

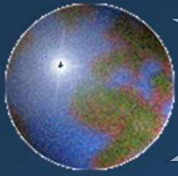
Unfinished Business: Reforming Hong Kong's Mental Health Ordinance to Comply with International Norms

Presentation for :

Compulsory Mental Health Treatment In Hong Kong:
Which Way Forward?

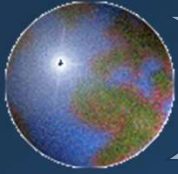
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Hong Kong's Mental Health Ordinance is overdue for reform By now, it should have undergone a comprehensive review in light of:

- (1) 1992: Enactment of the Bill of Rights Ordinance (binds the HK government and public authorities; incorporates most of the ICCPR into HK's domestic law);
- (2) 1995: Disability Discrimination Ordinance (prohibits unfavorable treatment on the ground of disability);
- (3) 1997: HK Basic Law came into force (incorporates ICCPR into HK's regional constitution (BL Article 39) and also includes a separate provision protecting liberties of HK residents (BL Article 28); and
- (4) 2008: Convention on the Rights of Persons with Disabilities (CRPD) applied to Hong Kong by the PRC. HK's MHO conflicts with many provisions in the CRPD.



Why has HK not reformed the Mental Health Ordinance?

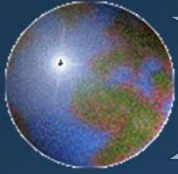
Governments rarely initiate reforms unless there is strong pressure to do so – either from litigation or lobbying.

Individuals who may be adversely affected by the MHO lack political power; tend to be ignored or shunned by the public.

Consider the example of: *K, Y, and W v. Secretary for Justice* [2000] 3 HKLRD 777 (HK District Court) which found that branches of the “disciplined services” were routinely violating the DDO by excluding job applicants based on the mental health records of the applicants’ relatives.

Even after litigation (with assistance from EOC), some government departments (e.g. police) tried to continue the discriminatory policy.

Many members of the public strongly sided with the government; the case revealed the depth of prejudice and many misconceptions.



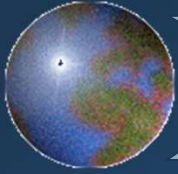
Convention on the Rights of Persons with Disabilities (CRPD)

“Paradigm shift” – embraces the social & human rights models; Inclusive drafting process generated a detailed & progressive treaty.

But governments not prepared to fully embrace the treaty and many disagreements on the interpretation.

The provisions on legal capacity and compulsory mental health care have proven to be particularly contentious.

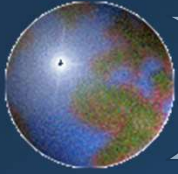




Summary of CRPD Art. 12: Governments must:

- 1 Reaffirm that PWDs have a right to recognition everywhere as persons before the law.
2. Recognize that PWDs enjoy legal capacity on an equal basis with others in all aspects of life.
3. Take appropriate measures to provide access by PWDs to the support they may require in exercising their legal capacity.
4. Ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse.

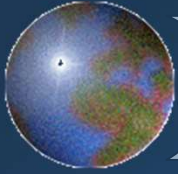
In particular . . .



Art. 12 (4) provides that states must 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.

The Committee on the Rights of Persons with Disabilities insists that adult guardianship be abolished but many states interpret Article 12(4) differently.

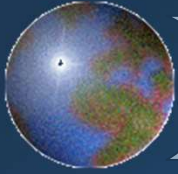


CRPD Article 13 is also relevant – access to justice for PWDs

MHO is very thin (in my view) when it comes to safeguards.

CRPD Article 14 – Liberty and security of the person:

1. States Parties shall ensure that PWDs, on an equal basis with others:
 - a) Enjoy the right to liberty and security of person; and
 - 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.**



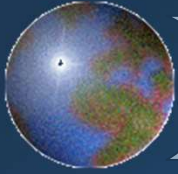
Additional relevant articles in the CRPD

Art. 15: No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his or her free consent to medical or scientific experimentation.

Art. 17: Every PWD has a right to respect for his or her physical and mental integrity on an equal basis with others

Art. 19: Protects the right of PWD to live in the community.

There has been a vigorous debate on whether these CRPD provisions, taken together, require states to completely dismantle systems of guardianship, detention, and compulsory treatment of PWDs.

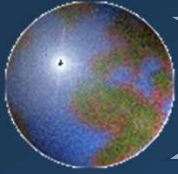


Some states filed Interpretive Declarations upon ratification of the CRPD to preserve the right to use substituted decision-making.

Example from Canada (although considered a leader in supported DM):

“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. . . .”

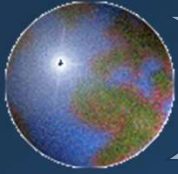


Other States filed reservations to Article 12

Example:

“The Republic of Singapore’s current legislative framework provides, as an appropriate and effective safeguard, oversight and supervision by competent, independent and impartial authorities or judicial bodies of measures relating to the exercise of legal capacity, upon applications made before them or which they initiate themselves in appropriate cases.

