 11, 2016).

59. Robert Van Voren, *The Abuse of Psychiatry for Political Purposes* in Derrick Silove & Fran Gale, (Eds.), *In Mental Health Human Rights: Vision, Praxis, and Courage*, Oxford University Press (2012).
60. Sally McManus, Howard Meltzer, Traolach Brugha, Paul Bebbington & Rachel Jenkins (ed.), *Adult Psychiatry Morbidity in England, Results of a Household Survey*, The NHS Information Centre for Health and Social Care (2007).
61. Sangeeta Shah, *Detention and Trial* in Daniel Moeckli, Sangeeta Shah & Sandesh Sivakumaran (ed.), *International Human Rights Law*, 2nd ed. Oxford University Press (2014).
62. *The Bristol Post*, *Cruel Nurse Struck Off for Bullying Patients at Winterbourne View*, (4th June 2015)
63. Tina Minkowitz, *Abolishing Mental health Laws to Comply with the Convention on the Rights of Persons with Disabilities* in Bernadete McSherry & Penelope Weller ed., *Rethinking Rights- Based Mental Health Laws*, Oxford Hart Publishing (2010).
64. Tom Shakespeare & Nicholas Watson, *The Social Model of Disability: An Outdated Ideology*, 2 *Research in Science and Disability* (2002).
65. Tom Burns & Stefan Priebe et al., *Community Treatment Orders for Patients with Psychosis (OCTET): A Randomised Clinical Trial*, 381 *The Lancet* (2013).
66. Van Heerden Belinda, *Boberg's, Law of Persons and the Family*, Juta Legal and Academic Publishers (2nd ed) (1999)
67. Vera Okeyo & Eunice Kilonzo, *Abandoned and Neglected: Kenya's Mentally ill Suffer in Bitter Silence*, *Daily Nation Kenya* (24th February 2015)
68. Vikram Patel, Arthur Kleinman and Benedetto Saraceno, *Protecting the Human rights of People with Mental Illnesses: A Call to Action for Global Mental Health* in Michael Dudley, Derrick Silove & Fran Gale ed., *Mental Health and Human Rights: Vision Praxis and Courage*, Oxford University Press (2012).

International & Regional Documents

A. Conventions

1. Universal Declaration of Human Rights,
2. International Covenant on Civil and Political Rights,
3. Convention on Elimination of All Forms of Discrimination against Women,
4. Convention on the Rights of the Child,
5. African Charter on Human and Peoples Rights
6. African Charter on Human and People's Rights on the Rights of Women in Africa (2003)
7. American Convention on Human Rights.
8. European Convention on Human Rights
9. Inter-American Convention on the Elimination of all Forms of Discrimination against Persons with Disabilities (1999).
10. Statute of the International Court of Justice, (1945).
11. UN General Assembly Principles for the Protection of Persons with Mental illness and the Improvement of Mental Health Care (1991)
12. UN General Assembly, Report of the Working Group on Arbitrary Detention: United Nations Basic Principles and Guidelines on Remedies and Procedures on the Right of Anyone Deprived of Their Liberty to Bring Proceedings Before a Court, A/HRC/30/37 (July 6th 2015).

