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A Mental Disorder of a kind or degree warranting confinement: examining justifications for psychiatric detention.

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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.

Winterwerp v the Netherlands, Application no. 6301/73,
judgment of 24 October 1979, para 39, emphasis added.

Introduction: Re-Thinking the Need for Regulation of Detention

These comments by the ECtHR are well known. While there has been considerable litigation in Strasbourg as to the required procedures for detention of 'persons of unsound mind' under Article 5(1)(e) of the ECHR,¹ there has been much less discussion of the substance: what, precisely, is a mental disorder 'warranting compulsory confinement'? Certainly, the court has held that people may be detained when they require treatment for their mental disorder, or when they are dangerous because of their mental disorder may be detained even if they are not treatable,² but this is a long way from providing a convincing substantive standard for civil psychiatric detention.

It is of course a fair question how far it is for Council of Europe institutions such as the ECtHR and the CPT to prescribe standards for individual states. Just as individual states have a considerable margin of appreciation in how they phrase their criminal laws, they equally have an appropriate freedom in the establishment of their mental health laws, so long as the results comply with the ECHR. The appropriate role of the Council of Europe institutions is not necessarily to prescribe appropriate standards, but to see that appropriate standards are prescribed.

Too often, it is the case in CoE countries that this process of clear prescription does not happen. Instead, detention becomes a matter of discretion on the part of clinicians and/or social services personnel, with courts, where they are required to approve detentions, becoming little

¹ For a discussion of these cases, see P Bartlett, O Lewis and O Thorold, *Mental Disability and the European Convention on Human Rights* (Leiden: Martinus Nijhoff, 2007), particularly chapter 2.

² See, eg., *Hutchison Reid v the United Kingdom*, Application no. 50272/99, judgment of 20 May 2003, (2003) 37 EHRR 9.

more than a rubber stamping exercise. The criminal law parallel would be a statute allowing imprisonment for severe naughtiness, with it being left to the police to determine what constitutes naughtiness, when it is sufficiently severe, and how long the individual will spend in prison. While there can be no doubt of the good faith of the considerable bulk of mental health and social service professionals (or, in the criminal law parallel, the considerable bulk of police officers), a belief in the rule of law makes this situation unacceptable. Insofar as jurisprudential support is required for that proposition, it is to be found in *Sunday Times v the United Kingdom*, which requires sufficient legislative precision that the citizen may, with legal advice if necessary, reasonably foresee the consequences of his or her actions.³ While foreseeability by the subject is certainly relevant in the context of mental health detentions, the standard is at least as important because of its governance of practitioners: a clear standard is required to ensure that different practitioners will respond to similar cases in similar ways. It is also necessary if procedural protections such as court hearings are going to have any meaning: if a judge is to satisfy himself or herself that statutory criteria are met, he or she must be clear what those criteria are, and what evidence is necessary to demonstrate that they have been met. Absent such clarity, detention becomes a lottery.

The failure of States Party to establish and enforce meaningful criteria for detention suggests that a more robust approach from Strasbourg may be necessary. While the sovereignty of States Party must of course be maintained, meaningful guidance does need to be provided to governments and courts as to what constitutes appropriate substantive standards. Certainly, as the ECHR jurisprudence acknowledges, drafting can never cover all eventualities; but the impossibility of perfection should not be used to avoid insistence on a vast improvement in statutory criteria and their implementation.

The issue clearly has relevance for the ECtHR, but it may also be of relevance to the CPT for at least two reasons. First, the experience of people detained in psychiatric contexts moves considerably beyond the deprivation of liberty. The individual is likely to be subjected for example to non-consensual psychiatric treatment, from highly intrusive chemical treatments sometimes to electro-convulsive therapy. Less discussed in the legal literature is the fact that individuals may be deprived of educational possibilities and social environments that allow for personal development. When individuals are in these environments for a long period of time, their development of self is substantially stunted, often with permanent effects. The long-term institutionalisation of people with intellectual disabilities in much of central Europe, often commencing at a very young age, is a particularly clear example of this latter phenomenon. Further, the disempowerment experienced in psychiatric and similar detentions, and the stigma (including self-stigma) that flows therefrom, is often experienced by people detained as exceptionally violative. These are not simply questions of detention. When bodily integrity is violated by intrusive medical treatments, when a person's environment is sufficiently restricted that personal development is effected, or when a person inappropriately experiences the psychological effects of systematic disempowerment, issues under Article 3 must also arise. While these issues are of concern for anyone admitted to institutions because of mental disabilities, the situation of people who do not meet appropriate admission criteria (either because they do not meet the criteria on admission, or because they no longer do so) is particularly poignant: ex hypothesi they should not be in the institution; therefore the effects of institutionalisation raise particular questions under Article 3. This is consistent with the line of case law that finds the use of force beyond that strictly necessary constitutes a violation of Article 3.⁴ It is

³ *Sunday Times v the United Kingdom*, Application no. 6538/74, judgment 26 April 1979, (1979) 2 EHRR 245, para 49.

