[The following is a pre-publication version. The final paper is to be published in the *International Journal of Law and Psychiatry*, probably in 2020.]

Articulating Future Directions of Law Reform for Compulsory Mental Health Admission and Treatment in Hong Kong

Daisy Cheung[a],[1] Michael Dunn[b], Elizabeth Fistein[c], Peter Bartlett[d], John McMillan[e], Carole J. Petersen[f]

[a] Faculty of Law, University of Hong Kong, Hong Kong, [b]The Ethox Centre and Wellcome Centre for Ethics and Humanities, University of Oxford, United Kingdom, [c]Centre for Law, Medicine and Life Sciences, University of Cambridge, United Kingdom, [d]School of Law and Institute of Mental Health, University of Nottingham, United Kingdom, [e]Bioethics Centre, University of Otago, New Zealand, [f]William S. Richardson School of Law and Matsunaga Institute for Peace, University of Hawaii at Manoa, USA

This article explores and outlines four possible pathways for law reform in the area of compulsory mental health admission and treatment in Hong Kong: the (i) abolition, (ii) risk of harm, (iii) mental capacity and (iv) consensus pathways. The discussion of each pathway takes into account local challenges in implementation, as well as Hong Kong's international commitments for the protection of rights. In outlining these pathways for reform, the authors intend to also provide a blueprint for regulatory change in other jurisdictions that are in the process of reforming their mental health laws.

Keywords:

[1] Corresponding author at CCT 4.06, Centennial Campus, University of Hong Kong, Pokfulam, Hong Kong. Tel: +852 3917 1850. Email address: dtcheung@hku.hk.

Compulsory treatment

Hong Kong

Mental health

Law reform

UNCRPD

1. Introduction

This article builds on the work of an international conference on the topic of compulsory mental health admission and treatment in Hong Kong (the 'Conference') and explores the pathways for reform in this area. A number of jurisdictions around the world are currently reviewing their mental health laws, in part because of the requirements of international treaties that seek to protect the rights of persons with disabilities. The challenge in the review and reform process is aligning local mental health needs, frameworks and traditions with overarching commitments to treat people with mental illness in ways that safeguard their control over their own treatment, reduce coercive interventions, and protect against arbitrary deprivations of liberty. In outlining four possible pathways for potential law reform in Hong Kong, we intend to also provide a blueprint for regulatory change in other jurisdictions that seek to draw a balance between local needs and international norms. The comparative value of this piece lies not in its direct applicability to other jurisdictions, but in its demonstration of how an exercise like this might be undertaken, and the kinds of considerations that should be taken into account when addressing relevant features of each of the four pathways in alternative local contexts.

Our article proceeds as follows. Part II presents a brief overview of the mental health system and legal framework in Hong Kong. Part III considers Hong Kong's international commitments for the protection of human rights, in particular the International Covenant on Civil and Political Rights ('ICCPR') (which is incorporated into Hong Kong's domestic legal system) and the United Nations Convention on the Rights of Persons with Disabilities ('CRPD'), which has applied to Hong Kong since 2008. Part IV summarises the key local challenges that Hong Kong faces in any attempt at reform. We then set forth, in Part V, four different strategies for reforming mental health law in Hong Kong: (i) the abolition pathway, (ii) the risk of harm pathway, (iii) the mental capacity pathways, and (iv) the consensus pathway. Part VI provides a brief conclusion for the article.

2. The Hong Kong context

2.1 Mental health law

The mental health law regime of Hong Kong is contained in the Mental Health Ordinance (Cap. 136) ('MHO'). The MHO consists of nine parts, covering criminal and civil aspects in relation to both patients with and without mental capacity.[2] The first version of the MHO was enacted in 1960.[3] Although it was enacted after the UK's Mental Health Act of 1959, it retained several aspects of the more archaic forms of the UK's mental health legislation, such as the judicial component of the compulsory admission process and the formal voluntary admission process. The Mental Health Review Tribunal ('MHRT') was not introduced until the Mental Health (Amendment) Ordinance of 1988, which also oversaw the tightening of the

[2] Unlike jurisdictions like the UK, Hong Kong does not have a separate piece of legislation for those without mental capacity.
[3] For a discussion of mental health legislation in Hong Kong pre-1960, see Cheung (2018).

conditional discharge regime.[4] The MHO was substantially expanded in 1997,[5] but no significant amendments have been made since then.

In its current form, many aspects of the MHO remain archaic and unsatisfactory for how persons with mental disability ought to be treated in the 21st century. The legislation is primarily focused on public safety and paternalism, with minimal statutory safeguards to ensure the adequate protection of patients' rights. The compulsory admission and treatment process, for example, takes a highly medical approach, with judicial involvement that amounts to a rubber-stamp and fails as an effective safeguard (Cheung, 2017). The views of patients are largely marginalized, and support for decision-making is essentially absent. As will be discussed further in section 5.4 below, review mechanisms after an individual is detained are insufficient and often ineffective, in particular for short-term detentions, and individuals have no statutory right of access to independent mental health advocates.[6]

2.2 Mental health services

Hong Kong's mental health services are primarily provided by the Hospital Authority ('HA'), a statutory body established under the Hospital Authority Ordinance (Cap. 113) in 1990 to manage public hospital services in Hong Kong. The HA provides a range of mental health services, including inpatient facilities, day hospitals, specialist outpatient clinics and community outreach services. As of March 2017, the HA is currently responsible for the care of approximately 150,000 patients with mental illness (Mental Health Review Report, 2017 at 117). The HA's specialist outpatient clinics are where most of the ambulatory care (both in

[4] See Cheung (2018) for a discussion of the historical background to the enactment of the conditional discharge provisions in the Mental Health (Amendment) Ordinance of 1988.

[5] The existing Part IIIA (Guardianship of Persons Concerned in Criminal Proceedings), Part IIIB (Supervision and Treatment Orders Relating to Persons Concerned in Criminal Proceedings), Part IVB (Guardianship) and Part IVC (Medical and Dental Treatment) were added to the MHO via the 1997 amendment.

[6] For a detailed overview of the problems with the civil aspects of Hong Kong's mental health law, see Cheung (2018).

terms of acute management and maintenance of patients who are stabilised) for patients with mental illness is provided. The number of outpatient attendances in 2015-16 was approximately 808,000, which was around a 7% increase from 2011-12 (Mental Health Review Report, 2017 at 118). In the community, the HA provides medical social worker services, Integrated Community Centers for Mental Wellness, peer support services (in pilot phase), Parents/Relatives Resource Centers, residential care services and day training and vocational rehabilitation services to assist with the rehabilitation and reintegration into society of persons with mental illness (Mental Health Review Report, 2017 at 119-121).

2.3 Other legal and policy mechanisms

In addition, Hong Kong also has a number of other legal and policy mechanisms in place to protect the rights of persons with mental disability. At the constitutional level, the Basic Law and the Hong Kong Bill of Rights Ordinance ('HKBORO') (which was largely copied from the ICCPR) protect the fundamental rights of all persons, including the right to liberty and security of person and the right not to be subjected to inhuman and degrading treatment (HKBORO, Arts 5 and 3). The HKBORO binds the government and all public authorities, including the public hospitals. In addition, the Disability Discrimination Ordinance (Cap. 487) ('DDO') prohibits discrimination on the ground of disability in certain spheres, including employment, accommodation, education, and the provision of goods and services. The DDO applies to both the public and private sectors and thus could be enforced against both public and private hospitals.

The Equal Opportunities Commission ('EOC'), a statutory body established by the Sex Discrimination Ordinance (Cap. 480) ('SDO') in 1996, is charged with the responsibility of

implementing anti-discrimination legislation in Hong Kong. The EOC's functions and powers include, among others, conducting investigations (either self-initiated or pursuant to complaints lodged under the relevant legislation), developing Codes of Practice and drafting proposals to the government for amendments of the relevant legislation when necessary (SDO, ss 64, 69 and 70). The EOC can also grant assistance to litigate claims under the DDO but it has a statutory obligation to attempt to conciliate complaints and this enforcement model tends to limit the amount of strategic litigation (Petersen, 2005). The EOC does not have the statutory power to enforce the ICCPR or the HKBORO and there is no general human rights commission in Hong Kong to fulfil this role. However, an individual who is challenging detention or making an application to the MHRT could apply to the Legal Aid Department for legal assistance.

