



Submission to the Department of Health for its Consultation on the Deprivation of Liberty Safeguard Proposals

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SUMMARY

The ICCL welcomes the State's long-overdue effort to establish legal safeguards to protect the rights of individuals who are or may be deprived of their liberty in care settings. Ireland has a long history of failing to prevent widespread arbitrary detention and mistreatment of people who depend on others and/or the State for care. The past few decades have been marked by repeated investigations into, and political and public expressions of alarm about, the State's practice of supporting and allowing the care of adults and children in systems that are inadequately regulated, and in which there are weak or non-existent mechanisms for respecting individual rights and ensuring that complaints are heard and responded to. Successive governments have been pleaded with to provide sufficient alternatives to institutional care so that people are enabled to live independently and included in the community.

The Department of Health's [preliminary draft Heads of Bill on deprivation of liberty](#), which are intended to form Part 13 of the [Assisted Decision-Making \(Capacity\) Act 2015](#), are unfortunately seriously inadequate to ensure adequate protection from arbitrary detention and mistreatment in care settings. The draft Heads of Bill fail to provide a number of safeguards which are necessary in order to comply with Ireland's obligations under numerous human rights instruments, including the Irish Constitution, the European Convention on Human Rights (ECHR), the United Nations Convention on the Rights of Persons with Disabilities (CRPD) and other international treaties. In particular:

1. The draft Heads of Bill do not cover numerous care settings where people are routinely deprived of their liberty, including hospitals, community-based settings and the home.
2. In applying only to people deemed to lack capacity to make a decision about where to live, the draft Heads of Bill offer no protection from arbitrary detention to people who are deemed capable of making care-related decisions.
3. There are wholesale exemptions from the requirement for deprivations of liberty to be authorised by law, including for wards of court and where the person in charge of an institution 'reasonably believes' that a person's capacity is 'fluctuating' or that the person will die within a 'short period'.
4. The grounds for triggering an application to court to authorise a deprivation of liberty do not comply fully with the Assisted Decision-Making (Capacity) Act 2015 or the CRPD, and therefore allow for arbitrary detention.

5. There is no statutory right to the alternatives to institutional care or restraint which are required in order to avoid unnecessary (and therefore arbitrary) deprivations of liberty. These alternatives include home care, community-based services and psychology services.
6. There are no requirements in the draft legislation for care providers to obtain informed consent (with supported decision-making where necessary) to all restricting forms of care, which is a necessary safeguard to prevent arbitrary detention of all people in the care context.
7. There is no statutory right to the independent advocacy services which are necessary to ensure that the procedures intended to prevent arbitrary detention are in fact accessible to people who require care and effective.
8. Despite signing the instrument, Ireland still has not ratified the Optional Protocol to the United Nations Convention against Torture (OPCAT), which requires states to establish a National Preventive Mechanism to inspect and monitor all places of deprivation of liberty in order to prevent arbitrary detention or torture or ill-treatment.

The remainder of this submission supports these arguments by setting out the relevant human rights law that applies to the State in this area and relevant factual evidence.

A. The State is obliged to protect from arbitrary deprivation of liberty in the care context.

The right to liberty, otherwise understood as the right to freedom from arbitrary or unlawful detention, is enshrined in Article 40.4.1 of the Irish Constitution, which states:

'No citizen shall be deprived of his personal liberty save in accordance with law'.

The right to liberty and freedom from arbitrary detention is also enshrined in the ECHR,¹ the International Covenant on Civil and Political Rights (ICCPR),² the EU Charter of Fundamental Rights³ and the CRPD.⁴ The prohibition of arbitrary detention is of such importance that it is a universally binding rule of customary international law (meaning that it binds states even when they have not ratified a particular Convention outlawing it).⁵ According to numerous international treaties and customary international law, the prohibition of arbitrary detention does not allow for any exceptions. Thus, as the UN Working Group on Arbitrary Detention explains, 'a State can never claim that illegal, unjust, or unpredictable deprivation of liberty is necessary for the protection of a vital interest or proportionate to that end.'⁶

Not only is the State obliged to refrain from arbitrarily detaining people itself, but the State also has positive obligations to protect from arbitrary detention by non-State actors. In *Storck v Germany*, the European Court of Human Rights (ECtHR) held that states must 'take reasonable steps to prevent a deprivation of liberty of which the authorities have or ought to have knowledge'.⁷ In *Storck*, this meant the regulation of all public and private psychiatric institutions. The ECtHR explained that '[t]he State cannot completely absolve itself from its responsibility by delegating its obligations in this sphere to private bodies or individuals', and that 'private psychiatric institutions...in particular those where persons are held without a court order, need not only a licence, but a competent supervision on a regular basis of the justification of the confinement and medical treatment'.⁸

Due to the power imbalances that exist in the healthcare context (where people are dependent on others), the State's obligations to protect and defend human rights take on extra significance in this

arena. Care settings are places of heightened risk of arbitrary deprivation of liberty, torture or other ill-treatment, lack of respect for legal capacity and the right to informed decision-making, and unlawful interferences with privacy. These risks are even greater for people who fall into groups that have traditionally experienced discrimination and negative stereotyping.

A key aspect of ensuring that individuals are not arbitrarily deprived of their liberty in care settings is protection of the right to recognition of one's legal capacity, and the right to informed consent to care. The UN Special Rapporteur on torture and the UN Special Rapporteur on health have both highlighted that 'while informed consent is commonly enshrined in the legal framework at the national level, it is frequently compromised in the health-care setting. Structural inequalities, such as the power imbalance between doctors and patients, exacerbated by stigma and discrimination, result in individuals from certain groups being disproportionately vulnerable to having informed consent compromised'.⁹ The UN Committee on the Rights of Persons with Disabilities has stated that 'The denial of legal capacity to persons with disabilities has, in many cases, led to their being deprived of many fundamental rights, including...the right to liberty.'¹⁰

The UN Independent Expert on the enjoyment of all human rights by older persons has explained that 'Legal capacity has particular relevance for older persons regarding making fundamental decisions regarding their social and health care, in particular medical treatment. The respect for and the strengthening of older persons' autonomy in care settings means that they must be able to give consent to, refuse or choose an alternative medical intervention.'¹¹ Noting that 'Ageist attitudes still persist throughout the world, leading to discriminatory practices towards older persons, including in care settings',¹² the Independent Expert has stated that 'Safeguards to free and informed consent should be adopted through legislation, policies and administrative procedures in conformity with international and regional standards.'¹³

B. The State is on notice of arbitrary deprivation of liberty in a wide range of care settings.

There is evidence to show that arbitrary deprivation of liberty is widespread in care settings in Ireland and abroad, as explained below. The State is on notice that people are routinely experiencing deprivations of liberty which are unauthorised by law, and the State is therefore failing in its positive obligations under the human rights instruments mentioned above to prevent and protect from arbitrary detention. The settings where arbitrary deprivations of liberty are occurring go beyond those covered in the draft Heads of Bill and include hospitals, community-based settings and people's homes. It is important to highlight that the Law Reform Commission recommended in 2012 that professional home care should be regulated and monitored by HIQA.¹⁴ These heads of Bill fail to address the area of home care, continuing to leave that sector unsupervised in violation of the State's positive obligations to protect the human rights of those receiving care.