B. Related Documents

1. UN Human Rights Committee, General Comment 35: Article 9 (Liberty and security of person) CCPR/C/GC/35 (2014).

2. UN Human Rights Committee, General Comment 29: States of Emergency (article 4), CCPR/C/21/Rev.1/Add.11 (2001).
3. UN Human Rights Committee General Comment 8, HRI/GEN/1/Rev.9 (Vol I) (1982)
4. United Nations General Assembly, UN Doc, A/HRC/22/53, Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez (2013).
5. UN Doc, Interim Report of the Special Rapporteur on Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, Juan E. Méndez, A/68/295 (9 August 2013).
6. Human Rights Committee, General Comment No. 20: Article 7 (Prohibition of Torture, or Other Cruel, Inhuman or Degrading Treatment or Punishment), (1992).
7. The United Nations Committee Against Torture, General comment No. 2: Implementation of Article 2 by State Parties, CAT/C/GC/2 (2008).
8. General comment No. 31: The Nature of the General Legal Obligation Imposed on States Parties to the Covenant in Compilation of General of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, UN Doc HRI/GEN/1/Rev.9 (Vol. I) 27 (May 2008).
9. United Nations General Assembly, UN Doc, A/63/175, Interim Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Manfred Nowak, (2008).
10. UN Doc, ESC, Commission for Human Rights, E/CN.4/1992/20, “Question of the Human Rights Of all Persons Subjected to Any Form of Detention or Imprisonment, Report of WGAD” (January 1992).
11. UN Economics & Social Council, Economic, Social and Cultural Rights: Report of Special Rapporteur (Paul Hunt) on the Right to Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, E/CN.4/2005/51 (2005).
12. UN Committee on Economic, Social and Cultural Rights, General Comment 14, The Right to the Highest Attainable Standard of Health, U.N. Doc. E/C.12/2000/4 (2000).
13. UN Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, (sixty-fourth session, 2009), UN Doc A/64/272 (2009),
14. American Psychiatric Association & World Psychiatric Association Joint Response Letter to the Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez, UN Doc, A/HRC/22/53 (2013). Available at: http://antitorture.org/wp-content/uploads/2014/05/12a_APA-WPA-Joint-Response-on-Torture.pdf

C. CASES

1. A (name withheld) v. New Zealand, Communication No. 754/1997, CCPR/C/66/D/754/1997 (1999).
2. Aerts v. Belgium, Application No 25357/94, Eur. Ct. HR (1998).
3. Biziuk V. Poland (No.2) Application No. 24580/06 (2012).
4. Brough v. Australia Communication No 1184/03, CCPR/C/86/D/1184/ 2003 (2006).
5. Cantoral-Benavides v. Peru, Series C, No. 69 (2000)
6. Garcia v. Peru, Case 11.006, Report No. 1/95, Inter-Am.C.H.R.
7. Herczegfalvy v Austria (1992) 15 EHRR 437.
8. HL v UK, Application No. 45508/99, ECHR 471 (2004).
9. Johnson V The United Kingdom (1997) ECHR 88.
10. Lukas Bures V The Czech Republic, Application No. 37679/08, ECHR (2012).
11. Mukong V Cameroon, Communication No. 458/1991, in UN Doc. GOAR, A/49/40 (Vol II)

12. Pleso V Hungary, Application No. 41242/08 ECHR (2012).
13. Purohit and Moore V. The Gambia Communication No. 241/2001(2003).
14. Selmouni v. France, Application No. 25803/94, ECHR (1999).
15. Stanev V Bulgaria, Application No. 36760/06 (2012) ECHR.
16. Winterwerp v. The Netherland 33 Eur. Ct. H.R. (ser.A) 1979.
17. X v Finland, Application No. 34806/04 (2012).
18. X v United Kingdom (1981) 4 EHRR 188