⁴ See, eg., *Mouisel v France*, Application no. 67263/01, judgment 14 November 2002, para 48; *Yankov v Bulgaria*, Application no. 39084/97, judgment 11 December 2003, para 120; *Valasinas v Lithuania*, Application no 44558/98, judgment 24 July 2011, para 117; *Van der Ven v the Netherlands*, Application no 50901/99, judgment 4 February 2003, para 62.

difficult to see how the forces described, when exerted on an individual who should not be in an institution, can be other than not strictly necessary.

Second, the CPT is unique in Council of Europe institutions in that it performs site visits and inspections. The CPT, more than any other CoE body, can see how law is implemented in something close to a systematic way, in the facilities it visits. Considerable judicial notice has been taken in the ECtHR of the vulnerability of people in psychiatric hospitals and similar environments,⁵ a set of concerns appropriately reflected in the CPT's visits to psychiatric hospitals, social care homes and similar institutions. This is not necessarily a population that can be expected to press vociferously for its rights. If meaningful standards are to be implemented in practice, then, it must be organisations such as the CPT that ensure that the standards are created and complied with.

The United Nations Convention on the Rights of Persons with Disabilities (CRPD), which came into effect in 2008, creates a new set of complications. Unlike other international instruments relating to mental disability, the CRPD reads in many ways like a standard human rights treaty. Previous international instruments had started from the premise that compulsion based on mental disability (be it detention or compulsory treatment) was justified in at least some circumstances; the issue was articulating and clarifying that permitted area of compulsion. Typically, the justification for such intervention was assumed, or at least not expressly articulated.⁶ The CRPD, by comparison, takes as a starting point that compulsion is not justifiable on the basis of disability.

Article 14(1) of the CRPD provides an example of particular relevance here:

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.** [emphasis added]

It is still early days for the CRPD, and there may be some room for debate as to the meaning of this provision. Early indications are that what is expected however is an uncoupling of detention from disability. Certainly, the existence of a disability per se will not be sufficient to justify detention under the CRPD.⁷ This last point is entirely consistent with the ECHR jurisprudence, which as noted above requires that a mental disability be of a nature or degree warranting confinement. Even this limited reading of the CRPD (and ECHR) requirements remains relevant, however: it would seem that insofar as courts in many countries offer oversight of admission at all, their scrutiny does not seem to extend much beyond whether the individual has a mental disability. Even on a minimalist reading of the CRPD, and even on the ECHR jurisprudence as it had developed before the CRPD, this is not acceptable.

⁵ See, eg., *Herczegfalvy v Austria*, Application no. 10533/83, judgment 24 September 1992, para 82; *Keenan v the United Kingdom*, Application no 27229/95, judgment 3 April 2001, para 111.

⁶ For a clear example of this approach, see CoE Rec(2004)10, in particular recommendations 17 and 18 regarding compulsory admission and treatment of persons with mental disorder.

⁷ This may, perhaps, be consistent with the report of the Committee on the Rights of Persons with Disabilities regarding Tunisia: see Concluding Observations on Tunisia, CRPD/C/TUN/CO/1, 13 May 2011, para 24-5, but it is difficult to know since the legal facts are not clear on the face of the report. The Tunisian report is as yet the only national report of the Committee, so it is difficult as yet to say with precision how its thinking is developing on the issue.