3. International commitments

Before proceeding to consider possible pathways for change, we must also consider Hong Kong's international commitments for the protection of rights. The key treaties of relevance that apply to Hong Kong include the ICCPR and the CRPD. In this section, we briefly consider what these commitments mean for Hong Kong law.

3.1 ICCPR

The ICCPR was first incorporated into Hong Kong's legal system through the HKBORO and later through Article 39 of the Hong Kong Basic Law, which became the territory's constitutional instrument in 1997. The ICCPR is considered to be the human rights 'gold standard' in Hong Kong, a standard that is used to assess its laws and policies, and to link the

territory to international norms (Petersen, 2007 at 36-37). Its prominence has been underscored by numerous court judgments. Even government lawyers acknowledge that local laws that cannot be interpreted consistently with the ICCPR must be declared invalid when they are challenged in court.[7]

What does such a strong commitment to the ICCPR mean for mental health law in Hong Kong, specifically in relation to compulsory admission and treatment? Article 9(1) of the ICCPR states:

> 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.

In December 2014, the Human Rights Committee adopted General Comment No 35 on Article 9. In relation to mental health laws, the Committee emphasised that any deprivation of liberty had to be necessary and proportionate, and had to be either to protect the individual from serious harm or to protect others. The existence of a disability, in and of itself, cannot justify such deprivation. Where an individual is detained, this must be used only as a last resort, for the shortest appropriate duration, and with sufficient safeguards as established by law. Any deprivation of liberty must be reassessed for its continuing necessity at appropriate intervals, and any individual subjected to detention should be given assistance in accessing effective remedies, such as judicial review of the detention (General Comment 35, 2014 at para 19).

[7] See Petersen (2007) at 35 for an analysis of cases that demonstrate the importance of the ICCPR in Hong Kong courts.

Currently, compulsory powers under the MHO are generally exercised either to protect the individual from harm or to protect others (MHO, ss 31, 32 and 36). In order to be fully compliant with the ICCPR, however, the MHO needs to have sufficient safeguards to ensure that detained individuals are reassessed at appropriate intervals and have access to effective legal remedies.[8] In Hong Kong's most recent report, which was submitted to the Human Rights Committee in 2011, there was no discussion of mental health law and the powers to compulsorily detain and treat individuals with mental illness in the section on Article 9 (Third Report, 2011). In its section on the CRPD and persons with disabilities, the report asserts that the MHO safeguards the rights of patients without any detail or discussion of whether the existing safeguards are sufficient to meet either the requirements of the ICCPR or the CRPD (Third Report, 2011 at para 113). We consider the report submitted to the Committee on the Rights of Persons with Disabilities further below.

3.2 CRPD

The CRPD is the first human rights treaty of the new millennium. It was the result of a broad consensus that existing treaties had not delivered human rights to people with disabilities. Whether one adopts what we characterise below as the 'strong' or the 'weak' interpretation of the CRPD, that point seems indisputable.[9] The CRPD provides the usual array of civil, political, economic, social and cultural rights, but tailors them to the specific situation of people with disabilities. It is not a libertarian document – if anything, quite the reverse.

[8] See Cheung (2018) for an argument that this is currently not the case.
[9] See reports of the United Nations Subcommittee for the Prevention of Torture (SPT) at https://www.ohchr.org/EN/HRBodies/OPCAT/Pages/Documents.aspx; the European Committee for the Prevention of Torture (CPT) at https://www.coe.int/en/web/cpt/states, Validity (formerly MDAC) at http://validity.ngo/resources/, and Disability Rights International at https://www.driadvocacy.org/media-gallery/our-reports-publications/. All accessed 17 October 2018.

States are obliged to provide the legal frameworks, services and programmes to make the CRPD rights a reality.

The CRPD came into force for Hong Kong in 2008.[10] Although the DDO goes some way to prevent discrimination on the ground of disability, there remain many issues that need to be addressed in order for Hong Kong to be considered compliant with the CRPD (Petersen, 2008).

In this article, we consider a number of potential approaches to mental health law reform that may be characterised as compatible with different approaches to the interpretation of the CRPD. In order to clarify our discussion in Part V, we set out here two approaches to the CRPD that have been discussed in the literature.

The first approach, which we are terming the 'strong' interpretation, is the position that any law that permits deprivation of liberty, compulsory treatment or substitute decision-making on grounds which include presence of a mental disorder or disability as a necessary criterion is incompatible with the CRPD.[11] Admission to hospital and the provision of medical treatment are only justified if either:

a) the person being treated gives legally valid consent or, where this is impossible,
b) nothing is done that is inconsistent with their will and preferences.

This is the position taken by the Committee on the Rights of Persons with Disabilities ('CRPD Committee'), the treaty-monitoring body for the CRPD.

[10] The People's Republic of China ratified the CRPD in 2008, and decided to apply it to Hong Kong pursuant to Article 153 of the Basic Law. See Petersen (2008) for a more detailed discussion of the history surrounding China's ratification of the CRPD and its subsequent application to Hong Kong.
[11] See, for example, Bartlett (2012) and Flynn & Arstein-Kerslake (2014).

The strong interpretation is characterised by a commitment to eliminate discrimination on the ground of diagnosis and to maximise the scope for agency of people with disability through the provision of support. In this context, that support may include supported decision-making 'where a designated supporter or supporters help P implement a course of action that is determined by P's own will and preferences in the matter' (Martin et al., 2014 at 11). As such, it may be viewed as being grounded in the social model of disability and in relational models of autonomy, which hold that it is possible to develop strategies for protecting the autonomy of one person by means of the supportive actions of another. P does not need decision-making capacity in order to exercise autonomy: so long as Q can identify P's preferences and ensure that those preferences are satisfied, P's autonomy is realised in that matter.[12]

The second approach, which we are terming the 'weak' interpretation, is the position that a law that permits compulsory hospitalisation or treatment of mental ill-health may, under certain circumstances, be compatible with the CRPD, provided particular criteria are satisfied.[13] This interpretation is characterised by a recognition that mental ill-health can affect decision-making capacity and that, while this fact does not justify denying legal capacity to all people with a mental disorder or disability, it may justify the use of substitute decision-making to protect the best interests of a person with disability, if:

a) supported decision-making cannot be achieved, or
b) satisfaction of apparent preferences is incompatible with the underlying will of the person with disability, or with some other legitimate aim supported by the CRPD.

[12] For an exploration of this position, see Bach & Kerzner (2010) and Flynn & Arstein-Kerslake (2014).
[13] See, for example, Martin et al. (2014) and Dawson (2015).

On the face of it, General Comment 1 excludes the weak interpretation:

> 'On the basis of the initial reports of various States parties that it has reviewed so far, the Committee observes that there is a general misunderstanding of the exact scope of the obligations of States parties under article 12 of the Convention. Indeed, there has been a general failure to understand that the human rights-based model of disability implies a shift from the substitute decision-making paradigm to one that is based on supported decision-making'. (General Comment 1, 2014 at para 3).

> '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'. (General Comment 1, 2014 at para 28)

> The 'will and preference' paradigm must replace the 'best interests' paradigm to ensure that persons with disabilities enjoy the right to legal capacity on an equal basis with others. (General Comment 1, 2014 at para 21)

General Comment 1 deserves careful consideration because it reflects the treaty-monitoring body's view of state obligations under the CRPD. However, General Comments are not binding on governments in the same way that the treaty itself is binding. This particular General Comment has proven controversial. For example, some authors note that the CRPD itself makes no mention of the abolition of substitute decision-making[14] and that the CRPD allows states parties to deny legal capacity to an individual with disability, provided that the relevant provisions of law apply to all persons on an equal basis.

[14] See, for example, Fennell & Khaliq (2011), Richardson (2012) and Lush (2011).