D. Convention the Rights of Persons with Disabilities & Related Documents.

1. Committee on the Rights of Persons with Disabilities, General comment No 1: Article 12: Equal Recognition Before the Law, CRPD/C/GC/1 (2014),
2. UN Press Release: Secretary General Hails Adoption of Landmark convention on rights of People with Disabilities, 13 December 2006, Ref SG/SM/10797, HR/4911, L/T/4400. Available at: www.un.org/News/Press/docs/2006/sgsm10797.doc.htm.
3. UN Press Release: Arbour Welcomes Entry into Force of ground-breaking Convention on Disabilities, 4 April 2008. Available at: www.unhcr.ch/hurricane/hurricane.nsf/view01/1AD533A6AB95F873C1257421003A8DA8?opendocument.
4. United Nations Treaty Collection Database, Convention on the Rights of Persons With Disabilities (2008). Available at: https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=iv-15&chapter=4&lang=en.
5. Texts of Reservation to the CRPD, Available in: https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-15&chapter=4&lang=en.
6. See, Texts of Periodic Reports to the CRPD Committee, Available in: http://tbinternet.ohchr.org/_layouts/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=4&DocTypeID=29.
7. Texts of Concluding Observations by the CRPD Committee, Available in: http://tbinternet.ohchr.org/_layouts/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=4&DocTypeID=5.
8. Federal Republic of Germany, German Statement on the Draft General Comment on Article 12 CRPD (20th February 2014),p. 1. Available at: <http://www.ohchr.org/Documents/HRBodies/CRPD/GC/FederalRepublicOfGermanyArt12.pdf>.
9. NewZealand Submission on Draft General Comment on Article 12: Equal Recognition Before the Law (11 March 2014). Available at: <http://www.ohchr.org/EN/HRBodies/CRPD/Pages/DGCArticles12And9.aspx>.
10. Danish Government. Draft General Comment No. 1 on Article 12 of the Convention on the Rights of Persons with Disabilities. Available at:<http://www.ohchr.org/EN/HRBodies/CRPD/Pages/DGCArticles12And9.aspx>.
11. Norwegian Government. Draft General Comment No. 1 on Article 12 of the Convention on the Rights of Persons with Disabilities. Available at:<http://www.ohchr.org/EN/HRBodies/CRPD/Pages/DGCArticles12And9.aspx>.
12. CRPD Committee Concluding Observation to Peru, UN Doc, CRPD/C/PER/Co1
13. Joint submission from the Equality and Human Rights Commission, the Equality Commission for Northern Ireland, the Northern Ireland Human Rights Commission and the Scottish Human Rights Commission, UN Committee on the Rights of Persons with

- Disabilities, Draft General Comment on Article 12, (28th February 2014). Available at: <http://www.ohchr.org/EN/HRBodies/CRPD/Pages/DGCArticles12And9.aspx>.
14. The Danish Institute for Human Rights, Drafts General Comment to Article 9 and 12, (21 February 2014). Available at: <http://www.ohchr.org/EN/HRBodies/CRPD/Pages/DGCArticles12And9.aspx>.
 15. University of Cambridge, Cambridge Intellectual & Developmental Disabilities Research Group, Draft General Comment on Article 12 of the Convention (31st January 2014). Available at: <http://www.ohchr.org/EN/HRBodies/CRPD/Pages/DGCArticles12And9.aspx>.
 16. International Disability Alliance, Position Paper on the Convention on the Rights of Persons with Disabilities (CRPD) and Other Instruments, (April 25, 2008).

E. World Health Organisation Documents

1. World Health Organization (WHO), International Classification of Functioning, Disability and Health, Geneva (2001).
2. World Health Organization (WHO), Resource Book on Mental Health, Human Rights and Legislation, World Health Organization Publication (2005).
3. World Health Organization, MhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-specialized Health Settings, World Health Organization Publication (2010).
4. World Health Organization, Mental Health action Plan 2013-2020, Geneva World Health Organization Publication (2013).
5. World Health Organization, Mental Health and Development: Targeting People with Mental Health Conditions as a Vulnerable Group, World Health Organization publication (2010).
6. World Health Organization Estimation Available at: <http://www.who.int/countries/gha/en/>

National Legislations & Cases

Ontario (Canada)

A. Legislation

1. The Constitution Act of Canada (1982)
2. Canada Health Act (1985),
3. Habeas Corpus Act (1990), R.S.O. 1990, c. H
4. Ontario Human Rights Code (1990)
5. Ontario Health Care Consent Act (1996).
6. Personal Health Information Protection Act (2004).
7. Ontario Substitute Decisions Act (1992).
8. Ontario Ministry of Health and Long Term Care, Designated Psychiatric facilities under the Mental Health Act

B. Related Documents

1. Ontario Hospital Association, A Practical Guide to Mental Health and the Law in Ontario, (October 2012).
2. College of Physicians and Surgeons of Ontario Consent to Medical Treatment, Policy Number: #4-05 (February 2006). Available at: <http://www.cpso.on.ca/uploadedFiles/policies/policies/policyitems/Consent.pdf>.