Residential care

Although there is no legislation permitting deprivation of liberty in nursing homes or social care institutions, Sage Support and Advocacy Service states that, in their experience, 'many residential care settings for vulnerable adults and older people are commonly secured by key code locks as a safety mechanism, requiring residents to ask permission to leave the premises'.¹⁵ Sage adds that '*de facto* detention can extend as far as limiting people's access to recreational grounds outside of the building,

justified by an assessment that the resident is a “fall risk” or likely to “escape”.¹⁶ Sage’s experience is similar to that reported internationally.¹⁷

A recent University College Dublin (UCD) study of the experiences of 38 social workers supporting 788 older people in Ireland found that ‘many older people with a mental health issue and/or cognitive impairment/dementia were excluded from the decision-making process [about their care] regardless of their level of functional capacity’.¹⁸ The social workers reported that older people with dementia were particularly likely to be excluded due to ‘[a] status approach to dementia, where people were deemed to lack capacity’, because their ‘family didn’t want them involved’, because they had ‘communication difficulties which impacted on their involvement’ and/or because they had ‘no opportunity to be involved’.¹⁹ Sage Support and Advocacy Service reports, likewise, that ‘In Sage’s experience it is not uncommon for a third party, often a next of kin, to be asked to sign the contract for care to consent to care although they may have no legal authority to make decisions for that person.’²⁰

The same UCD study found that the government’s neglect of home care services means that older people who require assistance with basic needs are frequently forced to enter long-term residential care settings unnecessarily and prematurely.²¹ One of the social workers interviewed by Donnelly et al is reported as stating: ‘I could count on one hand the number of people who want to be in the facility. Many people eventually accept their situation—they see it as having no other choice’.²² HIQA has reported, in relation to residential care settings, that ‘many residents expressed a wish to be cared for in their own homes.’²³ This research echoes the finding of the UN Independent Expert on older persons’ human rights, that institutional care ‘can often take the form of forced institutionalization and compulsory placements, especially when no other form of care is available for the individual or when relatives are unable or unwilling to provide care’.²⁴

Restraint

Internationally, it is acknowledged that older people with dementia are frequently chemically restrained in care contexts.²⁵ It appears that Ireland is no different; Sage Support and Advocacy Service states that it ‘has observed the use of sedation to manage behaviours for the convenience of staff and benefit of other people in congregated settings’²⁶ and that it believes that ‘for a variety of reasons, some based on a lack of skill in addressing behaviours which are challenging, some based on ignorance of basic human rights and some based on expediency, it would seem that a culture has developed in which the use of chemical restraint has become normalised, i.e. it is being used as a first rather than a last resort’.²⁷ Sage has also reported the use of sedating medication to encourage an older woman in hospital to ‘adapt’ to incontinence pads.²⁸

Chemical restraint is generally understood to involve the use of medication (usually anti-psychotic medication) as sedation or otherwise to control a person’s behaviour.²⁹ According to Feng et al, the prevalence of anti-psychotic medication use to control the behaviour of older persons in nursing homes ranged in 2009 from 38% of nursing home residents in Finland, to 34% in Switzerland, to 27% in the United States to 11% in Hong Kong.³⁰ In the English context, Banerjee estimated in 2009 that between 30% and 50% of English residential and nursing home residents with dementia may have been receiving antipsychotic medication.³¹ Banerjee notes that older people in England are also frequently chemically restrained in hospital³² and by doctors in the community.³³

Banerjee states that anti-psychotic medication is prescribed mostly unlicensed (or 'off-label') to older people with dementia,³⁴ and he has estimated that at least 80% of people with dementia who are treated with anti-psychotic medication in England do not derive any benefit from it.³⁵ Banerjee also highlights substantial evidence that the use of such medication significantly increases the incidence of death and stroke.³⁶

Harding and Peel, Banerjee and the Austrian Ombudsman Board report that sedating medication is routinely administered to older people with dementia without their consent and often without providing information to relatives, representatives or carers.³⁷ Banerjee and the Austrian Ombudsman Board note that prescribing physicians frequently fail to demonstrate that they have considered alternatives to anti-psychotic medication or that they have planned for reduction and cessation of the use of such medication on their patients.³⁸ Feng et al argue that '[t]he persistent use of physical restraints and antipsychotics warrants additional monitoring and research' and that '[a] number of studies have demonstrated that a substantial reduction in restraint use, combined with meaningful alternatives, could result in no adverse outcomes or even in possible benefits'.³⁹

Regarding physical restraint in older people's nursing homes, Drennan et al note that '[t]he excessive use of restraints to control residents has been reported as the most frequently-occurring type of physical abuse in a number of studies undertaken in the US and Europe'.⁴⁰ In 2009, using a measurement common to 20 countries, Feng et al found the prevalence of physical restraint use in nursing homes to vary from 6% of residents in Switzerland, to 20% in Hong Kong, to over 31% in Canada.⁴¹

Measures of physical restraint may be applied to older people in hospital, too. In a 2011 report on hospital care of older adults in English and Welsh hospitals, Tadd et al stated that 'throughout our observations on the acute wards...concerns for patient safety, particularly for confused patients or those with dementia, mean that staff spend a great deal of time preventing patients from moving out of their chairs'.⁴² The report stated, further, that '[d]ue to concerns of potential risks to the system, of falls and other untoward incidents, the culture of acute care practice encourages patients to remain in their chairs and use bedpans or commodes rather than being helped to a toilet'⁴³ and that '[s]taff are also more likely to adopt habits of using bed rails when perhaps they are not necessary'.⁴⁴

C. The definition of deprivation of liberty under human rights law is broader than the draft Heads of Bill recognise.

The definition of deprivation of liberty under human rights instruments is broad and does not, in principle, exclude any particular form of detention or restraint.