Initial indications are however that the interpretation of Article 14 will go considerably further, holding not simply that disability cannot be the sole reason for detention, but instead that disability may not form any part of the justification for detention.⁸ The precise scope of this view remains as yet unclear. One view could be that the provision means what it says: disability cannot be used as a factor in detention, and in the same way that we do not engage in preventive detention for other people, we may not do so for people with disabilities. This view warrants more than passing consideration. The CRPD emphasises the social model of disability – the view that the limiting factors of disability flow from society’s failure adequately to accommodate difference, rather than factors intrinsic to the disabled person himself or herself. Insofar as this model is convincing, it is not obvious why compulsion of people with disabilities is required, once society adapts itself to the diversity within it. If appropriate services and supports are provided, the argument goes, compulsion will be no more necessary for people with mental disabilities than anyone else. There is much to recommend this view in many circumstances, including those related to psychiatric and related detention. Thus in much of Europe, provision of proper community housing and community support would provide an option likely to be preferred by many people with mental disability. If services are provided that people want, it will not be necessary to force them to use them. For a large number of people in psychiatric and related institutions, this is almost certainly a convincing argument. And if the state refuses to offer services that people do want to use, it is ethically dubious to force them to use services they do not want to use.

This approach is convincing to the extent that the social model is convincing, and many people will find it not entirely convincing. While it seems highly likely that it applies for many people and many situations, it is certainly arguable that, at least with the array of interventions and support mechanisms available even in the wealthiest and most progressive countries, there is a kernel at the core of mental disability that means the social model is not wholly adequate. In this view for some people, in some situations, disability is not just about society’s failure to adapt, and the impairment at the core of the mental disability is relevant to policymaking in some (albeit generally much restricted) circumstances.

Even if this is accepted, it does not follow that compulsory measures are easily justified. It would appear that even in countries with relatively developed health care systems, a minority of people who are detained are grateful for the detention afterwards. In Priebe’s study of service user views a year after hospitalisation in England, only 40 percent of the 396 patients interviewed thought their involuntary admission justified.⁹ This is broadly consistent with the smaller study by Gardiner and Lidz of retrospective approval of admissions in America, where roughly half of the 65 patients who did not think their detention justified when it occurred changed their view over time, but Gardner and Lidz note that even those who retrospectively viewed their detention as justified did not change in the way they felt about the admission: those that were angry at the time of admission were still angry. Even those that viewed their detentions as justified were still not grateful. Gardiner and Lidz view this as flowing from the feeling of injury consequent on the

⁸ See, eg., Annual report of the High Commissioner for Human Rights to the General Assembly. A/HRC/10/49, presented 26 January 2009, para 48-9. See also UN, Office of the High Commissioner for Human Rights ‘Persons with Disabilities’ Dignity and Justice for Detainees Week, Information Note No. 4, (2008) p. 2. Available at http://www.ohchr.org/EN/UDHR/Documents/60UDHR/detention_infonote_4.pdf. Accessed 26 July 09.

⁹ S Priebe et al, ‘Patients’ views and readmissions 1 year after involuntary hospitalisation’ (2009) 194 British Medical Journal 49. The authors consider that this may in fact be higher than the actual number, as roughly half of their original sample dropped out prior to the interview at the one year period.

coercive elements of the detention, and the consequent loss of autonomy.¹⁰ Consistent with this, Katsakou finds treatment satisfaction among those subject to enforced treatment lower than for those not coerced.¹¹ I am not aware of follow-up work done on the patient careers of those who were not grateful after their period of incarceration, but it seems likely given the lower treatment satisfaction that their negative experience will have undermined rather than buttressed the doctor-patient relationship, suggesting that these people will be more hesitant to engage with services in the future. Quite apart from human rights concerns, coercion does have down sides, and these are not necessarily considered in policy-making in this area.

The literature surrounding the detention provisions of Article 14 of the CRPD has at least two caveats warranting consideration. First, it has been argued that while disability is a prohibited criterion, this does not preclude specific characteristics related to the disability from being criteria. Thus while for example schizophrenia could not be a criterion, the inability to control impulse could be.¹² Second, and perhaps closely related, the view of the UN High Commissioner for Human Rights is that notwithstanding the prohibition on the use of disability as a criterion for detention, people with disabilities can nonetheless be subject to preventive detention, but 'the legal grounds upon which restriction of liberty is determined must be de-linked from the disability and neutrally defined so as to apply to all persons on an equal basis.'¹³ These interpretations are neither doctrinally nor practically satisfying. In both cases, the provisions envisaged are likely to be applied disproportionately to people with disabilities, because of characteristics directly related to their disabilities. It is unconvincing to draw a distinction between the disability and the characteristic of the disability, when the characteristic may be a core diagnostic criterion of the disability, and is certainly caused by the disability. Insofar as the concern is that detention of people because of disability is discriminatory – a key concern of the CRPD – it is difficult to see that the problem has been solved: instead, direct discrimination has merely become indirect discrimination. It is difficult to see that this resolves anything. Further, the interpretations emphasise a consistency with the existing approaches. There is perhaps something of a sense that the problem is one of drafting, rather than of substance. Insofar as this is the intent, it must be aggressively challenged. As will be discussed below, the usual justifications for detention are themselves problematic, and require careful analysis. In much of the world, including many Council of Europe countries, meaningful standards of detention do not in fact exist. People with intellectual disabilities may for example be placed in institutions shortly after birth and remain institutionalised for all their lives. This is not a drafting issue, but an issue of substantive human rights; and 'business as usual' should not be considered an option. It remains to be seen how Article 14 of the CRPD will be interpreted; but it must be interpreted to provide real human rights protections for people with disabilities.