The Republic of Singapore reserves the right to continue to apply its current legislative framework in lieu of the regular review referred to in Article 12, paragraph 4 of the Convention.”

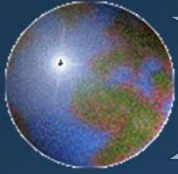


Some states also made it clear that they intended to retain compulsory treatment:

Netherlands: filed declarations to Articles 14 and 15 of the CRPD to allow “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

Australia: interprets CRPD to allow 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”.

Disability rights movement mobilized to condemn such reservations and interpretative declarations.

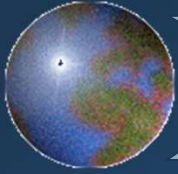


Other states filed no reservations but simply maintained guardianship; detention; and compulsory treatment orders.

Examples: early “Initial Reports” (e.g. Tunisia & Spain & China)

Committee on the Rights of Persons with Disabilities repeatedly sought more information regarding guardianship in “List of Issues” leading up to reviews of states’ initial reports.

Committee also criticized the use of guardianship in Concluding Observations and called for a complete replacement of systems of substituted decision-making in favor of supported decision-making.



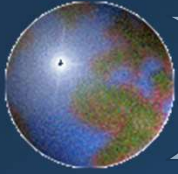
Committee on the Rights of Persons with Disabilities decided to issue a General Comment on Article 12

GC = interpretation of an article in a human rights treaty, based on: expertise of the treaty body; its experience reviewing state reports; and input from governments, international agencies, and NGOs.

October 2009: Invited submissions for day of “general discussion.”

Two working groups: legal content & practical measures for implementing Article 12.

General Comment was issued in 2014 (5 years!) and is controversial. It addresses not only the specific issue of legal capacity but also the relationship between Article 12 and other rights (e.g. those pertaining to liberty, security of the person, and the right to refuse treatment).



Brief Summary of General Comment 1

Governments must not conflate concepts of mental capacity and legal capacity. **Must not deprive a person of legal capacity based upon:**

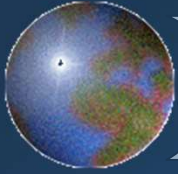
Existence of an impairment/disability (status approach); or

History of “flawed” decisions (outcome approach); or

Because skills are considered deficient (functional approach)

“Best interests” standard (hallmark of many guardianship systems) must be replaced by a system that fully implements person’s will and preferences.

Must repeal (and not just reform) all guardianship laws and replace them with systems of supported decision-making.

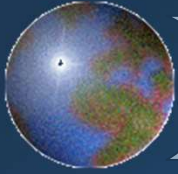


General Comment 1 also connects Art. 12 of the CRPD to Article 14 (liberty) and to Article 25 (right to health)

“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 . . . 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.”

“The right to enjoyment of the highest attainable standard of health . . . includes the right to health care on the basis of free and informed consent. States parties have an obligation 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.”

HK government can expect rigorous questioning on the provisions and operation of the MHO at its next review. Recent reviews indicate that the Committee will object to anything less than full compliance with GC 1.

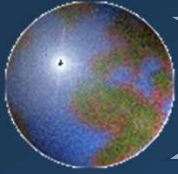


In its last review of HK (2012), the Human Rights Committee made the following request:

Please include information on the number of persons deprived of their liberty in psychiatric hospitals and other institutions for persons with psychosocial disabilities. What is the situation with respect to alternative forms of treatment, such as community-based rehabilitation services and other forms of outpatient treatment programmes? (para 13).

HK's response: approximately 800 patients currently detained at the psychiatric in-patient units . . . on the basis of medical testimony that the patient is suffering from mental disorder of a nature or degree which warrants his/her detention in a mental hospital for observation (or for observation followed by medical treatment) . . .

(For comparison purposes: approximately 90 convicted persons compulsorily detained in psychiatric units of Correctional Services Dept.)

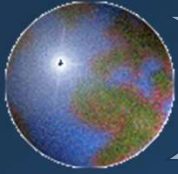


Since its last review of HK, the Human Rights Committee has adopted General Comment 35, interpreting on Article 9 of the ICCPR (liberty and security of the person):

While calling for revisions to “outdated laws and practices in the field of mental health,” the HRC did not go as far as the Committee on the Rights of Persons with Disabilities. It does not consider detention “arbitrary” whenever disability is a factor.

GC 35 states that 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.” Such detention should be applied as a measure of last resort, for the shortest appropriate period of time, and accompanied by procedural & substantive safeguards.

Some disability rights groups have strongly criticized GC 35 (they did lobby members of the HRC but were not successful in persuading them to follow the approach of the Committee on the Rights of Persons with Disabilities).

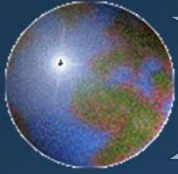


A few examples from the MHO demonstrates the need for reform.