If the strong interpretation is adopted, the MHO clearly is not compliant with Articles 12 and 14 of the CRPD. One of the most obvious examples of this is the compulsory detention and treatment regime, under which individuals are detained for being 'dangerous' to themselves or others. Even if a weak interpretation of the CRPD is adopted, much consideration would need to be given to whether the criteria justifying the use of substitute decision-making can be met. In Hong Kong's initial report to the CRPD Committee in 2010, however, none of the issues identified above were discussed. In relation to Article 12, there was a description of the current guardianship system that did not address legal capacity or substitute decision-making. The discussion of Article 14 did not mention compulsory mental health detention and treatment (Initial Report, 2010 at 63-65, 70-71). Hong Kong submitted a combined second and third periodic report in 2018, which once again largely ignored the difficult issues regarding compulsory treatment (Second and Third Report, 2018). Indeed, the 2018 report incorrectly claims that the MHO protects persons from medical treatment without their freely given and informed consent (Second and Third Report, 2018 at para 17.1). It is likely that the CRPD Committee will challenge this statement and seek more detailed information, such as the number of persons subjected to compulsory treatment, when it reviews Hong Kong's 2018 report.

4. Local challenges

What are the challenges that exist for compulsory mental health admission and treatment in Hong Kong, given the context as discussed above? A clear challenge that needs to be addressed is the regime's lack of compliance with its international commitments under the CRPD and arguably the ICCPR. As discussed above, what it will take to be considered compliant with the CRPD is still very much a matter subject to debate, but in its current form,

with criteria for detention based upon diagnosis and apparent risk, it is likely that significant reforms will have to be undertaken before the Hong Kong regime can begin to consider itself on the path to compliance.

In addition, a number of local challenges can be identified, the most daunting of which is one that also plagues many other jurisdictions – the insufficiency of resources available for the delivery of mental health care in the public sector.[15] This manifests itself in different ways, including high case-loads, lengthy waiting times at specialist out-patient clinics and short consultation times for each patient (Cheung, 2017). Coupled with this is the concern that Hong Kong lacks a comprehensive mental health policy guiding the development of mental health services,[16] together with the sense that there is minimal impetus for change from the government (Lee & Lam, 2015 at 644). This, in turn, has led to great difficulty in pushing for mental health law reform.

Apart from policy and resource restraints, Hong Kong, as a former colonial outpost of the United Kingdom, also faces the difficulty of working with an archaic regime which remains, to a large extent, based on outdated regulatory approaches from the mid-20th century. Much of the current legislation is a result of piecemeal and reactionary amendments, and the last 22 years have not seen any significant moves to bring it in line with modern thinking on mental disability, as discussed above.

In light of these various challenges, there are different avenues that can be taken to move forward with reform. In the discussion below, we propose four pathways to capture these

[15] See, for example, the Bauhinia Foundation Research Centre Report (2017), which focuses on the insufficiency of resources devoted to child and adolescent psychiatric care, and Chan (2017).
[16] See, for example, Tsang (2007), Lee & Lam (2015), Chan (2017) and Tong (2017).

different possibilities for the way forward. It is not our objective to espouse any one of these pathways in particular, but rather to illuminate the types of considerations and challenges that may arise when these proposed pathways are considered by those responsible for legal reform in the Hong Kong context.

5. The Pathways

5.1 Pathway 1 - Abolition

Pathway 1 involves repeal of the MHO, with no replacement legislation authorising compulsion. If this pathway were followed, psychiatric treatment could only be provided with the patient's consent and refusals of treatment would have to be respected, although the expectation would be that a full array of good services would be made available, and systems of support would be available to assist people with disabilities to decide upon and access the treatments they consider would meet their needs.

The advantage of this pathway is that, of all the approaches discussed in this article, it is the one that is most clearly consistent with the focus of General Comment 1: equality before the law. Indeed, this is the only pathway that does not view people as being eligible for compulsion on the basis of their mental health difficulties. By allowing refusals of treatment to be overridden in cases where the treatment concerned is for a mental health condition and under circumstances where a refusal of treatment for a physical health condition would have to be respected, the MHO is discriminatory in how it treats people affected by mental health conditions. Adoption of this approach would mean that if doctors believe psychiatric treatment is necessary, the onus would be on them to explain to their patient why they believe

this is the case and to try to persuade the patient to accept the treatment on offer. It would follow that, if the patient refuses the recommended treatment, the doctor cannot be held responsible for any adverse consequences that arise from that refusal.[17]

A disadvantage of pursuing the abolitionist approach is the problem of public acceptability. If the MHO is repealed, there will be no mechanism outside the criminal justice system for detaining people who, as a result of a mental disorder, are thought to pose a risk to public safety. This would be a big step for a jurisdiction such as Hong Kong, which currently takes a cautious approach to the management of risk to the public, in response to rare but high-profile events where a person previously diagnosed with a mental illness fatally assaulted members of the public.[18] However, granting psychiatrists relatively wide-ranging powers to detain and treat people is not necessarily a reasonable or proportionate response to public anxiety. Citing the evidence that the vast majority of people who experience mental ill-health pose no additional risk of harm to others than that posed by the general population, and significant violence is a relatively rare event and therefore often too difficult to precisely predict for it to be effectively managed by detention, some authors argue that in order to prevent one incidence of violence, multiple people who would never have gone on to harm others would have to be deprived of their liberty (Szmukler, 2003; Taylor & Gunn, 1999). Making mental health-care widely available may, therefore, be more effective than the use of detention as a means of managing risk to the public. Nonetheless, events such as the murders

[17] While the doctor would not be able to compulsorily admit the patient if s/he refuses the recommended treatment, the argument here would be that with good service alternatives and better support during a crisis, the need for compulsory admissions could conceivably be eliminated altogether.

[18] S42B of the MHO is illustrative of this approach. Where the medical superintendent is of the opinion that a detained patient has a 'history of criminal violence or a propensity to commit such violence', they may impose conditions on discharge (such as the requirement to live in specified accommodation, attend out-patient appointments and take medication). Failure to comply results in liability to be recalled to hospital and the liability to recall is indefinite, regardless of any subsequent improvement in the patient's condition. This amendment to the MHO was made following a high-profile incident in 1982. A man, who had previously been hospitalised for treatment for schizophrenia, attacked members of his family and the public (including children at a nearby kindergarten) with knives. The dead and wounded included pre-school children. See further Lo (2003) at 26.

at the Anne Anne Kindergarten in 1982 cast a long shadow and may be cited by policy-makers as evidence of the need for measures to control people who have been diagnosed with mental illness.

Another potential disadvantage of this approach is the risk that it may result in *de facto* detention that is difficult to challenge. The CRPD requires protections to be put in place for this, but in practice, it is not clear what those would look like. Without the legal checks associated with detention and treatment under mental health legislation, a patient may be pressurised to accept treatment that they actually object to, and this may never come to light. If the MHO were abolished, a system of inspection and review of psychiatric hospitals would be required to ensure that no one being treated in hospital actually objects to their hospitalisation or treatment.

A third disadvantage concerns equality of access to healthcare. Some mental health conditions can result in impairment of cognitive ability, of insight into the nature of the experience and the potential for recovery with treatment, or of the ability to evaluate the risks and benefits of treatment in relation to the values that the patient holds when well. Accepting a refusal of treatment from someone who, as a result of their illness, has lost the ability to appreciate the potential benefits of such treatment imposes a barrier to recovery that does not affect people with physical health conditions that do not impair cognition, volition, insight or evaluative capacity (Peele & Chodoff, 1999). For people with relapsing and remitting conditions, advance directives potentially provide a partial solution to this problem: care-planning can occur during periods of remission when insight is intact, and the treatment that the person, when well, says s/he wants if s/he becomes unwell can be administered on the basis of advance consent. However, this approach is not viable for use in the first episode of

illness, or for people who never gain insight. An abolitionist approach could effectively exclude these people from potentially beneficial treatment, leading some authors to argue for less radical approaches that could, nonetheless, go some way to reducing inequality before the law (Dawson, 2015; Kelly, 2014).

5.2 Pathway 2 – Risk of Harm

Pathway 2 involves reform of the MHO to conform with a model that 'raises the bar' for detention, limiting its use to cases where, as a result of mental illness or disability, someone is at risk of harming themselves or others. This approach to mental health law reform was used widely during the 1970s-90s, beginning with the Lantermann-Petris-Short Act in California (Appelbaum, 1997), which was described by then-Governor Ronald Reagan as 'a Magna Carta for the mentally ill'. Following this approach, detention and compulsory treatment purely in the interests of the health of the person being detained would no longer be lawful; once the acute risks had passed, further treatment to restore health and prevent relapse would need to proceed on a voluntary basis.