3. Law commission of Ontario, Legal Capacity, Decision-Making and Guardianship: Discussion Paper (Toronto: May 2014).

C. Cases

1. AG (Re), 2014 CanLII 26425 (ON CCB)
2. Canada (Attorney General) v. Hislop (2007) SCC 10
3. Cuthbertson V Rasouli, (2013) SCC 53
4. ES (Re), 2014 CanLII 55695 (ON CCB)
5. Fleming v. Reid, 1991 CanLII 2728 (ON CA)
6. Godbout v. Longueuil (City), (1997) 3 S.C.R. 844
7. KS (Re), 2013 CanLII 66989 (ON CCB)
8. L.C. v. Dr. Duff, 2013 ONSC 2974.
9. LG (Re), 2014 CanLII 32647 (ON CCB)
10. Malette v. Shulman (1990), 72 O.R. (2d) 417 (C.A.),
11. Masih v Siekierski, (2015) ONSC 2877
12. Ontario (Attorney General) v. Patient, 2005 CanLII 3982 (ON SCDC)
13. P.S. v. Ontario, (2014) ONCA 900 (CanLII).
14. P (Re), 2011 CanLII 4935 (ON CCB)
15. Reibl v. Hughes, [1980] 2 S.C.R. 880
16. R v Oakes (1986) 1 S.C.R. 103
17. R. v. Morgentaler, (1988) 1 S.C.R. 30
18. S. v. Her Majesty the Queen, 2013 ONSC
19. S.E. (2010; CanLII 41574 (ON C.C.B.)
20. Starson v. Swayze, [2003] 1 S.C.R. 722
21. Thompson and Empowerment Council v. Ontario, (2013) ONSC 5392
22. TH (Re), 2011 CanLII 18236 (ON CCB).

England& Wales (United Kingdom)

A. Legislation

1. The Human Rights Act (1998).
2. The Mental health Act (2007).
3. Mental Health Act (1983) as amended.
4. Mental Capacity Act (2005) as amended
5. Mental Capacity (Deprivation of Liberty: Standard Authorizations, Assessments and Disputes about Ordinary Residence) Regulations 2008.
6. Health and Social Care Act (2008)
7. United Kingdom, Habeas Corpus Act (1816).
8. Mental Health (Hospital, Guardianship and Treatment) (England) Regulations. (2008. SI 2008/1184), regulation 24.
9. UK Tribunals, Courts and Enforcement Act(2007), section 3
10. Transfer of Tribunal Functions Order (2008-SI/2833) , article 3 & Schedule 1

B. Related Documents

1. Care Quality Commission, Monitoring the Mental Health Act in 2012/2013, Care Quality Commission Publication (2014),
2. Care Quality Commission, Monitoring the Mental Health Act in 2013/2014(Summary), Williams Lee Group (2015)
3. Care Quality Commission, Monitoring the Mental Health Act in 2014/2015, Williams Lee Group (2015).

4. United Kingdom Department of Health, Post- Legislative Assessment of the Mental Health Act 2007-Memorandum to the Health Committee of the House of Lord, The Stationery Office, (July 2012).
5. UK Department of Health, Mental Health Act 1983: Code of Practice, The Stationery Office (2015).
6. United Kingdom Department of Constitutional Affairs, Mental Capacity Act 2005: Code of Practice, The Stationery office (2007).