The view that the CRPD does not allow for disability to be used as any part of the criteria for detention creates particular difficulties in countries governed by the ECHR. Article 5 of the ECHR precludes deprivations of liberty, subject to certain exceptions, including as part of 5(1)(e), persons of unsound mind. The ECHR therefore creates an exception on the very grounds that the CRPD

¹⁰ See W Gardiner, C Lidz et al. 'Patients' Revisions of Their Beliefs About the Need for Hospitalization' (1999) 156 *American Journal of Psychiatry* 1385; and W Gardner and C Lidz, 'Gratitude and Coercion between Physicians and Patients' (2001) 31 *Psychiatric Annals* 125.

¹¹ C Katsakou et al. 'Treatment Satisfaction among Involuntary Patients' (2010) 61 *Psychiatric Services* 286, 290. This study also finds that the relevant measure of coercion is the perceived coercion by the service user, not the formal legal mechanism, reminding us of the complex relationship between legal mechanisms and the experience of coercion.

¹² See R Kayess and P French, 'Out of darkness into light? Introducing the Convention on the Rights of Persons with Disabilities' [2008] HRLR 1 at 21.

¹³ Annual report of the High Commissioner for Human Rights to the General Assembly. A/HRC/10/49, presented 26 January 2009, para 49.

would appear to prohibit. It is difficult to see how the sort of 'non-discriminatory' criteria proposed by the UN High Commissioner could be instituted in Council of Europe countries, consistent with Article 5. The conflict of laws here does not appear to have been recognised during the development of the CRPD, and it is not obvious how the tension between the two instruments will be resolved.

While it must be acknowledged that CoE institutions are to implement CoE instruments, some cognisance of the CRPD and the developing jurisprudence of the CRPD Committee is necessary. The EU and all CoE member states are also signatories of the CRPD, and at the very least, integration of requirements must be such that it is possible for parties to both conventions to fulfil their obligations under both conventions: it is not acceptable that one system positively require states to do X, and the other system to prohibit states from doing X. Even under the strongest readings of article 14 of the CRPD, this is not necessarily a problem for the ECHR, since article 5(1)(e) of the ECHR allows but does not require the detention of persons of unsound mind. If this distinction is relied upon, it is possible that at least as regards detention of persons of unsound mind, 5(1)(e) becomes a dead letter, with the detentions it permits precluded in practice by the CRPD. While this is a logically consistent result, it would lead to the result that the primary human rights instrument in Europe and the most important regional human rights instruments in the world would be silent on a fundamental area of human rights for people with disabilities. This would be, at the very least, a surprising and disappointing result.

However the CRPD is eventually interpreted, it is clear that much clearer justifications will be required when people with mental disabilities are detained, if indeed such detention is permitted at all. It was argued above that the situation based on the Council of Europe institutions similarly argues for clearer articulations of detention criteria. To this degree, the overall direction of travel of the two conventions is broadly similar, even if full integration of CRPD and ECHR approaches may prove problematic.

While it will, in the end, be for individual States Party to determine the relevant legislation within their jurisdictions within the frameworks described above, a brief overview of the options and the potential pitfalls of those criteria may be of assistance.