There are, however, some very practical constraints associated with putting Pathway 2 into practice. The entire rationale for this pathway hinges on being able to assess and manage risk reliably. There are, however, a wide range of concerns in psychiatry concerning the predictive accuracy of risk assessment instruments (Fazel et al., 2012). Langan (2010) explains the limited utility of these instruments in terms of the multi-factorial nature of violence, the discontinuity between prediction at individual and group levels, and the low base rates for violence. There are even concerns that the use of risk assessment instruments in mental health practice can lead to harmful or wrongful outcomes in and of themselves; by

promoting a culture of accountability that threatens responsive and caring engagement, by undermining trust in the psychiatrist-patient relationship, and by heightening stigma and discrimination (Szmukler and Rose, 2013). Unless the accuracy of risk assessment can be improved and the potential benefits of risk management are realised, then the justification for Pathway 2 is distinctly lacking.

When comparing Pathway 2 with Pathway 1, it is also important to note that Pathway 2 does not preclude the detention of people thought to present a risk of harm to others, as a result of mental ill-health. Therefore, it may be more acceptable to members of the public and to law-makers, and more likely to succeed as a strategy for law reform. However, despite this advantage, Pathway 2 fails to address the concerns regarding equality of access to treatment associated with Pathway 1. These concerns have led to a 'watering-down' of the risk of harm criterion in some jurisdictions, to include the need to prevent serious deterioration in health as a criterion for detention,[19] thereby promoting health but also reducing the effectiveness of this approach as a means of limiting paternalism.[20]

Furthermore, by sanctioning the preventive detention of potentially dangerous people judged to be in need of psychiatric treatment, and not of dangerous people who do not have any form of mental ill-health, this approach fails the test of compliance with the CRPD, according to both the strong and the weak interpretations. In order to enact mental health legislation that is compatible with commitments under modern human rights instruments and promotes equality of access to treatment, another approach must be explored.

[19] This approach has been taken in jurisdictions including: New Zealand, Australia (in Australian Capital Territory, New South Wales, Northern Territory, Queensland, South Australia and Tasmania) and Canada (in New Brunswick and Quebec).
[20] See, for example, Leys (2018).

5.3 Pathway 3 – Mental Capacity

Pathway 3 departs entirely from any reliance on a 'risk of harm' criterion to ground and justify the content of mental health law. In recent years, a wide range of jurisdictions have enacted legislation, or have articulated a body of case law, that recognises the crucial role that a person's mental capacity to make decisions should play in authorising health and other personal welfare decisions. Mental capacity law varies in important ways across jurisdictions, but is generally founded upon the following principles:

- That mental capacity consists in a set of cognitive and communicative abilities that act as a threshold for the person's lawful ability to make decisions about his/her own life
- That mental capacity is decision-specific and should be presumed in each and every decision-making context, with determinations of incapacity only being made if there is sufficient evidence that the person lacks mental capacity.
- That substitute (or surrogate) health and welfare decision-making is only permitted when a person is judged to lack decision-making capacity
- That the subjective values, beliefs and desires of the person who lacks mental capacity should play at least some role in determining how decisions are made on that person's behalf.

In the vast majority of jurisdictions, mental capacity law sits alongside mental health law, and there is often an uncomfortable relationship between the two.[21]

[21] In England, for example, there is a fundamental difference between the application of the Mental Capacity Act 2005 to treatment decisions concerning physical illness and the application of the Mental Health Act 1983 to psychiatric treatment decisions for people with mental disorder. The former endorses an approach to decision-making that does not depend on overarching diagnostic criteria, but rather takes the person's autonomy as an overarching value that underpins health care decision-making, and adopts a person-centred approach to substitute decision-making. The latter endorses an approach to compulsory treatment for those who meet certain diagnostic criteria (independent on their ability to make treatment

A number of legal commentators have used the emergence of an overarching body of mental capacity law, and its application to health care and treatment decisions, to argue against a separate legal regime that allows for the compulsory treatment of people with mental disorders. Reflecting broader policy developments that call for a 'parity of esteem' in approaches to the management of physical and mental illness, this shift has been articulated in the so-called need for 'fusion legislation'. Fusion legislation, and the formulation of this approach into a model law, seeks to incorporate the best, most ethically defensible, features of established mental health and mental capacity legislative regimes, whilst exposing the lack of a compelling rationale for separate approaches to be adopted for the management of patients with mental and physical illnesses. As Dawson and Szmukler put it, "One major aim of bringing all involuntary treatment under a single legislative scheme is to avoid discrimination against people with mental disorders… by not making psychiatric treatment, unnecessarily, the subject of special legislation" (Dawson & Szmukler, 2006 at 504; Appelbaum, 2010).

In brief, the fusion law approach seeks to authorise justifications for interventions into the lives of people with mental illness on the same grounds as those that apply for those with physical illnesses, with a person's capacity to make treatment decisions being paramount to this justificatory framework. Thus, only when a person's capacity to consent to psychiatric treatment is lacking can treatment be provided without the individual's consent. Moreover, a capacity law-based approach to the management of mental illness would also bring the same principles to bear in guiding how psychiatric treatment should be provided to an adult lacking capacity in his/her best interests. This would represent a shift in justification for compulsory

decisions for themselves), with a person being forcibly treated and deprived of their liberty (with appropriate safeguards), potentially for very long periods of time.

detention and treatment away from the objective risk that the person presents to him/herself or others, and onto a person-centred calculation of the person's interests, in ways that are sensitive to his/her values, wishes, feelings and beliefs. Additional safeguards for protection against depriving non-objecting incapacitated patients of their liberty would also be included. Consideration would also need to be paid to introducing more robust rights-protecting measures and safeguards that might be undermined if Pathway 1 were adopted, but that are common to established mental health law frameworks. These include the roles of nearest relatives, advocates, and formal mechanisms for challenging the decisions made on behalf of patients.

The fusion law approach has gained much momentum in recent years, and has been picked up and adopted in a small number of jurisdictions, most notably in Northern Ireland, which have recently sought to amend its legislative frameworks for health care decision-making. There are two main concerns, however, with advocating for this pathway in Hong Kong.

5.3.1 Limitations in Hong Kong's current approach to mental capacity law

The first concern is specific to Hong Kong's mental health law and practice. In contrast to other countries, Hong Kong does not have an overarching statute to govern medical treatment decision-making and mental capacity. Moreover, the law relating to mental capacity and decision-making in Hong Kong, to the extent to which it can be elucidated as a distinctive legal concept or approach, is problematically woven into the current outdated mental health legislation that governs compulsory detention and treatment.

Hong Kong's MHO adopts two capacity-related terms: 'mental incapacity' and the 'mentally incapacitated person' (s 2). The first term is defined as equivalent to 'mental disorder' and 'mental handicap', eschewing a functional test, which problematically suggests that all people diagnosed with a 'mental disorder' or 'mental handicap' lack the capacity to make decisions about their care and treatment. The functional tests, which differ according to context, only appear in subsequent Parts of the MHO (Cheung, 2018). The second term has two parts to its definition. The first part is the inability to make decisions about one's property or affairs, and the second part is being, for all other purposes, a 'patient' or a 'mentally handicapped person'. In relation to the first definition, a decision-specific test for capacity is applied, but there is no detail about the content of this test, and its application does not extend to the ability to make care or treatment decisions. The second definition appears similar to the use of the first term 'mental incapacity' in the MHO, though here the broader, unspecified concept of the 'patient' is preferred.

As Cheung (2018) has argued, the reason for this confusing legal picture can be traced back to the process of amending the MHO in 1997, where the term 'mental incapacity' was thought to operate as a useful, convenient shorthand to capture a wide group of patients with mental illness and intellectual disabilities. The use of this term was also seen as a way of addressing the tendency in health care in Hong Kong to perceive those with mental illness and intellectual disabilities as the same. Clearly, however, there are significant problems with co-opting this term in ways that not only suggest an incorrect understanding of the nature of mental incapacity, but may also lead to undesirable stigmatising effects.