It is important to highlight that deprivation of liberty need not be caused by physical force. A person's inability to leave a place or escape a situation may also arise due to non-physical forms of coercion, including the exercise of power over a person who is dependent on another for care. The denial of a person's right to make decisions about how they are cared for may lead to them being deprived of their liberty if it means that a restricting or isolating form of care is imposed on them without their informed consent.

The draft Heads of Bill only cover a fraction of the forms of deprivation of liberty that are occurring in care settings in Ireland.

First, the draft legislation applies only to ‘relevant facilities’, which are explained to be nursing homes and care/residential accommodation in addition to approved centres under the Mental Health Act 2001.⁴⁵ In contravention of the State’s obligation to protect against arbitrary deprivation of liberty wherever it knows or ought to know of its occurrence, the Heads of Bill explicitly exclude institutions in which ‘the majority of persons being cared for and maintained are being treated for acute illness or provided with palliative care’ and institutions ‘primarily used for the provision of educational, cultural, recreational, leisure, social or physical activities’.⁴⁶ There is a need to recognise and protect against arbitrary deprivations of liberty in hospitals, step-down facilities, respite facilities, supported living accommodation and community/voluntary housing associations, and through home care provision and the administration of sedating medication in the community.

Second, the draft legislation excludes whole categories of people who are or may be arbitrarily deprived of their liberty from its remit. The Heads of Bill are explicitly stated not to apply to wards of court.⁴⁷ The Heads of Bill do not apply at all to people who are *not* ‘reasonably believed’ to ‘lack capacity to make a decision to live in the relevant facility’.⁴⁸ Furthermore, the Heads of Bill contain exemptions from the requirement to authorise deprivations of liberty where the person in charge of a relevant facility ‘reasonably believes’ that a person’s capacity is ‘fluctuating’⁴⁹ or that ‘there is a high probability of the person’s demise within a short period’.⁵⁰

Physical confinement

In some Article 5 ECHR jurisprudence, the ECtHR defines deprivation of liberty as ‘confinement in a particular restricted space for a length of time which is more than negligible’.⁵¹ The UN Human Rights Committee’s (HRC) definition under Article 9 ICCPR is similar: ‘more severe restriction of motion within a narrower space than mere interference with liberty of movement under article 12’.⁵² The HRC explains that ‘[l]iberty of person concerns freedom from confinement of the body’.⁵³ These definitions are particularly relevant to restraint practices.

A related, common definition of deprivation of liberty under international human rights law is lack of freedom to leave a place at will. Article 4(2) OPCAT defines deprivation of liberty as ‘any form of detention or imprisonment or the placement of a person in a public or private custodial setting which that person is not permitted to leave at will by order of any judicial, administrative or other authority’.⁵⁴ According to the Inter-American Commission on Human Rights, ‘the concept of “deprivation of liberty” encompasses: [a]ny form of detention, imprisonment, institutionalization, or custody of a person in a public or private institution which that person is not permitted to leave at will’.⁵⁵ The ECtHR finds the objective aspect of a deprivation of liberty to exist where a person is ‘under continuous supervision and control and not free to leave’.⁵⁶ The HRC, meanwhile, has held that a person will not be deprived of their liberty if they ‘know that they are free to leave at any time’.⁵⁷

Coercion

Physical confinement or lack of physical freedom to leave a place at will is not the only established conception of deprivation of liberty in international human rights law. The ECtHR has held that an ‘element of coercion’ is indicative of a deprivation of liberty.⁵⁸ The Court rejects the notion that deprivation of liberty must take any particular form.⁵⁹ It holds that what matters is the ‘degree or intensity’ of the restriction on movement⁶⁰ and the ‘concrete situation’ of the person concerned having regard to the ‘type, duration, effects and manner of implementation of the measure in question’, among other factors.⁶¹

The ECtHR has found deprivations of liberty to exist in the mental health care context even where premises are unlocked⁶² and where a person has previously gone on outings or visits away from the institution.⁶³ Individuals have been found to be ‘not free to leave’ where permission to leave the premises is required,⁶⁴ where a person’s guardian is required to consent to the person leaving,⁶⁵ where there are restrictions as to the length of time and destination to which a person may go,⁶⁶ where an institution restricts access to a person’s identity documents or finances, which would enable them to travel,⁶⁷ where a person is returned—for example, by the police—when they leave,⁶⁸ or where it is clear that a person would be prevented from leaving if they tried or returned to the institution if they did.⁶⁹

The ICCL argues that a deprivation of liberty can occur where a person who is dependent on others for care is unable to avoid or escape a form of restricting or isolating care because they have been denied the opportunity to make their own decisions about the care that they receive. The former United Nations Special Rapporteur on torture, Manfred Nowak, highlighted in a 2008 report to the UN Human Rights Council that people with disabilities are often rendered ‘powerless’ when their ‘exercise of decision-making and legal capacity is taken away by discriminatory laws or practices and given to others’.⁷⁰

D. Deprivations of liberty are not permissible on the basis of a disability, and people with disabilities must be enabled to exercise their legal capacity.

The Heads of Bill fail to meet the State’s requirement under the CRPD to protect against arbitrary detention because the grounds upon which a person may be deprived of their liberty do not fully correspond to Articles 12 and 14 CRPD, nor indeed the Assisted Decision-Making (Capacity) Act 2015 (ADM Act). The draft legislation evinces a medical, substitute decision-making approach to determining whether a person has sufficient capacity to decide where to live, where a decision about their living arrangements has not already been made through the full and informed consent of the person or in accordance with the ADM Act.

Under the draft legislation, the trigger for the process of authorising (or not) a deprivation of liberty where a decision has not already been made through the full and informed consent of a person or through the ADM Act is that a healthcare professional or the person in charge of an institution ‘reasonably believes’ that the person lacks sufficient capacity to decide where to live. As Sage highlight in their submission on the draft Heads of Bill, the draft legislation ‘does not enable a process of capacity building with the person and supported decision-making in accordance with the ADM Act 2015 prior to the healthcare professional determining the person lacks capacity and triggering an application to court if an appointed decision-making role is not in place’.⁷¹

Disability cannot justify a deprivation of liberty and legal capacity must be respected

Article 14 CRPD provides that ‘the existence of a disability shall in no case justify a deprivation of liberty’. Article 14 CRPD corresponds with a well-established principle under Article 9 ICCPR and customary international law that detention on discriminatory grounds is in principle arbitrary.⁷²

Article 14 CRPD requires, according to the UN Office of the High Commissioner for Human Rights (OHCHR), that ‘the legal grounds upon which restriction of liberty is determined must be de-linked from the disability and neutrally defined so as to apply to all persons on an equal basis.’⁷³