The stated purpose of the MHO violates the letter and spirit of the CRPD.

“To amend and consolidate the law relating to mental incapacity and the care and supervision of mentally incapacitated persons, to provide for the management of the property and affairs of mentally incapacitated persons, to provide for the reception, detention and treatment of mentally incapacitated persons who are mentally disordered persons or patients, to provide for the guardianship of such patients and for mentally incapacitated persons generally, to make provision for the giving of consent for treatment or special treatment in respect of mentally incapacitated persons who have attained 18 years of age, to provide for the removal of objectionable terminology relating to mental incapacity in other statutory provisions and to provide for matters incidental or consequential thereto.”

Despite the stated purpose, there is a great deal of “objectionable terminology” in the MHO, as well as provisions violating HK’s obligations under international law (even if implemented with the best of intentions).



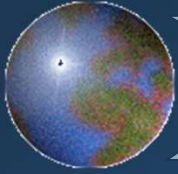
Definitions in Section 2 are also broad, outdated, and confusing:

Mental handicap: “sub-average general intellectual functioning with deficiencies in adaptive behavior”; a **mentally handicapped person** is “a person who is or appears to be mentally handicapped”.

Mental disorder: “(a) mental illness; (b) a state of arrested or incomplete development of mind which amounts to a significant impairment of intelligence and social functioning which is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned; (c) psychopathic disorder; or (d) any other disorder or disability of mind which does not amount to mental handicap.”

Mental incapacity defined as: (a) mental disorder; or (b) a mental handicap and “mentally incapacitated” . . . “shall be construed accordingly”.

Yet the term **mentally incapacitated person** is defined rather differently as. . .



Definitions in Section 2 (continued):

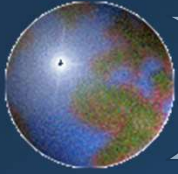
The term **mentally incapacitated person** is defined in Section 2 as follows:

(a) for the purposes of Part II, (entitled “Management of Property and Affairs of Mentally Incapacitated Persons”): “a person who is incapable, by reason of mental incapacity, of managing and administering his property and affairs; or

(b) for all other purposes, a patient or a mentally handicapped person, as the case may be.”

And who is a “**patient**” for the purposes of the ordinance? A “person suffering from or appearing to suffer from a mental disorder.”

These extremely vague (sometimes circular) definitions can have real consequences for a person’s right to liberty and physical integrity



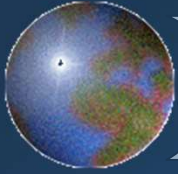
Reception, Detention & Treatment of Patients (Part III of MHO):

Section 30: “Voluntary” patients

s. 30 (1) considers a patient to be “voluntary” if s/he “appears to require treatment in a mental hospital” and desires treatment.

However, pursuant to s. 30 (2) (a) the “voluntary patient” does not necessarily have the right to leave the hospital when s/he wishes to do so. Rather, s/he only becomes **legally entitled** to leave 7 days after giving written notice of the intention to leave the hospital.

In contrast, if the medical superintendent decides that a voluntary patient does not require treatment, the voluntary patient can be **required** to leave the hospital within 72 hours (see s. 30(2)(b)).



Part III of the MHO (continued): Sections 31 & 32

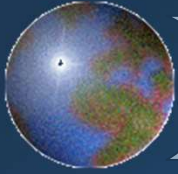
Legal threshold for detaining a patient “for observation” is very low.

Section 31(1): “An application may be made to a District Judge or magistrate for an order for the detention of a patient for observation on the grounds that the patient (a) is suffering from mental disorder of a nature or degree which warrants his detention in a mental hospital for observation (or for observation followed by medical treatment) for at least a limited period; and (b) ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons.”

The application is “founded” on the written opinion of a registered medical practitioner who has examined the individual within the previous 7 days.

Unless the individual requests it, the judge need not see the individual.

Although s. 31 is limited to 7 days, s. 32 can extend detention for up to 21 additional days (if 2 registered medical practitioners certify it is “necessary”).



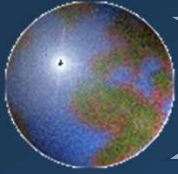
Part III of the MHO (continued): long-term detention

Section 36 is particularly worrying. It empowers the District Court to order long-term detention of a "voluntary patient" or a patient who has been detained under other sections of the MHO, so long as the patient has been examined by 2 registered medical practitioners who are of the opinion that:

“(i) the patient is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in hospital; and

(ii) 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.

In my view, Sections 31, 32, and 36 do not meet the requirements of General Comment 35 (interpreting Article 9 of the ICCPR) Also clearly violate several provisions in the CRPD.



Next steps . . .

Statutory language may (or may not) reflect what occurs in practice.

But the Mental Health Ordinance is long overdue for reform.

A comprehensive review, of both law and practice, should be initiated, preferably with assistance from the Law Reform Commission and practitioners.

Questions?