One important implication of the limited and problematic way that mental capacity has been conceptualised within Hong Kong's mental health law is that Hong Kong lacks an

overarching statutory test for capacity, with piecemeal and competing approaches being adopted in different health and welfare contexts. The need for overarching mental capacity law reform in Hong Kong is pressing, and it is difficult to see precisely how the reform of the MHO could proceed on mental capacity-led grounds until separate provisions for decision-making capacity in health and welfare law more generally are introduced.[22]

5.3.2 Mental capacity law and the requirements of the CRPD

The second concern relates to objections that have been made to mental capacity-based approaches to governing health care decision-making from the standpoint of the requirements of the CRPD outlined above. We have outlined above two interpretations of the CRPD: the 'strong' interpretation and the 'weak' interpretation, which have different implications for the justification of mental capacity-led approaches to the reform of mental health law. Despite mental capacity legislation, as adopted across a range of Commonwealth jurisdictions, being largely seen as more respectful of a patient's autonomy and freedoms compared to parallel mental health legislation, both the 'strong' and 'weak' interpretations of the CRPD bring this assumption into question.

From the standpoint of the 'strong' interpretation, two main concerns have been raised. The first concern is that the functional test for mental incapacity is itself problematic because it endorses a differential approach to those with mental impairments, when compared to people

[22] It could be argued here that the legislative reform experience in Northern Ireland, through the passing of the *Mental Capacity (Northern Ireland) Act 2016* demonstrates that it is in fact easier to introduce fusion legislation where there is only one piece of legislation to replace, and not two (although it should be noted that this Act has not yet been fully implemented). The difference between Northern Ireland and Hong Kong, however, is that decisions on capacity in Northern Ireland had previously been taken under the common law, which arguably led to the development of a more coherent legal picture of capacity than the piecemeal and competing tests contained in Hong Kong's MHO. Without an established coherent and unified test with which to assess decision-making capacity, it is likely that the objectives of fusion legislation would be very difficult to meet.

who have no such impairments, meaning that people with disabilities cannot enjoy legal capacity on an equal basis with others in all aspects of life (Art 12). Additionally, and more practically, fusion legislation, like all mental capacity legal frameworks, draws a clear 'line in the sand' between those who have mental capacity from those who do not, with regards to specific decisions. However, people with mental disorders typically present with a more complex picture, with mental capacity that fluctuates in line with the manifestation of their psychopathology and the treatment they receive, making decisions around compulsion difficult to implement to shape treatment regimens in the short or long terms. Moreover, there are also broader concerns that the cognitive-based account of mental capacity that underpins the functional test does not track the wide-ranging impairments in decision-making that are experienced by people with different mental illnesses.[23]

The second concern is that any framework for deciding on behalf of someone judged to lack mental capacity cannot be founded on substitute decision-making. Nor can judgements be made in a person's objective 'best interests' as perceived by professional or personal carers, because both of these approaches equate with a fundamental denial of the rights of persons with disability to exert full and meaningful control over their lives. As General Comment 1 puts it, "at all times, including in crisis situations, the individual autonomy and capacity of persons with disabilities to make decisions must be respected" (General Comment 1, 2014 at para 18). In reformulating how mental capacity law needs to be modified to better safeguard the rights of people with disabilities, the CRPD Committee endorses what has come to be regarded as the 'will and preferences' model. We outline this approach and consider it as a modified pathway to a mental capacity-based approach to the reform of Hong Kong's MHO that could signify increased compliance with the CRPD.

[23] See, for example, Charland (1998) and Tan et al. (2006).

5.3.3 A modified pathway: The 'will and preferences' approach

A 'will and preferences' approach endorses the removal of functional tests for capacity when these tests are 'either discriminatory or disproportionately affect' the rights of people with disabilities to equality before the law. The CRPD Committee has also advanced the view that the concept of mental capacity itself is problematic, in the way it is presumed to capture an overarching and objective reality of the person's ability to make decisions, rather than being contingent on social and political contexts, including those of the medical disciplines that are typically seen as able to assess mental capacity accurately and objectively. There has been much debate about the precise intention of the CRPD Committee on this point, with some arguing that the functional test as adopted under the MCA in England and Wales is neither discriminatory nor disproportionate (Martin et al., 2014; Szmukler et al., 2014). The same commentators do note, however, that functional tests of capacity become discriminatory when they include a diagnostic threshold prior to the assessment of the specific cognitive and communicative abilities that are widely seen as underpinning a person's capacity to make an autonomous decision (Martin et al., 2014). This view has led to calls to revise the MCA in order to remove the requirement for a person to have an 'impairment of, or disturbance in, the functioning of mind or brain' prior to the person being eligible for his/her capacity to be assessed further.

On a 'strong' interpretation of the CRPD, as advanced by the CRPD Committee, supported decision-making for people who lack mental capacity must be endorsed as the only way to ensure that people with disabilities are able to exercise their right to legal capacity and decisions must be made in ways that advance this person's 'will and preferences'.

Importantly, attempts to offer formal and informal support to enable the person's will and preferences to guide the decision-making process cannot co-exist with an alternative substitute decision-making approach that is founded upon an attempt to advance an all-things-considered view of the person's best interests. As such, mental health treatment for those with significant decision-making impairments can only be provided when the person for whom treatment is being considered ratifies the decision to receive that treatment, enabled by appropriate support in the decision-making process.

The 'weak' interpretation of the CRPD by comparison takes the position that sole reliance on a will and preferences-based approach to making decisions for people who lack mental capacity is problematic at best, and incoherent at worst. Much of the debate here attends to the nature of the relationship between mental capacity, the will, and the person's autonomy.[24] Adopting a preference-satisfaction approach to decision-making, as the will and preferences model encourages, advances a very thin and unpersuasive account of personal autonomy. This is true regardless of whether, with support, a person might be able to regain the autonomy to make a decision that is founded on their own values and beliefs, or that autonomy understood relationally could be safeguarded through the provision of such decision-making support.

Moreover, the idea that the person's 'will' can be supported in such a way as to govern a decision when that person lacks mental capacity requires a different way of thinking about the person's ability to exercise control over their lives in ways that are not grounded in a set of cognitive capacities. As Donnelly (2016) puts it, "While autonomy principles underpin the

[24] See Szmukler (2019) for a recent discussion of the phrase 'rights, will and preferences' and the potential difficulties associated with the adoption of the CRPD committee's interpretation of the will and preferences approach. See also Bartlett (2019) for a response to Szmukler's paper.

right to decision-making support (both generally and in respect of individual decisions), respect for autonomy can only justify respect for will and preferences in respect of an individual decision where the conditions for an autonomous decision have been met in respect of the decision in question." In this sense, it is not precisely clear how the moral grounds for safeguarding the rights of people with disabilities can be properly respected when advancing notions of 'will and preference' when the person lacks the ability to make autonomous decisions. Those who advocate for a 'weak' interpretation seek to address this ethical concern by retaining a role for making judgments about substitute decision-making for people who lack mental capacity on the basis of a robust account of the person's interests (including making substitute decisions relating to compulsory admission and treatment for mental disorder) when supported decision-making is ineffective or when there is an apparent disjuncture between identifiable preferences and the underlying will of the person.

On a 'weak' interpretation, the emerging consensus is that the approach to substitute decision-making standardly adopted within mental capacity legislation, such as the MCA in England and Wales, needs to be modified slightly to endorse and emphasise a more person-centred and supportive approach to decision-making. One suggestion is to amend and rename the current best interests principle adopted within mental capacity law to give overarching precedence to the person's current wishes, preferences, values and beliefs in any assessment of how decisions for that person should be made. This would enable the person's current preferences to be accorded special value, with additional considerations (e.g. the person's previous values and preferences, or any objective considerations about what course of action would be best for the person) to be accorded limited priority in a new hierarchy of decision-making (Donnelly, 2016; Martin et al., 2014). A focus on acting in the person's best interests could also be replaced with a requirement to act to 'benefit' the person (Assisted Decision-

Making (Capacity) Act Ireland 2015), though as Donnelly (2016) recognises, this shorthand, rather than one focused on rights-protection language, is not ideal.