C. Cases

1. B v Forsey [1988] SLT
2. B, R (on the application of) v SS (Responsible Medical Officer) & Ors [2006] EWCA Civ 28
3. Chatterton V Gerson (1981) 1 All E. R. 257
4. J.T. v. United Kingdom , [2000] 1 FLR 909
5. J, Reg. v Managers of South Western Hospital, Ex parte M [1993] QB
6. MH, R (on the application of) v Mind (The National Association for Mental Health) & Ors [2004] EWHC 56 (Admin)
7. MB, Re [1997] EWCA Civ 3093
8. MH v the United Kingdom (2013) ECHR 1008
9. Modaresi, R (on the application of) v Secretary of State for Health [2013] UKSC 53
10. Nottinghamshire Healthcare NHS Trust v RC [2014] EWCOP 1136
11. GJ v The Foundation Trust & Anor [2009] EWCOP 2972
12. P v Cheshire West and Chester Council and another and P and Q v Surrey County Council. 2014. WLR 2
13. Regina (B) v Ashworth Hospital Authority [2005] UKHL 20
14. Re S-C (Mental Patient: Habeas Corpus) (1995) EWCA Civ 60
15. R. v Bournewood Community and Mental Health NHS Trust Ex p. L [1997] EWCA Civ 2879
16. R (MH) v Secretary of State for the Department of Health (2005) UKHL 60
17. R. v Wilson, ex p. Williamson, The Independent, April 19 (1995)
18. R (Sessay) v South London and Maudsley NHS Foundation Trust (2011) EWHC 2617 (QB).
19. R v. Riverside Mental Health Trust ex parte Huzzey (1998) 43 BMLR 167
20. St George's Healthcare NHS Trust v S; Regina -v- Collins and Others ex parte S (1998) 3 ALL
21. TTM v London Borough of Hackney & Ors [2011] EWCA Civ 4
22. Wilkinson, R (on the application of) v Broadmoor Hospital, Responsible Medical Officer & Ors [2001] EWCA Civ 1545

Ghana

A. Legislation

1. The Constitution of the Republic of Ghana (1992).
2. Mental Health Act of Ghana (2012)
3. Lunatic Asylum Ordinance (1906).
4. Criminal and other Offences (Procedure) Act (1960).
5. Traditional Medicine Practice Act 575 (2000).

B. Related Document

1. Ghana Health Service, HealthCare Assurance Manual (2004), p. 4, para 1.3.3. Available at: http://ghanaqhp.org/fileadmin/user_upload/QHP/Healthcare_Quality_subdistrict.pdf.

South Africa

A. Legislation

1. The Constitution of South Africa (1996).
2. Mental Health Care Act (2002):
3. General Regulation Relating to the Mental Health Care Act, 2002 Amendment (2014).
4. National Health Act (2003),
5. National Patients' Rights Charter: Guidelines for Good Practice In the Health Care Professions, Book 3 Pretoria (2008).

B. Related Documents

1. South Africa Federation for Mental Health, Understanding Mental Illness (Presentation in the Mental Illness Awareness Month) (2011).
2. Statistics South Africa, South African Statistics (2014). Available at: <http://beta2.statssa.gov.za/publications/SAStatistics/SAStatistics2014.pdf>.
3. Department of Health of The Republic of South Africa, National Mental Health Policy Framework and Strategic Plan 2013-2020, (2013).
4. Mental Health and Poverty Project, Policy Brief 4: Promoting Community-Based Services for Mental Health in South Africa, (November 2008).

C. Cases

1. *Bedderson v Sparrows Schools Education Trust* [2009] ZALC
2. *Castell V De Greef* (1994) 4 SA 408 (C)
3. *Christian Lawyers' Association v National Minister of Health and Others* 2004 (10) BCLR 1086 (T)
4. *De Vos N.O. and Others v Minister of Justice and Constitutional Development and Others* (CCT 150/14) [2015] ZACC 21
5. *Hassam v Jacobs NO* [2009] ZACC 19.
6. *Hoffmann v South African Airways* 2001 (1) SA 1 (CC)
7. *IMATU and another v The City of Cape Town* 2005 (11) BLLR 1084.
8. *National Coalition for Gay and Lesbian Equality V Minister of Home Affairs and Others* (2000) 2 SA 1 CC.
9. *Nkwentsha v Minister of Law and Order, Republic of South Africa and Another* (554/86) [1988] ZASCA 33
10. *Larbi-Odam and Others V MEC for Education (North-West Province)* (1998) 1 SA 745 CC
11. *S v Makwanyane and Another* (CCT3/94) [1995] ZACC 3