Criteria for Detention

Status Approaches

Status approaches allow detention of individuals based on a condition of body or mind, for current purposes generally having an intellectual impairment, or a psychiatric diagnosis. While detention under the *Winterwerp* criteria require clear evidence by a medical professional of such a condition prior to detention as a person of unsound mind under Article 5(1)(e), such a status is not meant to be a sufficient condition for detention. As noted above, the condition is meant to be 'of a kind or degree warranting compulsory confinement'- typically some combination of need for treatment, dangerousness to self or others, and mental incapacity. As further noted above, however, while the Ministers' Recommendation of 2004 includes a combination of these factors, along with requirements that the views of the individual be taken into account and that the admission is the least restrictive option available,¹⁴ domestic legislation often does not include these criteria. Clearly, however, failure to include additional criteria such as those listed in the 2004 recommendation cannot be considered *Winterwerp* compliant.

¹⁴ CM(2004)97, Art 17.

Even if legislation does include additional such as those contained in the 2004 recommendation, it is not obvious how carefully the criteria are actually applied. Systematic research as to the application of national criteria is relatively scarce, but anecdotal reports leave an impression there are some countries in the CoE where people are detained, either according to the law or de facto, often for long periods of time, where there has been no obvious reference to the additional criteria of the sort noted. These impressions correspond to the anecdotal reports of practitioners and human rights activists in many CoE countries. Insofar as this represents an accurate picture, the result is akin to the status approach, and ought to be of considerable concern to the human rights organisations in the CoE. This would not constitute compliance with the ECHR jurisprudence, let alone CRPD standards.

The requirement in *Winterwerp* that a diagnosed mental illness is a condition precedent for detention under article 5(1)(e) raises the questions noted above regarding interface with the CRPD, insofar as Article 14 would appear to require the uncoupling of criteria of detention from disability. The criteria for detention discussed in the following sections of this paper, when they appear in the legislation of CoE states, include a requirement for a mental disorder to be present, consistent with the *Winterwerp* criteria. As the CRPD may require us to move away from this criterion, the discussion that follows will consider both the application of the criteria when mental disorder is a further condition precedent to detention, and when it is not.

Dangerousness to self or others

As noted above, the ECtHR has expressly stated that the detention of a dangerous person with mental disorder is justified under Article 5(1)(e). Indeed, such justification is justified even if no effective treatment exists.¹⁵ In this it would seem to be in conflict with the 2004 Recommendation of Ministers, which would require both evidence of dangerousness and a therapeutic purpose (along with a requirement of least restrictive alternative, and consideration of the views of the potential detainee) prior to detention.¹⁶ The dangerousness requirement is contained, in some form or other, in many of the relevant domestic laws relating to detention of persons with mental disabilities.

It is a problematic approach, in that it re-enforces the myth that people with mental disabilities are dangerous, a highly stigmatising stereotype. While studies (mainly in America) have shown that people with mental disabilities are slightly more dangerous than average, the difference is marginal; and the proportion of violence caused by people with mental disabilities is small. It is also on its face discriminatory: societies do not detain people based on their dangerousness in the future; instead, the individual is left at large until violence or other criminal behaviour actually occurs, at which point the state can intervene. Particularly given the problems of prediction noted below, it is not obvious why detention of people with mental disabilities is not subject to the same approach.

'Dangerousness to self or others' is frequently recited uncritically as a unified phrase, but the theoretical justifications for intervention to protect the self are quite different than to protect others. The protection of self is largely a paternalist justification, where the protection of others is a part of the state's policing role, ensuring public safety. Given the state's different interests in these categories, the approach to intervention should arguably be quite different. In particular, it is fair to ask what the justification for intervention in the interests of protection of self is. Certainly if an individual understands the risks to himself or herself of remaining outside a psychiatric institution, it is fair to ask why he or she should not be allowed to run those risks. If an individual is not able to

¹⁵ *Hutchison Reid v the United Kingdom*, Application no. 50272/99, judgment of 20 May 2003, (2003) 37 EHRR 9.

¹⁶ Rec(2004)10, recommendation 17(1).

understand, the argument may perhaps change; but that is a question of whether the individual has capacity, a subject that will be discussed further below.

It is not self-evident that it is a theoretically defensible requirement, at least insofar as it relies on prediction of dangerous behaviour rather than violent behaviour actually performed. Decisions based on the impressions of psychiatric professionals are roundly criticised as inaccurate, sometimes little better than chance. More formalised systems are often based on criteria such as race, sex, age, or social class. These raise obvious human rights problems. How would we defend a system where the decision to confine was based, even if only in part, on the basis that an individual was black, male, young or poor? Such systems may also be quite accurate for classes of people, but problematic to apply in individual cases. Thus we know that statistically, women are better drivers than men; but that does not necessarily tell us much about whether a given man is a better driver than a given woman. Similarly, knowing the likelihood of dangerousness in a class of individuals defined by a variety of demographic variables does not necessarily tell us whether a given individual in that class will be dangerous or not.