There remains much uncertainty about the relationship between existing statutory regimes for mental capacity and the requirements of the CRPD and General Comment 1, and obviously the fusion legislation proposed by Szmukler and colleagues would be open to the same criticisms put forward by the CRPD Committee. Just as importantly for the possibility of adopting this pathway as a blueprint for mental health law reform in Hong Kong is the limited prominence and force given to the individual's will and subjective preferences in the existing legislative framework. For example, under the guardianship provisions of the MHO, the "views and wishes of the mentally incapacitated person [ought to be], in so far as they may be ascertained, respected" (s 59S(g)), but the "interests of the mentally incapacitated person will be promoted by the proposed guardian, including overriding the views and wishes of that person where the proposed guardian (once appointed) considers such action is in the interests of that person" (s 59S(f)). With the standard approach requiring objective assessment of the person's interests to trump that person's will and preferences, there is clearly a long way to travel – in policy, legal and practical terms – in order to adopt a framework that is founded upon the entirely opposite position.

In summary, then, it is far from clear what a modified 'will and preferences' based approach to reforming mental health law and practice would require in precise legal terms, and how – if at all – this could gain traction as a strategy for law reform in Hong Kong. Any attempt to instigate changes to Hong Kong's MHO on the basis of an 'original' or modified capacity-based model would need to address these concerns head on.

5.4 Pathway 4 - Consensus

Pathway 4 involves making specific changes to the current MHO to address problematic areas, either through legislative reform or judicial interpretation in the course of litigation. The aim of such reform would be to avoid legal inconsistencies, improve rights protections and limit the arbitrariness of medical decision-making by psychiatrists and other medical practitioners. Unlike the three pathways described above, such an approach to mental health law reform would not be based on any underlying ideology. It would instead be piecemeal and reactive in nature, tackling only specific, identifiable problems.

There has been some debate as to whether piecemeal reform is a desirable way to move forward.[25] Bartlett (2014) has explored this issue in the context of mental disability law. While the CRPD promises a paradigm shift for persons with disability, implementing this in the form of comprehensive, large-scale reforms will involve a significant amount of time and difficulty. In the meantime, many individuals continue to be subjected to indefensible conditions, suggesting that piecemeal reform may be necessary to address ongoing human rights abuses in the interim. In proceeding with piecemeal reform, however, there is a danger that the larger vision of the CRPD may be undermined. This leaves us in a practical dilemma regarding the way forward. We do not attempt here to draw any broad conclusions about the desirability of piecemeal reform generally, but will return to discuss this in the context of Hong Kong below.

We have labeled this pathway the 'consensus approach' because the key issues for reform identified below are those that emerged from the two roundtable discussions that took place

[25] For general arguments against piecemeal reform, see, for example, Gullifer (2015). For counterarguments, see, for example, Kousser (2011).

during the Conference. The participants of these discussions included stakeholders from various disciplines, including psychiatrists, family medicine practitioners, clinical psychologists, social workers, lawyers, members of the EOC and mental health service users and representatives from mental health advocacy groups.

5.4.1 Section 42B conditional discharge order

The conditional discharge order, which is currently Hong Kong's only form of civil compulsory treatment in the community, was the subject of much discussion. Pursuant to section 42B of the MHO, a patient can be placed on conditional discharge if two criteria are satisfied: (i) the patient has a medical history of criminal violence or a disposition to commit such violence, and (ii) the patient may safely be discharged subject to conditions. The conditional discharge regime is arguably one of the most problematic in terms of the protection of patient rights (Cheung, 2018 at 11-15). One of the key priorities for reform, as identified in the discussion, is to make clear in the legislation how a patient under a conditional discharge order can be released. Currently, the patient can only be discharged by the MHRT[26] – section 42B provides no means by which the responsible medical practitioner can actively discharge the patient even if the order is no longer considered necessary. Because section 42B does not specify the duration of the order, the patient will also not be released by virtue of the order's expiration. The local government is apparently considering expanding the categories of people who can be subjected to a conditional discharge order, which would make the lack of safeguards even more worrying (Mental Health Review Report, 2017 at 201). One possibility is to require the responsible medical practitioner to discharge the patient from the conditions once they are no longer necessary to manage the

[26] The conditional discharge order will also cease to have effect if the patient is recalled to hospital, at which point the patient will be deemed compulsorily admitted under section 31 of the MHO. See further section 42B(4) of the MHO.

risk of harm. Another would be to specify a time limit for the conditional discharge order, such that the patient would have to be released upon expiration unless the continuing need for the order is demonstrated.[27,28]

5.4.2 Safeguards – review mechanisms

The importance of safeguards was a theme that continually arose in the discussions. In particular, the need for effective review mechanisms was emphasised. Several regimes in the MHO currently lack such review mechanisms. The short-term compulsory admission and treatment regime as contained in sections 31 and 32 of the MHO is an example of this. Under these sections, an individual may be compulsorily admitted and treated for up to 28 days. Although the individual can technically apply for a review, the procedure laid down in the MHRT Rules takes a default length of two months and 28 days (s 59B(1)). The absence of a swift review mechanism in this case means that the patient will not be able to review the appropriateness of her detention at all prior to her release. A reform of the current procedures would require that the patient be guaranteed a hearing within a certain period of her detention. For example, patients in the UK who are detained for up to 28 days can apply for a tribunal hearing once within the first 14 days of detention, and are guaranteed that the hearing will take place within seven days of receipt of the application.[29] Implementing this in Hong Kong would ensure that the patient's right to review her case will not be rendered meaningless by the lengthy procedures involved.

[27] See Cheung (2018) for a more detailed discussion of the conditional discharge system.
[28] It is acknowledged that despite the addition of safeguards, civil compulsory treatment in the community on the basis of risk of harm to others may still be regarded as unacceptable by many.
[29] See further MHA, ss 66(1)(a) and 66(2)(a); First-tier Tribunal HESC Rules 2008, r 37(1); and MHRT Wales Rules 2008, r 24(1).

5.4.3 Safeguards – independent advocacy services

Another safeguard that was proposed was the introduction of independent advocacy services for mental health service users. The MHO currently does not provide for any such services. The provision of an independent mental health advocate for patients subjected to the various compulsory regimes under the MHO would assist them in better understanding their rights, the avenues through which they can have their case reviewed (and the implications of not doing so), the restrictions to which they are being subjected, the safeguards that apply to them, and other similar issues.

Of the five pathways we have explored in this article, this is the pathway most likely to achieve consensus amongst the stakeholders in Hong Kong, and it will be particularly well-received by those who are more conservative and wish to see reform undertaken in a gradual manner. This is in fact the way that much of law reform in Hong Kong has proceeded, in particular where controversial matters are involved.[30] As Kousser (2011) has argued, such an approach can be much more politically feasible in effecting change. This is especially true in the Hong Kong context, where the legislature is not fully accountable to the people of Hong Kong,[31] which in turn makes effective law reform extremely difficult when confronted with even the slightest opposition from vested interests (Tilbury et al., 2014 at 8).[32]

The changes effected by this pathway will also be likely to bring Hong Kong closer to compliance with its commitments under the ICCPR. The extent to which compliance is

[30] See, for example, Petersen & Loper (2014), which discusses in detail the piecemeal development of anti-discrimination law in Hong Kong.
[31] See further Tilbury et al. (2014) for why this is the case.
[32] Of course, such opposition will make it difficult to achieve consensus even for piecemeal reform – any hesitation from even one major stakeholder will likely derail the consensus-building process.

obtained will depend on the problem areas that are identified and the amendments that are made in response, and whether the examples discussed above result in the implementation of further safeguards in terms of duration, review of detention and effective access to legal remedies.