In relation to people who have or are perceived to have a disability, Article 12 CRPD requires States to recognise that ‘persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life’. States are required by Article 12 to ‘take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity’. The CRPD Committee has explained that where a person is detained in a care context without their consent and on the basis of substitute or ‘best interests’ decision-making (rather than making their own decision, with support where necessary to express their will and preferences), this amounts to arbitrary detention.⁷⁴

E. Detention will be arbitrary where the law does not contain sufficient safeguards to protect individuals’ rights.

A deprivation of liberty, including a measure of restraint, will only be lawful if it happens in accordance with procedures established in domestic law which are fair and protect against arbitrariness.⁷⁵

Regarding the first criterion – that a deprivation of liberty must be ‘in accordance with a procedure prescribed by law’ – the ECtHR has held that:

- (1) There must be a clear and precise legal basis in domestic law for the deprivation of liberty, over the entire period of detention;⁷⁶ and
- (2) The grounds and conditions for depriving people of their liberty must be clearly defined, and the law must be foreseeable in its application.⁷⁷

Regarding the second criterion – that the law must protect against arbitrariness – this criterion has been described as being ‘broader than unlawfulness, concerning as it does avoidance of abuse of power and the requirement of compliance with the rule of law broadly defined.’⁷⁸ International courts and other human rights actors have clarified some of the basic elements of laws that adequately protect against arbitrariness. The ICCL argues that the draft Heads of Bill fail to meet several of these basic standards, for the following reasons.

The law does not sufficiently provide for independent and impartial authorisation and review of deprivations of liberty

In order to avoid arbitrariness, the law must provide for independent authorisation and review of deprivations of liberty. As mentioned above, the draft Heads of Bill exempt whole categories of people who are or may be deprived of their liberty in care settings from the protection of the law, thereby depriving them of the opportunity of independent authorisation or review of their detention. Even where the draft legislation appears to provide protection, much of it is dependent upon the initiative of the person in charge of a care institution who cannot be considered independent.

The UN Subcommittee on Prevention of Torture (UN SPT) states that ‘Involuntary confinement of any person is a form of arbitrary detention unless it is ordered by a competent and independent judicial authority through due process, which must include close and constant review.’⁷⁹ The ECtHR jurisprudence, on the other hand, suggests that a deprivation of liberty need not have been ordered by a Court.⁸⁰ The CPT accepts this, although it notes that the Council of Europe Parliamentary Assembly recommended in 1994 that decisions regarding involuntary placement in care settings be taken by a

judge.⁸¹ Regardless of the decision-maker, the CPT states that ‘the procedure by which involuntary placement is decided should offer guarantees of independence and impartiality’.⁸²

Article 5 ECHR requires that everyone who is deprived of their liberty is informed promptly of the reasons for the action taken. Those reasons must clarify for the person concerned the legal and factual grounds for the deprivation of liberty, so that the person can apply to a court to challenge the lawfulness of the arrest or detention.⁸³

Regarding restraint, the CPT requires that ‘every single case of resort to means of restraint be authorised by a doctor or, at least, brought without delay to a doctor’s attention in order to seek approval for the measure.’⁸⁴ The CPT contrasts this to the frequent practice of ‘prior blanket consent [being] given by the doctor, instead of decisions being taken on a case by case (situation by situation) basis.’⁸⁵ The CPT stresses the importance of ‘detailed and accurate recording of instances of restraint’⁸⁶ and recommends that a specific register be established for this purpose, which individuals should have access to along with their medical file.⁸⁷

The UN SPT states: ‘Restrains, physical or pharmacological, are forms of deprivation of liberty and, subject to all the safeguards and procedures applicable to deprivation of liberty, should be considered only as measures of last resort for safety reasons. The State must take into account, however, that there is an inherently high potential for abuse of such restraints and as such these must be applied, if at all, within a strict framework that sets out the criteria and duration for their use, as well as procedures related to supervision, monitoring, review and appeal. Restraints must never be used for the convenience of staff, next of kin or others. Any restraint must be recorded precisely and be subject to administrative accountability, including through independent complaint mechanisms and judicial review.’⁸⁸

Article 9 ICCPR, Article 5 ECHR and the Irish Constitution guarantee the right of habeas corpus for any person deprived of their liberty – that is, the right to prompt judicial review of the procedural and substantive lawfulness of detention and release if such detention is found to be unlawful or arbitrary.⁸⁹ The HRC states that those deprived of liberty in health and social care contexts ‘must be assisted in obtaining access to... initial and periodic judicial review of the lawfulness of the detention, and to prevent conditions incompatible with the Covenant’.⁹⁰ The ECtHR, likewise, has held that those deprived of liberty in care institutions are entitled ‘to take proceedings at reasonable intervals before a court to put in issue the ‘lawfulness’ – within the meaning of the Convention – of his detention’.⁹¹ The ECtHR has refrained from specifying the form(s) of judicial review which would satisfy Article 5(4) ECHR,⁹² but has held that persons deprived of their liberty must actually have access to a court and the opportunity to be heard either in person or, where necessary, through some form of representation.⁹³

HRC and ECtHR jurisprudence, and the CPT Standards, provide that persons deprived of their liberty in the health and social care context also have a right to automatic, regular review of the necessity (and proportionality) of their detention.⁹⁴

The law provides inadequate safeguards to ensure that only necessary and proportionate deprivations of liberty are authorised

The law must ensure that any deprivation of liberty for care purposes is only imposed where strictly necessary and proportionate. It is now well recognised that international human rights law prohibits

deprivation of liberty for reasons of treatment or ongoing care in relation to a mental illness or disability. Furthermore, the ECtHR prohibits deprivation of liberty for the purpose of providing physical care.

The State's failure to create statutory rights to community-based forms of care gives rise to a real risk of unnecessary and disproportionate deprivations of liberty in care settings. As discussed above, it appears that people in Ireland are frequently being forced into institutions against their will due to the unavailability of home- and other community-based forms of care. It also appears that chemical restraint and other forms of restraint are being practised due to a lack of staff training and resources in institutional settings, and due to a lack of investment in non-pharmacological, positive behaviour support services (e.g. for people experiencing behavioural symptoms of dementia).