Some tools for the assessment of dangerousness include consideration of the individual's personal history. While this has the advantage of moving the calculation out of the realm of broad demographic criteria into factors associated with the individual, it does not change the fact that the criteria are unchanging: one's history, like one's race or sex, does not change over time. It is therefore likely to be very difficult, once one has scored high enough on the dangerousness assessment to justify detention, ever to fall below that threshold: there are too few variables that are open to change during the process of detention. If these tools are relied upon, it may well be that the individual will be detained for a very long time.

Some improvements have been made in predictions of dangerousness in the last decade or so, but they remain weak. The MacArthur scale developed in the United States is the best available. They divide dangerousness into a five-point scale. If detention were restricted to the most dangerous – people scoring 5 on the scale – one in eight people detained would not be violent in the following year, and only 27 per cent of the violence caused by people with mental disabilities would have been identified. Including people scoring 4 on the scale would increase the percentage of violent people detained to 59, but 44 per cent of those scoring 4 would not go on to be dangerous, so that an increasingly large number of people would be detained who would not go on to be dangerous. We would find these numbers unacceptable in the context of wrongful convictions and detentions of criminals; it is not obvious why they would become acceptable for people with mental disabilities.

The MacArthur scale is the best predictor we currently have; but its authors acknowledge that it is too complex to be used in a clinical setting. The tools for dangerousness prediction that can be used at this time are *less* accurate than the MacArthur scale, and the consequent numbers of false positives and false negatives for dangerous will in practice therefore be higher than those noted above.

Statutes adopting a dangerousness standard tend to be poorly drafted, leaving much to the discretion of admitting physicians and social services staff, and no clear criteria for the courts to use for subsequent assessment. For this reason, it is worth citing the criteria in Ontario, Canada, which uses a dangerousness standard and does provide at least some measure of clarity:

15(1) 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

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.¹⁷

No doubt other criteria could be adopted, but the Ontario criteria do have the advantage of clear drafting.

As discussed above, it may be the case that the CRPD will require the uncoupling of detention from disability, but will allow some of the criteria traditionally used alongside disability to continue to justify so long as they are equally applied to people without disabilities. In this context, the question would be whether dangerousness could be used as a criterion of detention generally, and not merely for people with disabilities.

In terms of the development of predictive tools, this might be possible. As noted above, mental disability is not a particularly good predictor of dangerousness, so its removal from isometric tests would not necessarily undermine the predictive value of the test. Further, comparable instruments are in use in parole and similar hearings for people without mental illness. If we wish to lock up people on the basis of dangerousness simpliciter, that could presumably be done.

Whether it is desirable is of course a quite different question. It is difficult to imagine that it will be politically attractive to the population as a whole, a significant number of whom may find themselves falling under the demographic variables or personal history variables that predict future dangerousness, and the number of false positives (ie., people showing up as dangerous on the instrument when they would not actually be violent in fact) would be likely to prove highly contentious.

Such objections are important, but they raise a different question: these are precisely the difficulties that exist already when this test is applied to people with mental disabilities. It is fair to wonder why they would be unacceptable if imposed on the population as a whole, but are considered acceptable if imposed on the community of people with mental disabilities. Is there an answer other than discrimination?

Need for Treatment

Psychiatric hospitals are considered to be places of medical treatment, and the availability of treatment is used as a criterion for detention in both the 2004 CoE Recommendation¹⁸ and some domestic legislation.¹⁹

¹⁷ RSO 1990, c M-7.

Certainly, it may make sense that the availability of treatment is used as a part of mental health legislation, and may be helpful in determining, for example, where an individual who has become subject to detention should be detained, although whether the individual ought to be subject to compulsory treatment is a different set of questions, considered in another paper in this collection, and whether it makes sense to admit the individual to a psychiatric hospital in the event that he or she will refuse the relevant treatment is at best doubtful.