The obvious concern with this pathway is that it will not institute large-scale, comprehensive ideological changes. As discussed above, Hong Kong has not formulated a clear mental health policy, and piecemeal changes to particular provisions, while helpful in bringing Hong Kong closer to modern standards, will not assist in providing Hong Kong with a comprehensive and principled way of approaching mental health law and policy. By introducing piecemeal changes that appear to address some of the human rights concerns in the legislation, the urgency and incentive for significant, rights-based reform will arguably also be lost. In addition, as Gullifer (2015) points out, piecemeal amendments may create or allow any existing inconsistencies with the rest of the regime to remain.[33]

Another clear concern is that this pathway will not bring the MHO in line with the CRPD, at least according to the strong approach espoused by the CRPD Committee in its interpretation of Articles 12 and 14. The consensus approach would bring about some, albeit limited, progress in the right direction. Strengthening safeguards in the various compulsory regimes will better protect the rights and interests of individuals subjected to them. Nonetheless, such changes are unlikely to render the MHO compliant with the CRPD, even on a weak interpretation, given the lack of supported decision-making mechanisms and the insufficient

[33] An example of such inconsistency can be found in the various mental capacity tests contained in the MHO, briefly discussed in relation to the mental capacity pathways above. The current situation is much like that of the United Kingdom pre-MHA 1983, which was described by the Law Commission of the United Kingdom as one of "incoherence, inconsistency and historical accident". At the time, the Law Commission considered whether piecemeal reform could suffice, but concluded that because these capacity tests had developed in response to specific contexts, they could not be considered an "effective or practical body of law", and any attempt to amend these tests separately would be much more difficult than devising a comprehensive solution. See further Report on Mental Incapacity (1995) at paras 2.45-2.50.

emphasis on the individual's will and preferences.[34] In fact, as Bartlett suggests, piecemeal amendments may even have the effect of undermining the larger vision of the CRPD (Bartlett, 2014 at 177).

6. Conclusion

Mental health law reform, no matter where it is attempted, is an arduous, politicised and highly contentious process. This is particularly so where the mental health law regime in place remains archaic and where there are a number of additional local challenges that create obstacles for reform. Hong Kong's mental health law regime is an example of this. In addition to having an outdated regime largely based on mid-20th century regulatory approaches, which has not seen significant amendment since 1997, Hong Kong also faces various policy and resource restraints that have made mental health law reform extremely difficult.

In response, this article proposes and explores four possible pathways for the reform of Hong Kong's compulsory mental health law. The abolition pathway considers the option of repealing all compulsory detention and treatment provisions without any replacement legislation. The risk of harm pathway largely retains the current compulsory detention and treatment model, with the exception that the use of detention and treatment is limited to cases where an individual with mental illness or disability is at risk of harming herself or others. The mental capacity pathway envisages a fusion law model, where the only justification for compulsory detention and treatment would be that the individual lacks capacity to consent to treatment, and where priority and special consideration is given to the person's expressed will

[34] The guardianship regime, briefly discussed in Pathway 3 above, exemplifies this.

and preferences. Finally, the consensus pathway involves piecemeal reform to address specific problem areas of the MHO which have been identified and agreed upon by stakeholders in relevant professions.

In considering each pathway for reform, we have highlighted the difficulties that may arise from a local perspective and explored the extent to which such reform would bring the current regime in line with international norms, including the ICCPR and the CRPD. In our discussions regarding compliance with the CRPD, we have noted that there are various interpretations in the literature, what we have termed the strong and weak approaches. As the aim of this article is to set forth the alternatives and explore the considerations involved with each; we have not committed to any of these approaches, or any one of the four pathways proposed. It is envisaged that our analysis will serve not only as a blueprint for reform in Hong Kong, but will additionally provide guidance for other jurisdictions which may similarly be undergoing mental health law reform to become more compliant with international norms and treaties while dealing with challenges associated with their local contexts.

Acknowledgements

The authors would like to thank Professor John Dawson and the two anonymous reviewers for their helpful comments and suggestions.

References

1. Appelbaum, P.S. (1997). Almost a revolution: an international perspective on the law of involuntary treatment. *Journal of the American Academy of Psychiatry and the Law*, 25, 135-147.

2. Appelbaum, P.S. (2010). Harnessing the Power of Fusion - A Valiant but Flawed Effort to Obviate the Need for a Distinct Mental Health Law. *Journal of Mental Health Law*, 25-33.

3. Assisted Decision-Making (Capacity) Act Ireland 2015. Retrieved from <http://www.irishstatutebook.ie/eli/2015/act/64/enacted/en/html>. Accessed 26 June 2019.

4. Bach, M. & Kerzner, L. (2010). A New Paradigm for Protecting Autonomy and the Right to Legal Capacity (Law Commission of Ontario). <https://www.lco-cdo.org/en/our-current-projects/the-law-and-persons-with-disabilities/disabilities-call-for-papers-january-2010/commissioned-papers-the-law-and-persons-with-disabilities/a-new-paradigm-for-protecting-autonomy-and-the-right-to-legal-capacity/> Accessed 26 June 2019.

5. Bartlett, P. (2012). The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law. *The Modern Law Review*, 75, 752-778.

6. Bartlett, P. (2014). Implementing a Paradigm Shift: Implementing the CRPD in the Context of Mental Disability Law. In *Torture in Healthcare Settings: Reflections on the Special Rapporteur on Torture's 2013 Thematic Report* (pp. 169-180).

Washington: Centre for Human Rights and Humanitarian Law, American University Washington College of Law.

7. Bartlett, P. (2019). Will and preferences in the overall CRPD project. *World Psychiatry*, 18, 48-50.

8. Bauhinia Foundation Research Centre. Mental Health Care Services for Hong Kong Youth. (2017). <http://www.bauhinia.org/index.php/english/analyses/615> Accessed 7 March 2018.

9. Chan, A. (2017, May 14). Mental health care in Hong Kong falls woefully short amid social stigma and lack of policy direction. *South China Morning Post*. Retrieved from <https://www.scmp.com/comment/insight-opinion/article/2094100/mental-health-care-hong-kong-falls-woefully-short-amid>.

10. Charland, L.C. (1998). Is Mr. Spock mentally competent? Competence to consent and emotion. *Philosophy, Psychiatry and Psychology*, 5, 67-81.

11. Cheung, D. (2017). The compulsory psychiatric regime in Hong Kong: Constitutional and ethical perspectives. *International Journal of Law and Psychiatry*, 50, 24-30.

12. Cheung, D. (2018). Mental Health Law in Hong Kong: The Civil Context. *Hong Kong Law Journal*, 48, 461-484.

13. Cheung, E. (2017, Feb 20). Long waiting times at Hong Kong public hospitals for mentally ill patients. *South China Morning Post.* Retrieved from <https://www.scmp.com/news/hong-kong/health-environment/article/2072183/long-waiting-times-hong-kong-public-hospitals>.

14. Constitutional and Mainland Affairs Bureau. Third Report of the Hong Kong Special Administrative Region (HKSAR) of the People's Republic of China (PRC) in the light of the International Covenant on Civil and Political Rights. (2011). <https://www.cmab.gov.hk/en/issues/prc_4.htm> Accessed 5 March 2018.

15. Dawson, J. (2015). A realistic approach to assessing mental health laws' compliance with the UNCRPD. *International Journal of Law and Psychiatry*, 40, 70-79.

16. Dawson, J. & Szmukler, G. (2006). Fusion of mental health and incapacity legislation. *British Journal of Psychiatry*, 188, 504-509.

17. Disability Discrimination Ordinance (Cap. 487, Laws of Hong Kong). Retrieved from <https://www.elegislation.gov.hk/hk/cap487>. Accessed 5 March 2018.

18. Donnelly, M. (2016). Best interests in the Mental Capacity Act: Time to say goodbye? *Medical Law Review*, 24, 318-332.

19. Fazel, S., Singh, J.P., Doll, H., & Grann, M. (2012). Use of risk assessment instruments to predict violence and antisocial behaviour in 73 samples involving

24 827 people: systematic review and meta-analysis. *British Medical Journal*, 345, e4692. Accessed 26 June 2019.

20. Fennell, P. & Khaliq, U. (2011). Conflicting or Complementary Obligations? The UN Disability Rights Convention, the European Convention on Human Rights and English law. *European Human Rights Law Review*, 6, 662-674.

21. Flynn, E. & Arstein-Kerslake, A. (2014). Legislating Personhood: Realising the Right to Support in Exercising Legal Capacity. *International Journal of Law in Context*, 10, 81-104.