As a result of Article 14 CRPD, the UN Human Rights Committee's General Comment 35 states that '[t]he existence of a disability shall not in itself justify a deprivation of liberty but rather any deprivation of liberty must be necessary and proportionate, for the purpose of protecting the individual in question from serious harm or preventing injury to others.'⁹⁵ This formulation has been echoed by the former UN Special Rapporteur on Torture, who contends that, pursuant to Article 14 CRPD, deprivation of liberty can only be justified when the person is 'a danger to him or herself or others' or 'in emergency circumstances', and 'in both cases for a limited time and with limited means, strictly sufficient only to prevent the risk of major harm'.⁹⁶

As to the question of what is necessary and proportionate for the purpose of protecting from serious or major harm to self or injury to others, the HRC states that the deprivation of liberty must involve 'programmes of treatment and rehabilitation that serve the purposes that are asserted to justify the detention',⁹⁷ that it 'must be applied only as a measure of last resort and for the shortest appropriate period of time',⁹⁸ that the procedures surrounding it 'should ensure respect for the views of the individual and ensure that any representative genuinely represents and defends the wishes and interests of the individual',⁹⁹ and that 'States parties should make available adequate community-based or alternative social-care services for persons with...disabilities, in order to provide less restrictive alternatives to confinement'.¹⁰⁰ The UN Subcommittee on Prevention of Torture explains that 'States should develop and make available alternatives to confinement such as community-based treatment programmes, which are particularly appropriate for avoiding hospitalization and for providing care for persons upon their discharge from hospitals.'¹⁰¹

The law does not adequately protect the right of all adults to make decisions regarding restricting forms of care

As discussed above, it is widely recognised that denial of the right to make one's own decisions about care can easily lead to arbitrary detention. Article 12 CRPD explicitly requires States to ensure that the right to legal capacity is respected. The UN Special Rapporteur on Torture,¹⁰² the UN Subcommittee on Prevention of Torture (UN SPT)¹⁰³ and UN Independent Expert on older persons' human rights¹⁰⁴ (among others) have all recognised the particular obligation on States to ensure that legal capacity is respected in the care context.

The draft Heads of Bill fail to require informed consent to all forms of restricting or isolating care as a mechanism of preventing arbitrary detention. The draft legislation is silent on the procedures that should apply *whenever* a person enters institutional care or experiences another form of care that will

limit their freedom of movement. The ICCL argues that this gap in the draft Heads of Bill constitutes a failure to ensure that the law effectively protects against arbitrary detention.

The UN SPT explains that it 'has observed situations in which State agents represent confinement as voluntary and present registries or legal decisions to that effect. It is concerned that in some of those instances those safeguards were practised as a mere formality. Confinement and institutionalization are voluntary only when the person concerned has decided on it upon informed consent and retains the ability to exit the institution or facility.'¹⁰⁵ The UN SPT adds: 'Informed consent is a decision made voluntarily on the basis of comprehensible and sufficient information regarding potential effects and side effects of treatment and the likely results of refraining from treatment. Informed consent is fundamental to respecting an individuals' autonomy, self-determination and human dignity.'¹⁰⁶

The UN Independent Expert on older persons' human rights points out that 'Ageist attitudes still persist throughout the world, leading to discriminatory practices towards older persons, including in care settings.'¹⁰⁷ She states that 'Legal capacity has particular relevance for older persons regarding making fundamental decisions regarding their social and health care, in particular medical treatment. The respect for and the strengthening of older persons' autonomy in care settings means that they must be able to give consent to, refuse or choose an alternative medical intervention.'¹⁰⁸ The Independent Expert adds:

The institutionalization of care, while it can be the result of an autonomous decision of a person as he or she becomes older, can often take the form of forced institutionalization and compulsory placements, especially when no other forms of care are available for the individual or when relatives are unable or unwilling to provide care...¹⁰⁹ When proper legal and institutional mechanisms and procedures are in place in care settings, thus ensuring freedom of choice and informed consent, older persons in need of care can lead a life with dignity. It is therefore crucial to ensure older persons' autonomy, in particular when it comes to any decision-making affecting their care.¹¹⁰

The law fails to provide a right to independent advocacy services, which are necessary in order to make any safeguards accessible and effective

Due to the vulnerabilities that people experience when they are in need of care, there is a clear need for statutory rights to independent advocacy services in the care context in Ireland. Independent advocacy is one means of ensuring that all of the safeguards that in principle protect from arbitrary detention are in fact accessible to people who are in need of care, and are effective.

The CRPD requires that independent advocacy support is available where necessary to ensure that people with disabilities are in a position to exercise their rights. States are required by Article 12 CRPD to 'take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity'. The CRPD Committee has explained that "'Support" is a broad term that encompasses both informal and formal support arrangements, of varying types and intensity. For example, persons with disabilities may choose one or more trusted support persons to assist them in exercising their legal capacity for certain types of decisions, or may call on other forms of support, such as peer support, advocacy (including self-advocacy support), or assistance with communication.'¹¹¹ The CRPD Committee has also explained that 'All persons with disabilities have the right to engage in advance planning and should be given the opportunity to do so on an equal basis

with others...Support should be provided to a person, where desired, to complete an advance planning process.¹¹²

Regarding older people who do not have disabilities, access to independent advocacy services is also crucial to ensuring that their rights are respected in the care context. The UN Independent Expert on older persons' human rights states that 'Effective safeguards for ensuring the autonomy of older persons should be developed and implemented to ensure the respect of the rights, wishes and preferences of older persons and to avoid undue interference.'¹¹³ Harding argues that formal complaints mechanisms in older people's care settings have proven ineffective, because they do not respond, for example, to informal carers' inability to pursue complaints at the same time as caring for a relative, or older people's worries about retribution by those upon whom they are dependent.¹¹⁴ In this vein, Charpentier and Soulières argue that, instead of formal and impersonal complaints systems, monitoring needs to be based on 'meaningful social relationships that exist in a context of proximity'.¹¹⁵ Meanwhile, the former Special Rapporteur on health, Anand Grover, has stated that ensuring that older people's right to informed consent requires a 'customized, individualized' approach, that could be assisted 'possibly through peer networks'.¹¹⁶

F. Ireland needs to ratify the Optional Protocol to the Convention against Torture (OPCAT)

Along with the Irish Human Rights and Equality Commission¹¹⁷ and numerous other organisations,¹¹⁸ the ICCL has been calling for many years for Ireland to ratify the Optional Protocol to the UN Convention against Torture (OPCAT). Ireland signed the OPCAT on 2 October 2007 but never ratified the instrument. The OPCAT requires member states to establish a National Preventive Mechanism, which is an independent body that conducts inspections (which may be unannounced) and reports on the conditions in any institution where people may be deprived of their liberty in the state.