Using the need for treatment as a criterion of detention, and particularly as the primary criterion of detention, is much more problematic. Certainly, after *Winterwerp*, it is not any mental disorder that will justify detention, but only one that warrants detention (implying, no doubt correctly, that some mental disorders do not warrant detention). This suggests that for purposes of detention, there must be a serious disorder, for which an appropriate and effective treatment is available. Drawing criteria around these factors will be nigh on impossible. How serious is serious? How effective is effective? It is difficult to see how a meaningful drafting standard can be reached for these issues.²⁰

The question of discrimination also arises once again. Societies do not generally detain people for treatment, except for people with mental disabilities. Why would this distinction be justified, particularly in the event that the individual understands the proposed treatment and does not want it?

In the context of the CRPD, the question of indirect discrimination seems particularly problematic here. If the CRPD is meant to require the uncoupling of disability from detention, it is difficult to see that a detention criterion that refers to the need for treatment can stand. The treatment by definition will be treatment for the mental disability that affects the detainee. To claim that one is not detaining on the basis of disability but instead for 'health' or 'treatment', when the treatment is for the disability in question is pure sophistry.

Capacity

In recent times, arguments have been made to base psychiatric and related detention on the capacity of individuals: if they lack the capacity to decide admission, they may in at least some circumstances be admitted under compulsion; if they do not, they may only be admitted with their agreement.²¹ In much of western Europe, North America and Australasia, capacity has in recent years been seen as a progressive way forward in regulation of mental disability, at least partly because it was perceived as non-discriminatory: societies do compel people without capacity, whatever the reason for that lack of capacity; it is therefore non-discriminatory to use it as a standard of compulsion for people with mental disabilities. Consistent with this, some of the academic literature relating to capacity-based detention laws argue that if the individual lacks

¹⁸ Rec(2004)10, recommendation 17(1)(iii).

¹⁹ See, eg., Mental Health Act 1983, s 3(2)(d) [England and Wales], as amended 2007.

²⁰ For a discussion of these issues in the related context of compulsory treatment, see P Bartlett, 'The Necessity must be convincingly shown to exist: Standards for compulsory treatment for mental disorder under the Mental Health Act 1983', forthcoming *Medical Law Review* (2011), doi:10.1093/medlaw/fwr025. This paper is/will be available on open access.

²¹ See J Dawson and G Szmukler, 'Fusion of mental health and incapacity legislation', 188 *British Journal of Psychiatry* (2006) 504. Capacity forms part of the admission criteria in both Scotland (see Mental Health (Care and Treatment) Act (Scotland) 2003, 2003 asp 13, s. 36(4)(b)) and France (Loi no 90-527 du 27 juin 1990, Art.L.333), although both these statutes have additional requirements prior to detention.

capacity, the decision to admit should not be automatic, but should reflect the decision the individual would have made had he or she had capacity. The Scots and French legislation that relies in part upon capacity does not use this approach, but does include other safeguards as to the severity of the mental disorder before an individual is admitted compulsorily.

Capacity must nonetheless be approached with considerable caution. The usual articulation of capacity includes not merely requirements that the individual be able to understand the information relevant to a decision, but also that he or she appreciate the consequences of making the decision in question. This last criterion is remarkably flexible, and has led to allegations that capacity means agreeing with the psychiatrist.²² While there is some evidence that the test may be administrable with reasonable consistency,²³ there does not appear to be a large-scale trial of this question. Similarly, while the one study of service user views of decisions based on show a remarkable retrospective approval rating in England,²⁴ the sample size of the study is small – only 35 patients – and it remains to be seen whether this finding can be generalised.

Concerns regarding the capacity test further flow from the fact that, implicitly, it is the test used in the detention of large numbers of persons with learning disability in central Europe. The result is the long-term detention of people in children's institutions, social care homes and similar institutions for long periods of time. The reasons for this are various. In part, they flow from an ossified conception of capacity, where capacity is largely conflated with the presence of the mental disability: there often appears to be little or no meaningful determination of whether an individual actually has capacity, once the existence of a learning disability or, often, mental health difficulty is identified. Further, there appears to be no concept of decision-specific capacity determination: a decision that an individual lacks capacity affects their entire life, depriving them of all decision-making authority. Finally, there appears to be no tradition of making the decision that the individual lacking capacity would have made if competent, although this set of questions quickly collapses into the issue of the choices that are available on the day: in countries where there is little if any community-based supported accommodation for people with mental disabilities, the determination that institutionalisation is in the 'best interests' of the individual appears a foregone, if macabre, conclusion.