22. Food and Health Bureau. Mental Health Review Report. (2017). <https://www.fhb.gov.hk/download/press_and_publications/otherinfo/180500_mhr/e_mhr_full_report.pdf> Accessed 12 September 2018.

23. Gullifer, L. (2015). Piecemeal reform: Is it the answer? In F. Dahan (Ed.), *Secured Financing in Commercial Transactions* (pp. 421-450). Cheltenham: Edward Elgar Pub. Ltd.

24. Hong Kong Basic Law. Retrieved from <https://www.basiclaw.gov.hk/en/basiclawtext/index.html>. Accessed 5 March 2018.

25. Hong Kong Bill of Rights Ordinance (Cap 383, Laws of Hong Kong). Retrieved from <https://www.elegislation.gov.hk/hk/cap383>. Accessed 5 March 2018.

26. Kelly, B.D. (2014). Dignity, human rights and the limits of mental health legislation. *Irish Journal of Psychological Medicine*, 31, 75-81.

27. Kousser, T. (2011). The Blessings and Curses of Piecemeal Reform. *Loyola of Los Angeles Law Review*, 44, 569-602.

28. Labour and Welfare Bureau. Initial Report of the Hong Kong Special Administrative Region of the People's Republic of China under the United Nations Convention on the Rights of Persons with Disabilities. (2010). <https://www.lwb.gov.hk/UNCRPD/Publications/HKSAR's%20UNCRPD%20report_Eng%20(version%20for%20publication).pdf> Accessed 7 March 2018.

29. Labour and Welfare Bureau. Second and Third Report of the Hong Kong Special Administrative Region of the People's Republic of China under the United Nations Convention on the Rights of Persons with Disabilities. (2018). <https://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD%2fC%2fCHN-HKG%2f2-3&Lang=en> Accessed 21 March 2019.

30. Langan, J. (2010). Challenging assumptions about risk factors and the role of screening for violence risk in the field of mental health. *Health, Risk & Society*, 12, 85-100.

31. Lee, A. & Lam, G. (2015). Hong Kong's Mental Health Policy - Preliminary Findings. *International Journal of Social Science and Humanity*, 5, 640-645.

32. Leys, T. (2018, June 14). Parents praise new Iowa mental health commitment law; critics fear loss of civil rights. *Des Moines Register*. Retrieved from <https://www.desmoinesregister.com/story/news/health/2018/06/14/mental-health-treatment-iowa-quicker-civil-rights-loss-feared/661109002/>

33. Lo, W.H. (2003). A Century (1885 to 1985) of Development of Psychiatric Services in Hong Kong —With Special Reference to Personal Experience. *Hong Kong Journal of Psychiatry*, 13, 21-29.

34. Lush, D. (2011). Article 12 of the United Nations Convention on the Rights of Persons with Disabilities. *Elder Law Journal*, 1, 61-68.

35. Martin, W., Michalowski, S., Jutten, 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 Disabilities? If Not, What Next? [An Essex Autonomy Project Position Paper]. <https://autonomy.essex.ac.uk/wp-content/uploads/2017/01/EAP-Position-Paper-FINAL.pdf> Accessed 26 June 2019.

36. Mental Health Act 1983 as amended. Retrieved from <https://www.legislation.gov.uk/ukpga/1983/20/contents>. Accessed 10 October 2018.

37. Mental Health Ordinance (Cap 136, Laws of Hong Kong). Retrieved from <https://www.elegislation.gov.hk/hk/cap136>. Accessed 10 October 2018.

38. UN Committee on the Rights of Persons with Disabilities. General Comment No. 1, Article 12 (CRPD) (CRPD/C/GC/1). (2014). <https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CRPD/C/GC/1&Lang=en> Accessed 26 June 2019.

39. UN Human Rights Committee (HRC). General Comment No. 35, Article 9 (ICCPR) (CCPR/C/GC/35). (2014). <https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CCPR%2fC%2fGC%2f35&Lang=en> Accessed 5 March 2018.

40. Peele, R. & Chodoff, P. (1999) The ethics of involuntary treatment & deinstitutionalization. In S. Bloch, P. Chodoff & S.A. Green (Eds.), *Psychiatric Ethics* (3rd edition) (pp. 423-440). New York: Oxford University Press.

41. Petersen, C.J. (2005). A Progressive Law with Weak Enforcement? An Empirical Study of Hong Kong's Disability Law. *Disability Studies Quarterly*, 25(4), 1-21. Retrieved from <http://dsq-sds.org/article/view/625>.

42. Petersen, C.J. (2007). Embracing Universal Standards? The Role of International Human Rights Treaties in Hong Kong's Constitutional Jurisprudence. In H. Fu, L. Harris, and S. N. M. Young (Eds.), *Interpreting Hong Kong's Basic Law: The Struggle of Coherence* (pp. 35-53). New York: Palgrave Macmillan.

43. Petersen, C.J. (2008). China's Ratification of the Convention on the Rights of Persons with Disabilities: The Implications for Hong Kong. *Hong Kong Law Journal*, 38, 611-644.

44. Petersen, C.J & Loper, K. (2014). Equal Opportunities Law Reform in Hong Kong: The Impact of International Norms and Civil Society Advocacy. In M. Tilbury, S.N.M. Young & L. Ng (Eds.), *Reforming Law Reform: Perspectives from Hong Kong and Beyond* (pp. 173-204). Hong Kong: Hong Kong University Press.

45. Richardson, G. (2012). Mental Disabilities and the Law: From Substitute to Supported Decision-Making? *Current Legal Problems*, 65, 1-22.

46. Sex Discrimination Ordinance (Cap. 480, Laws of Hong Kong). Retrieved from <https://www.elegislation.gov.hk/hk/cap480>. Accessed 5 March 2018.

47. Szmukler, G. (2003). Risk assessment: 'numbers' and 'values'. *Psychiatric Bulletin*, 27, 205-207.

48. Szmukler, G. & Rose, N. (2013). Risk assessment in mental health care: values and costs. *Behavioural Sciences & the Law*, 31, 125-40.

49. Szmukler, G., Daw, R. & Callard, F. (2014). Mental health law and the UN Convention on the rights of persons with disabilities. *International Journal of Law and Psychiatry*, 37, 245-252.

50. Szmukler, G. (2019). “Capacity”, “best interests”, “will and preferences” and the UN Convention on the Rights of Persons with Disabilities. *World Psychiatry*, 18, 34-41.

51. Tan, J.O.A., Hope, T., Stewart, A. & Fitzpatrick, R. (2006). Competence to make treatment decisions in anorexia nervosa: Thinking processes and values. *Philosophy, Psychiatry and Psychology*, 13, 267-282.

52. Taylor, P. & Gunn, J. (1999). Homicides by people with mental illness: myth and reality. *The British Journal of Psychiatry*, 174, 9-14.

53. The Law Commission. (1995). *Report on Mental Incapacity*. London: HMSO.

54. The Mental Health Review Tribunal for Wales Rules 2008. Retrieved from <http://www.legislation.gov.uk/uksi/2008/2705/contents/made>. Accessed 13 June 2018.

55. The Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008. Retrieved from < http://www.legislation.gov.uk/uksi/2008/2699/contents/made>. Accessed 13 June 2018.

56. Tilbury, M., Young, S.N.M. & Ng, L. (2014). Law Reform Today. In M. Tilbury, S.N.M. Young & L. Ng (Eds.), *Reforming Law Reform: Perspectives from Hong Kong and Beyond* (pp. 3-21). Hong Kong: Hong Kong University Press.

57. Tong, E. (2017, Feb 26). Lawmakers criticise gov't for lack of mental health policy and long waiting times for treatment. *Hong Kong Free Press*. Retrieved from <https://www.hongkongfp.com/2017/02/26/lawmakers-criticise-govt-lack-mental-health-policy-long-waiting-times-treatment/>

58. Tsang, F. K. (2007). Future Mental Health Services in Hong Kong: Conceptual and Practical (LC Paper No. CB(2)373/07-08(06)). <https://www.legco.gov.hk/yr07-08/english/panels/hs/papers/hs1122cb2-373-6-e.pdf> Accessed 7 March 2018.