It is an internationally recognised fact that people who are deprived of their liberty, including in care institutions, are at heightened risk of experiencing torture or other cruel, inhuman or degrading treatment due to the imbalance of power in the situation. The State is obliged under the rule against torture and ill-treatment (which is protected by the Irish Constitution, the ECHR and numerous other international human rights treaties to which Ireland is a party) to ensure that individuals who are deprived of their liberty receive respectful treatment and the basic resources necessary to protect their dignity. The work of a National Preventive Mechanism is essential to ensure that the human rights of people who are deprived of their liberty are protected and fulfilled. The vast majority of countries in Europe have ratified the OPCAT and established a National Preventive Mechanism, and Ireland's continuing failure to do so increases the risk of violations of the rights of people in vulnerable situations.

It is essential that the State ratifies the OPCAT immediately and sets about establishing a National Preventive Mechanism that encompasses all places where individuals may be, and are, deprived of their liberty. The text of OPCAT makes clear that the State does not need to have its National Preventive Mechanism in place before ratifying the instrument, but can seek advice and assistance from the UN Subcommittee for the Prevention of Torture in establishing the NPM thereafter.¹¹⁹ The development of an NPM should be informed by inclusive consultation with civil society and all those involved in and affected by deprivation of liberty.

In 2017, the UN Committee against Torture noted that 'existing bodies (the Inspector of Prisons, the Prison Visiting Committees, HIQA and the Inspector of Mental Health) do not systematically carry out

visits to all places of deprivation of liberty such as Garda stations, residential care centres for people with disabilities, nursing homes for the elderly and other care settings'.¹²⁰ The Committee recommended that Ireland should '(a) Immediately ratify the Optional Protocol and establish a national preventive mechanism, ensuring that this body has access to all places of deprivation of liberty in all settings; (b) Ensure that existing bodies which currently monitor places of detention as well as civil society organizations are allowed to make repeated and unannounced visits to all places of deprivation of liberty, publish reports and have the State party act on their recommendations.'¹²¹

CONCLUSION

The ICCL looks forward to engaging with the Department of Health further as this legislation is revised and, if necessary, further legislation is drafted in order to ensure that people who are receiving care are effectively protected from arbitrary detention and from the additional mistreatment that stems from it.

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- Many thanks are also due to Aoife Masterson for her research assistance.

¹ Convention for the Protection of Human Rights and Fundamental Freedoms (adopted 4 November 1950, entered into force 3 September 1953) 213 United Nations Treaty Series 222 (ECHR), Article 5.

² International Covenant on Civil and Political Rights (adopted 16 December 1966, entered into force 23 March 1976) 999 UNTS 171 (ICCPR), Article 9.

³ Charter of Fundamental Rights of the European Union 2000 OJ (C 364) 1 (EU Charter), Article 6.

⁴ Convention on the Rights of Persons with Disabilities (adopted 24 January 2007, entered into force 3 May 2008) (2007) 46 ILM 441 (CRPD), Article 14.

⁵ See United Nations General Assembly, Report of the Working Group on Arbitrary Detention, UN Doc A/HRC/22/44 (24 December 2012), paras 41 – 52, <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G12/189/35/PDF/G1218935.pdf?OpenElement>

⁶ Ibid, para 48.

⁷ *Storck v Germany* (2006) 43 EHRR 6, para 102.

⁸ Ibid para 103.

⁹ UN Human Rights Council, Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E Mendez, UN Doc A/HRC/22/53 (1 February 2013), para 29, http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf

¹⁰ UN Committee on the Rights of Persons with Disabilities, General Comment No 1 (2014): Equal recognition before the law, UN Doc CRPD/C/GC/1 (19 May 2014), para 8, <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G14/031/20/PDF/G1403120.pdf?OpenElement>

¹¹ UN Human Rights Council, Report of the Independent Expert on the enjoyment of all human rights by older persons, Rosa Kornfeld-Matte, UN Doc A/HRC/30/43 (13 August 2015), para 51.

¹² Ibid para 18.

¹³ Ibid para 101.

¹⁴ See <http://www.lawreform.ie/2012/law-reform-commission-publishes-report-on-professional-home-care.358.html>

¹⁵ Sage Support and Advocacy service, 'Submission as part of the Consultation on Deprivation of Liberty: Safeguard Proposals' (9 March 2018), 7, http://sageadvocacy.ie/wp-content/uploads/2018/03/Sage_Submission-DOL-Safeguards-Proposals_09032018.pdf

¹⁶ Ibid.

¹⁷ See The Law Society of England and Wales, *Identifying a Deprivation of Liberty: A Practical Guide* (London, 2015) 73, 103 – 04; Northern Ireland Human Rights Commission (NIHRC), *In Defence of Dignity: The Human Rights of Older People in Nursing Homes* (Belfast, 2012) 62. See also See Michelle H Y Shum and others, 'Protecting the rights of Chinese older persons in need of residential care: the social justice and health equity dilemma in the People's Republic of China' in Helen Meenan, Nicola Rees and Israel Doron (eds), *Towards Human Rights in Residential Care for Older Persons: International Perspectives* (Routledge 2016) 79. Michael J V White, *A Pathway Forward: The Scope and Role of the Optional Protocol to the Convention Against Torture (OPCAT) in Relation to Aged Day Care and Disability Residences and Facilities* (New Zealand Human Rights Commission 2016) 22

¹⁸ Sarah Donnelly and others, "'I'd Prefer to Stay at Home but I Don't Have a Choice" Meeting Older People's Preference for Care: Policy, but what about practice?' (University College Dublin 2016) 6.

¹⁹ *ibid.*

²⁰ Sage Support and Advocacy service, 'Submission as part of the Consultation on Deprivation of Liberty: Safeguard Proposals' (9 March 2018), 5, http://sageadvocacy.ie/wp-content/uploads/2018/03/Sage_Submission-DOL-Safeguards-Proposals_09032018.pdf

²¹ *ibid.* 5.

²² *ibid.* 17.

²³ Health Information and Quality Authority, *Overview of 2016 HIQA regulation of social care and healthcare services* (2017) 31.

²⁴ UNHRC, 'Report of the Independent Expert on the enjoyment of all human rights by older persons, Rosa Kornfeld-Matte' (13 August 2015) UN Doc A/HRC/30/43 para 74, citing UN Economic and Social Council (ECOSOC), 'Report of the United Nations High Commissioner for Human Rights on the human rights situation of older persons' (20 April 2012) UN Doc E/2012/51 para 25. See also a 2012 study of 1,300 nursing home staff in Ireland (one of the largest studies undertaken internationally) that found that 73.4% of staff had been involved in arguments with residents about leaving the institution setting: Jonathan Drennan and others, *Older People in Residential Care Settings: Results of a National Survey of Staff-Resident Interactions and Conflicts* (National Centre for the Protection of Older People, University College Dublin, 2012) x

²⁵ See Sube Banerjee, *The Use of Antipsychotic Medication for People with Dementia: Time for Action* (An independent report commissioned and funded by the United Kingdom Department of Health, 2009) 5–6. See also UNHRC, 'Report of the Independent Expert on the enjoyment of all human rights by older persons' (8 July 2016) UN Doc A/HRC/33/44 para 48.

