

**COMPULSORY MENTAL HEALTH INTERVENTIONS AND THE CRPD, BY
ANNA NILSSON (HART, 2021)
THE RIGHT TO BE PROTECTED FROM COMMITTING SUICIDE, BY
JONATHAN HERRING (HART, 2022)**

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Although not designed to be read together, these two works complement each other interesting ways in addressing obligations upon the State in the context of crisis.

The first, by Anna Nilsson, Postdoctoral Fellow at the Faculty of Law, Lund University, is based in large part upon her doctoral thesis, and is the more ambitious in scope. Motivated, as she describes, by a conflict between two competing positions within the current debate over the future of coercive psychiatry, the book seeks to articulate a framework for permissible compulsory care using the model of proportionality developed by Robert Alexy. For those unfamiliar with his work, it is a reconstruction and theorisation of the German Federal Constitutional Court. It can, perhaps rather crudely, be seen as a refined version of the principles by which the European Court of Human Rights tests whether interference with qualified ECHR rights are justified (i.e. asking whether the interference is in pursuit of a legitimate aim, is necessary in a democratic society, and is proportionate; Alexy adds a second stage, as to whether the policy or practice is suitable in the sense of contributing to the legitimate aim). It also, in a way distinctly unfamiliar to common lawyers, involves the use of formulae to assist in the balancing exercise required at each state.¹

Before she applies Alexy's framework to compulsory care, Nilsson opens with a crisp chapter on the approach to mental health care under the CRPD, serving as a helpful tour d'horizon of the debates, and identifying that the treaty text is silent on the key question, as it neither prohibits nor explicitly permits compulsory mental health care. In this chapter, she focuses, in particular, on the importance, but also the ambiguity, inherent in the concept of 'on an equal basis with others' which attaches to the central CRPD rights in play. She notes that the CRPD Committee has recognised that some state policies may give rise to differential treatment but be justified, so as not to give rise to unlawful discrimination but has "devoted little attention to the question of what standard such justifications must meet" (p.37). A central plank of her argument is that the standard is (or perhaps more accurately should be) that adopted by other UN bodies, namely that:

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¹ For a common law critique of attempts to use a cruder version of such formula – the balance sheet – in determining best interests for purposes of the Mental Capacity Act 2005, see Kong, C., Coggon, J., Dunn, M., & Ruck Keene, A. (2020). An aide memoire for a balancing act? Critiquing the 'balance sheet' approach to best interests decision-making. *Medical Law Review*, 28(4), 753-780. In fairness, Nilsson recognises the potential objection to Alexy's work as attempting to compare the incommensurable (page 102).

“not every differentiation of treatment will constitute discrimination, if the criteria for such differentiation are reasonable and objective and if the aim is to achieve a purpose which is legitimate under the [relevant convention].”²

Nilsson not the first person to have made the argument that the standard UN approach is applicable to the CRPD,³ but her argument is the most sustained and nuanced, using Alexy’s approach to help tease out each of the aspects of the objective and reasonable standard, and hence to provide a framework to evaluate domestic systems of compulsory mental health care. As she makes clear (see p.159) and applying this framework, she considers that the CRPD does permit some form of compulsory care for purposes of protecting the health and life of the person concerned, in the circumstances where an individual is in need of medical care and a free and informed treatment decision cannot be obtained, even though they have access to decision-making support. However, to be consistent, any rule that does apply in domestic law in this regard must apply regardless of whether the situation involves a person with a psychosocial condition. With specific regard to suicide, she proposes that it is possible to produce a consistent argument justifying the use of compulsion for purposes of suicide prevention for people with certain psychosocial conditions, as there is no other group of people at similar risk of ending their lives by their own hands. However, and as Nilsson does throughout the book, she emphasises that any such justification rests crucially on evidence – in this case about the rates of suicide amongst different groups. And, more broadly, the more evidence that there is that voluntary alternatives are as effective as compulsory means in preventing serious deterioration in health or suicide, the harder it will be to justify compulsory care.

As interesting as Nilsson’s argument is, and as helpful as it is in identifying a nuanced way through the debates, it does have two problems. The first is a simple matter of rhetoric. Recourse to Alexy’s abstruse formulae to justify what, in the eyes of a significant minority, is seen as medical torture, does feel close to analysing angels dancing on the head of a pin. It is, at minimum, unlikely to persuade those who are not, at some level, already persuaded – even in inchoate fashion – to the idea that there are some circumstances where intervention is legitimate.

The second is perhaps a matter of timing. Whilst Nilsson does make reference to the UNCRPD Committee’s General Comment 5 on Equality and Non-Discrimination, published in 2018,⁴ she does so only in relatively short compass, perhaps (I speculate here) because it post-dated the bulk of her doctoral work. It is unfortunate she does not engage with it in more detail, because this General Comment adds to a body of evidence suggesting that it is not clear that the UNCRPD Committee does, in fact, subscribe to the same approach as other UN bodies when it comes to

² UN Human Rights Committee General Comment on Non-Discrimination (1989/1994) at paragraph 13.