If there is any thought to using an improved conception of capacity as a detention criterion in these countries, serious thought will need to be given to questions of implementation. This will be pivotal whatever criteria are adopted, of course, but it is a particular concern in the event that incapacity is chosen. The language of incapacity already has a substantial history in these countries, and absent considerable work in re-orienting the workforce, significant change is unlikely to occur.

Capacity raises particular difficulties under the CRPD. Article 12(2) specifically provides that individuals have the right to 'enjoy legal capacity on an equal basis with others in all aspects of life.' Under some interpretations, this means that individuals never in law lose capacity. If this interpretation is adopted, capacity-based detention criteria would be in violation of the Convention. Even if Article 12 is given a more flexible interpretation, the same problem regarding uncoupling of disability from detention under Article 14 arises as has been noted previously: it is difficult to see that the incapacity can sensibly be separated from the mental disability, given that it is the mental

²² For a critical analysis of capacity as a criterion for psychiatric detention, see P Bartlett, 'The Test of Compulsion in Mental Health Law: Capacity, Therapeutic Benefit and Dangerousness as Possible Criteria' (2003) 11 Med L Rev 326.

²³ R Cairns and others, 'Reliability of Mental Capacity Assessments in Psychiatric In-patients' (2005) 187 Br J Psychiatry 372.

²⁴ G Owen and others, 'Retrospective Views of Psychiatric In-patients Regaining Mental Capacity' (2009) 195 Br J Psychiatry 403.

disability that is the direct cause of the incapacity. Insofar as the use of the disability as a criterion is discriminatory, therefore, the use of incapacity as a detention criterion therefore merely moves direct discrimination into indirect discrimination.

Here, as in all the detention criteria, the question remains as to the degree to which the use of mental disability is a discriminatory criterion in detentions and other compulsory interventions, reviving the question of whether the social model really can answer all issues relating to mental disability. People with mental disabilities living in the community may well be extremely vulnerable. While, consistent with the social model of disability, it is certainly appropriate to regulate the remainder of society to ensure that these people are not taken advantage of, it is fair to wonder whether there are at least some limits to such interventions. In the event that the individual is manifestly lacking capacity, for example, and unable to organise basic care for themselves, it is fair to wonder whether it is justifiable to introduce that basic care even if some form of compulsion is required. This is not to say that institutionalisation should be permitted uncritically in these circumstances (although some would argue that sufficient intrusion may sometimes be necessary to a degree that would constitute a deprivation of liberty under ECHR article 5 and thus, presumably, CRPD article 14), but it is to say that society may not need simply to let the individual rot in these circumstances. Indeed, intervention may perhaps be required under the CRPD's provisions regarding protection from exploitation, violence and abuse (art 16). The presence of incapacity seems relevant here: people with disabilities who are capable of making their own decisions should presumably be left to do so in these circumstances. When the individual lacks capacity, the issues are not so clear. It is unclear how the tensions between these articles and article 12's right to the enjoyment of capacity will be worked through.

Least Restrictive Alternative

Consistent with much of the academic literature, the 2004 recommendation states that detention should be pursued only if it is the least restrictive alternative available.²⁵ While this is unobjectionable (and indeed highly desirable), it begs questions as to how the least restrictive alternative is to be considered. Its context in the 2004 recommendation suggests that it is the alternatives available on the day that are at issue. In many central European countries, however, the only option available on the day may be institutionalisation, since there is little if any supported community housing available, and little additional funding to families to provide home care for their loved ones. The effect of focussing only on the options available on the day is that it creates no impetus for change: on the day, noninstitutional options will not be available ever, unless pressure is placed on governments to develop those services. In this sense, in much of Europe, least restrictive alternative is not actually a very meaningful concept, as it is currently construed. At the same time, as discussed in the introduction to this paper, it is vital to the understanding of article 3, since force on a detainee beyond that which is necessary raises the prospect of an Article 3 violation.

Conclusion

However the CRPD is interpreted, it must be the case that much more clarity and transparency of justification will be required for detentions of people with mental disabilities in the future, if such detentions are permitted at all. Given the intrusiveness and dehumanizing effects of many institutions, issues do arise under Article 3, in particular for those people who are not appropriately admitted to the institution. It is therefore appropriate that the CoE institutions, including the CPT, press for considerably enhanced statutory governance of admissions to psychiatric hospitals, social care homes, and similar institutions, and it is appropriate given the

²⁵ Rec(2004)10, rec 17(1)(iv).

vulnerabilities of the populations in question that the CPT make reasonable efforts to take into consideration the implementation of the laws.