²⁶ Sage Support and Advocacy service, 'Submission as part of the Consultation on Deprivation of Liberty: Safeguard Proposals' (9 March 2018), 8, http://sageadvocacy.ie/wp-content/uploads/2018/03/Sage_Submission-DOL-Safeguards-Proposals_09032018.pdf

²⁷ *Ibid.*

²⁸ See Sage Support and Advocacy Service, 'Older people being sedated for "convenience", senior consultant warns', Press Statement (28 July 2016) <www.thirdageireland.ie/sage/latest-news/press-releases/older-people-being-sedated-for-convenience-senior-consultant-warns> accessed 1 September 2017.

²⁹ See Sube Banerjee, *The Use of Antipsychotic Medication for People with Dementia: Time for Action* (An independent report commissioned and funded by the United Kingdom Department of Health, 2009) 11–13.

³⁰ Feng and others, 'Use of physical restraints and antipsychotic medications in nursing homes' (n **Error! Bookmark not defined.**) 1113.

³¹ Banerjee, *The use of antipsychotic medication for people with dementia* (n 28) 19, cited in Rosie Harding and Elizabeth Peel, "'He was like a zombie": Off-label Prescription of Antipsychotic Drugs in Dementia' (2013) 21 *Medical Law Review* 243.

³² Banerjee, *The use of antipsychotic medication for people with dementia* (n 28) 35.

³³ *ibid.* 30, 31, 35.

³⁴ *ibid.* 18.

³⁵ *ibid.* 6.

³⁶ *ibid.* 25–28. See also Rosie Harding and Elizabeth Peel, "'He was like a zombie": Off-label Prescription of Antipsychotic Drugs in Dementia' (2013) 21 *Medical Law Review* 243, 245, citing Lon S Schneider and others, 'Risk of Death with Atypical Anti-psychotic Drug Treatment for Dementia: Meta-analysis of Randomized Placebo-controlled Trials' (2005) 294 *Journal of the American Medical Association* 1934.

³⁷ See Austrian Ombudsman Board, 'Annual Report on the activities of the National Preventive Mechanism (International Version)' (2014) 84: 'The commission have uncovered cases where drugs were prescribed in the case of "restlessness" without a traceable diagnosis. In almost all of the incidents monitored in detail, the documentation in the nursing homes did not contain any indication whatsoever of a medical briefing or explanation or the patient's consent. In many cases, the staff did not even realise that giving sedatives with the purpose of tranquilising or immobilizing the person affected could be a measure depriving them of their liberty, that there were drugs with fewer side effects, etc. Accordingly, there were also no reports made to the residents 'representatives'. See also Banerjee, *The Use of Antipsychotic Medication for People with Dementia: Time for Action* (An independent report commissioned and funded by the United Kingdom Department of Health, 2009) 265; Harding and Elizabeth Peel, "'He was like a zombie": Off-label Prescription of Antipsychotic Drugs in Dementia' (2013) 21 *Medical Law Review* 265: 'In summary, the qualitative findings from these research projects highlight that carers overwhelmingly report negative experiences of the prescription of antipsychotic medication to people with dementia. In contrast to the severe adverse effects (e.g., stroke, death) of these drugs highlighted in clinical research, carers described a range of other harms experienced by the person with dementia that they care for. They described sedative effects of antipsychotics, leaving people with dementia like 'zombies' or 'catatonic'. Informal carers, including those with power of attorney, reported not being consulted prior to the use of antipsychotic medication nor given any information about the risk/benefit profile of the drugs prescribed. Several carers reported removing people with dementia from formal care settings because of failures of care associated with the prescription of antipsychotics' (citation omitted).

³⁸ Banerjee, *The Use of Antipsychotic Medication for People with Dementia: Time for Action* (An independent report commissioned and funded by the United Kingdom Department of Health, 2009) 35; Austrian Ombudsman Board, 'Annual Report on the activities of the National Preventive Mechanism (International Version)' (2014) 83

³⁹ Zhanlian Feng and others, 'Use of physical restraints and antipsychotic medications in nursing homes: a cross national study' (2009) 24 *International Journal of Geriatric Psychiatry* 1117. Citing Elizabeth Capezuti and others, 'The Relationship Between Physical Restraint Removal and Falls and Injuries Among Nursing Home Residents (1998) 53(1) *Journal of*

Gerontology Series A Biological Sciences and Medical Sciences M47; Richard R Neufeld and others, 'Restraint Reduction Reduces Serious Injuries Among Nursing Home Residents' (1999) 47(10) *Journal of the American Geriatrics Society* 1202; Laura Palmer and others, 'Reducing Inappropriate Restraint Use in Colorado's Long-term Care Facilities' (1999) 25(2) *Joint Commission Journal on Quality and Patient Safety* 78; Anna R Huizing and others, 'Short-term Effects of an Educational Intervention on Physical Restraint Use: A Cluster Randomized Trial' (2006) 6(17) *BMC Geriatrics* <<https://bmcgeriatr.biomedcentral.com/articles/10.1186/1471-2318-6-17>> accessed 26 September 2017

⁴⁰ Jonathan Drennan and others, *Older People in Residential Care Settings: Results of a National Survey of Staff-Resident Interactions and Conflicts* (National Centre for the Protection of Older People, University College Dublin, 2012) 73, citing K Pillemer and D W Moore, 'Abuse of patients in nursing homes: Findings from a survey of staff (1989) 29(3) *The Gerontologist* 314; Thomas Goergen, 'A multi-method study on elder abuse and neglect in nursing homes' (2004) 6(3) *Journal of Adult Protection* 15; Radka Buzgová and Katerina Ivanová, 'Elder abuse and mistreatment in residential settings' (2009) 16(1) *Nursing Ethics* 110

⁴¹ Zhanlian Feng and others, 'Use of physical restraints and antipsychotic medications in nursing homes: a cross national study' (2009) 24 *International Journal of Geriatric Psychiatry* 1110, 1113

⁴² Win Tadd and others, *Dignity in Practice: An exploration of the care of older adults in acute NHS Trusts* (Cardiff University, University of Kent, 2011) 90-91

⁴³ *Ibid.*

⁴⁴ *Ibid.*

⁴⁵ See Head 1 and accompanying Explanatory Note.