³ For instance, it was developed by reference to the Mental Capacity Act 2005 by the Essex Autonomy Project team led by Wayne Martin. See Martin, W., Michalowski, S., Jütten, T., & Burch, M. (2014). Achieving CRPD Compliance: Is the Mental Capacity Act of England and Wales compatible with the UN Convention on the Rights of Persons with Disability? If not, what next?.

⁴ CRPD/C/GC/6.

differential treatment.⁵ If this is so, then there is, even on the sometimes rarefied plane of debates in this context, a more fundamental problem to her analysis: namely that the UNCRPD Committee may simply not accept that there could ever be any justification for differential treatment in the context of mental health crisis. Whether the UNCRPD Committee are right in this (both as a matter of interpretation of the Convention, and in a broader, ethical, sense) is a different question, but it would have been interesting to see Nilsson tackling this issue head-on.

These two issues perhaps rather detract from the book's use for those seeking to win arguments. However, they do not stop the book being a very useful tool for those who might be seeking to design principled and evidence-based mental health care regimes, because it provides a helpful set of measures against which to stress test both legislation⁶ and policies.

In his latest book, Jonathan Herring, DW Wolf-Clarendon Fellow in Law at Exeter College and Professor of Law at the Faculty of Law, University of Oxford, takes on a narrower, but intensely problematic, aspect of the terrain covered by Nilsson: namely State obligations towards suicidal⁷ people. Herring explains in his introduction how he was motivated to write the book by his 'astonishment' at how many of his students thought that the appropriate response for a doctor faced with a patient expressing a wish to die was to facilitate suicide, and how the right to die had come to dominate in discussions about suicide and end-of-life questions. His book is a characteristically thoughtful and elegant development of the legal and ethical case for treating those with suicidal thoughts, and the taking of reasonable steps to prevent them attempting suicide. Each chapter takes the form, in effect, of a mini-essay. Some are very helpful convenient summaries, such as the opening

⁵ For a detailed analysis of this argument, see Gurbai, S. (2020). Beyond the Pragmatic Definition? the right to non-discrimination of persons with disabilities in the context of coercive interventions. *Health and Human Rights*, 22(1), 279. General Comment 6 only refers to the concept of objective and reasonable criteria in relation to the situation where reasonable accommodation is denied (see paragraph 27). At paragraph 17, the CRPD Committee identifies that the definition of discrimination within the CRPD "is based on legal definitions of discrimination in international human rights treaties, such as article 1 of the International Convention on the Elimination of All Forms of Racial Discrimination and article 1 of the Convention on the Elimination of All Forms of Discrimination against Women. It goes beyond those definitions in two aspects: first, it includes 'denial of reasonable accommodation' as a form of disability-based discrimination; second, the phrase 'on an equal basis with others' is a new component. In its articles 1 and 3, the Convention on the Elimination of All Forms of Discrimination against Women contains a similar but more limited phrase: 'on a basis of equality of men and women'. The phrase 'on an equal basis with others' is not only limited to the definition of disability-based discrimination but also permeates the whole Convention on the Rights of Persons with Disabilities. On the one hand, it means that persons with disabilities will not be granted more or fewer rights or benefits than the general population. On the other hand, it requires that States parties take concrete specific measures to achieve de facto equality for persons with disabilities to ensure that they can in fact enjoy all human rights and fundamental freedoms."

⁶ In this regard, it can also be seen as a useful adjunct to the tools developed by David Goddard in his recent, stimulating, book on "Making Laws that Work: How Laws Fail and How We Can Do Better" (Hart, 2022).

⁷ I am very conscious of the linguistic issues here. I am using this term broadly to encompass those with suicidal thoughts, and those who may have taken action upon those thoughts.

chapters on definitional issues, the empirical evidence for the causes of suicide,⁸ and of the arguments for societal responsibility for suicide. Other chapters seek to advance an argument, in particular the chapter on human rights and suicide, which involves a close reading of the case-law of the European Court of Human Rights to develop a thesis that the state's obligations to secure the right to life under Article 2 in the presence of suicide risk extend beyond the paradigmatic position of psychiatric patients. And the last chapter, about euthanasia and suicide, helpfully locates the debates around assisted dying/euthanasia within the wider (often too often lost) context of the 'right' approach to suicide.

As a self-confessed capacity nerd, I turned with particular interest to the sections on capacity in chapters 5 (ethics and suicide) and 7 (the current law on suicide). In crude paraphrase, Herring considers the test for capacity contained within the Mental Capacity Act 2005 does not serve the interests of the suicidal well. I do not dispute this; indeed, there are further avenues Herring could have explored here, including the Strasbourg jurisprudence relating to life-sustaining treatment refusal in the presence of doubts about mental capacity.⁹ Another could have been the phenomenon of capacity being used against those expressing suicidal ideas that has attracted increasing attention over recent years.¹⁰ In this regard, and as discussed in works highlighting that phenomenon, it is deeply problematic that professionals (often, but not exclusively liaison psychiatrists) appear often to be asking themselves whether a person has capacity to take their own life without actually (a) having a clear idea as to precisely what the components of that decision might be;¹¹ and (b) the relevance or otherwise of the question. As I have discussed elsewhere,¹²

⁸ Albeit with a strongly Western-centred focus; more broadly, it would be fascinating to read a book by an author from the Global South on the same theme.

⁹ In *Arskaya v Ukraine* [2013] ECHR 1235, for instance, the ECtHR found that there had been a breach of Article 2 ECHR where a person, S, repeatedly refused to life-saving treatment in circumstances where "*S. showing symptoms of a mental disorder, the doctors took those refusals at face value without putting in question S.'s capacity to take rational decisions concerning his treatment. Notably, if S. had agreed to undergo the treatment, the outcome might have been different [...]. the Court considers that the question of the validity of S.'s refusals to accept vitally important treatment should have been properly answered at the right time, namely before the medical staff refrained from pursuing the proposed treatment in relying on the patient's decision. From the standpoint of Article 2 of the Convention a clear stance on this issue was necessary at that time in order to remove the risk that the patient had made his decision without a full understanding of what was involved.*"

¹⁰ See, inter alia, Beale, C. (2022). Magical thinking and moral injury: exclusion culture in psychiatry. *BJPsych bulletin*, 46(1), 16-19; Aves, W. (2022). If you are not a patient they like, then you have capacity". DOI:10.13140/RG.2.2.34386.84163.

¹¹ Noting in this regard the Supreme Court decision in *A Local Authority v JB* [2021] UKSC 52, in which the Supreme Court emphasised both the relevance of foreseeable consequences as part of the information to be processed, and also (at paragraph 74) that
[t]he importance of P's ability under section 3(1)(a) MCA to understand information relevant to a decision is also specifically affected by whether there could be "serious grave consequences" flowing from the decision. Paragraph 4.19 of the Mental Capacity Act 2005 Code of Practice provides:

"If a decision could have serious or grave consequences, it is even more important that a person understands the information relevant to that decision."

¹² See my blogpost: <https://www.mentalcapacitylawandpolicy.org.uk/capacity-and-suicide/>

in many situations, it is completely irrelevant as to whether or not a person has capacity to take their own life: if the provisions of the Mental Health Act 1983 are likely to be in play, the question is the risk that they are at, not whether or not the risk they are at is (in effect) capacitously caused.

Whilst I found myself nodding in agreement with the majority of the book (and frequently emailing myself materials contained in the footnotes), two issues did niggle. The first is that I felt Herring did skate perhaps too rapidly over the question of whether and when compulsion to prevent suicide was justified. He addresses, in relatively brief compass, the recent Strasbourg jurisprudence¹³ identifying the tension between the right to liberty and bodily integrity on the one hand, and the right to life on the other. However, for my part, I would have welcomed a more granular investigation of this issue, not least because it would have been useful to have a discussion of the extent to which there is (or can be) a conflation in the public policy mind between detention and securing the right to life.¹⁴ That would also have allowed him to tease out another potential argument against zero-suicide policies (addressed in chapter 8), which he only addresses in very glancing terms: namely that it can lead to 'excessive' steps taken to avoid suicide – and especially excessive compulsory steps, which are not only not always effective in preventing suicide, but also can cause harm in and of themselves,¹⁵ Indeed, this is precisely an area where it would have been interesting to see Herring apply the sort of analysis applied by Nilsson in her book to the question of when compulsion can be justified in the interests of securing the right to life.

The second issue is one which, I have to say, I found very surprising, given Herring's usual sensitivity to language. I did wonder when I saw the reference to "committing suicide" in the title whether Herring was going to give an explanation in the introduction as to why he used this term. Suicide has not been a criminal offence in England & Wales since 1961; given the extensive literature on why the term should not be used,¹⁶ it was curious not to see an explanation as to why it was used. It is quite possible that it was, in effect, a sub-editorial decision on the part of the publisher as to the choice of title – if so, it was a revealing one about quite how far we still have to travel.

Nonetheless, despite these issues, I will definitely be putting this book on my reading list for my Law at the End-of-Life course at King's College London as a stimulating, important, and nuanced contribution to an area which can sometimes all too easily be portrayed in unhelpfully crude terms.

¹³ In particular *Fernandes de Olivera* (2019) 69 EHRR 8.

¹⁴ This came through very strongly in the *Rabone & Anor v Pennine Care NHS Foundation* [2012] UKSC 2, the tenor of which could on one view be read as being to the effect that 'keeping the person in hospital means keeping alive; letting the person out of the hospital means letting them die.'

¹⁵ Albeit that, by definition, if the harm is to a person who is still alive, there may be an argument to be had as to whether such harm is a price worth paying to keep another alive.

¹⁶ See, for instance, Nielsen, E., Padmanathan, P., & Knipe, D. (2016). Commit* to change? A call to end the publication of the phrase 'commit* suicide'. *Wellcome open research*, 1.