⁴⁶ See Head 1.

⁴⁷ See Head 2.

⁴⁸ Head 2.

⁴⁹ Heads 7 and 8

⁵⁰ Heads 7 and 8.

⁵¹ See, for example, *Kędzior v Poland*, App no 45026/07 (ECtHR, 16 January 2013) para 55.

⁵² See HRC General Comment No 35, 'Article 9 (Liberty and security of person)' (16 December 2014) UN Doc CCPR/C/GC/35 para 5 citing HRC, *González del Río v Peru*, Communication No 263/1987 (28 October 1992) UN Doc CCPR/C/46/D/263/1987 para 5.1; HRC, *Karker v France*, Communication No 833/1998 (26 October 2000) UN Doc CCPR/C/70/D/833/1998 para 8.5.

⁵³ HRC General Comment No 35 (*ibid*) para 3.

⁵⁴ Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (adopted 18 December 2002, entered into force 22 June 2006) (2003) 42 ILM 26 (OPCAT) art 4(2).

⁵⁵ IACmHR, Inter-American Commission on Human Rights (IACmHR), Principles and Best Practices on the Protection of Persons Deprived of their Liberty in the Americas (13 March 2008) IACmHR Res 1/08, OEA/Ser/L/V/II.131 doc 26 para 38.

⁵⁶ See *HL v United Kingdom* (2005) 40 EHRR 32 para 91; *DD v Lithuania*, App no 13469/06 (ECtHR, 14 February 2012) para 146.

⁵⁷ United Nations Human Rights Committee, General Comment No 35, 'Article 9 (Liberty and security of person)' (16 December 2014) UN Doc CCPR/C/GC/35, para 6.

⁵⁸ See, for example, *Gillan and Quinton v United Kingdom* (2010) 50 EHRR 1105. Although the Court did not ultimately make a finding in relation to Article 5 in this case, it stated at para 57 that being stopped and searched for 30 minutes was 'indicative of a deprivation of liberty'. In *Novotka v Slovakia*, App no 47244/99 (ECtHR, 4 November 2004), the ECtHR found a deprivation of liberty where a person was 'brought to a police station against his will and was held there in a cell' for less than an hour (p7). See also *DD v Lithuania* App no 13469/06 (ECtHR, 14 February 2012) para 149; *Krupko and Others v Russia*, App no 26587/07 (ECtHR, 26 June 2014) para 36; *Foka v Turkey*, App no 28940/95 (ECtHR, 24 June 2008) para 78.

⁵⁹ See *Guzzardi v Italy* (1981) 3 EHRR 333 para 93.

⁶⁰ See *Guzzardi v Italy*, *ibid*; *Rantsev v Cyprus and Russia* (2010) 51 EHRR 1 para 314; *Stanev v Bulgaria* (2012) 55 EHRR 22 para 115.

⁶¹ See *Guzzardi v Italy*, *ibid* para 92; *Medvedyev and Others v France*, App no 3394/03 (ECtHR, 29 March 2010) para 73; *Creangă v Romania* (2013) 56 EHRR 11 para 91.

⁶² *HL v United Kingdom* (2005) 40 EHRR 32 para 92, citing *Ashingdane v the United Kingdom* (1985) 7 EHRR 528 para 41.

⁶³ *Stanev v Bulgaria* (2012) 55 EHRR 22.

⁶⁴ *ibid* paras 124- 126.

⁶⁵ *Kędzior v Poland*, App no 45026/07 (ECtHR, 16 October 2012) para 57. The Court referred also to *Stanev v Bulgaria* (2012) 55 EHRR 22 para 128.

⁶⁶ *Stanev v Bulgaria* (2012) 55 EHRR 22 para 124.

⁶⁷ *ibid* para 125-26.

⁶⁸ *ibid* para 127; *DD v Lithuania* App no 13469/06 (ECtHR, 14 February 2012) para 146.

⁶⁹ *HL v United Kingdom* (2005) 40 EHRR 32.

⁷⁰ *ibid.*

⁷¹ Sage Support and Advocacy service, 'Submission as part of the Consultation on Deprivation of Liberty: Safeguard Proposals' (9 March 2018), 12, http://sageadvocacy.ie/wp-content/uploads/2018/03/Sage_Submission-DOL-Safeguards-Proposals_09032018.pdf

⁷² Human Rights Committee: “[D]etention on discriminatory grounds in violation of article 2, paragraph 1, article 3 or article 26 is also in principle arbitrary. (1314/2004, *O’Neill and Quinn v. Ireland*, para. 8.5 (finding no violation); see concluding observations: Honduras (CCPR/C/HND/CO/1, 2006), para. 13 (detention on the basis of sexual orientation), and Cameroon (CCPR/C/CMR/CO/4, 2010), para. 12 (imprisonment for consensual same-sex activities of adults) See also Human Rights Council, Report of the Working Group on Arbitrary Detention, Deliberation No. 9 concerning the definition and scope of arbitrary deprivation of liberty under customary international law UN Doc A/HRC/22/44 (24 December 2012)³⁸. The Working Group regards cases of deprivation of liberty as arbitrary under customary international law in cases where:

...
(e) The deprivation of liberty constitutes a violation of the international law for reasons of discrimination based on birth; national, ethnic or social origin; language; religion; economic condition; political or other opinion; gender; sexual orientation; disability or other status, and which aims towards or can result in ignoring the equality of human rights. 51. Consequently, the prohibition of arbitrary deprivation of liberty is part of treaty law, customary international law and constitutes a *jus cogens* norm.

⁷³ Thematic Study by the Office of the United Nations High Commissioner for Human Rights on enhancing awareness and understanding of the Convention on the Rights of Persons with Disabilities (29 January 2009) UN Doc A/HRC/10/48

⁷⁴ General Comment No 1, ‘Article 12: Equal recognition before the law’ (19 May 2014) UN Doc CRPD/C/GC/1 para 40. Although they note that Council of Europe Member States entered no reservations to the CRPD in this respect, Fennell and Khaliq argue that Article 14 CRPD is incompatible with Article 5 ECHR, because Art 5(1) ECHR allows for deprivation of liberty on the basis of ‘unsoundness of mind’. (Philip Fennell & Urfan Khaliq, “Conflicting or complementary obligations? The UN Disability Rights Convention, the European Convention on Human Rights and English Law”, 2011 EHRLR 662). The European Court of Human Rights is showing evidence of moving towards compliance with the CRPD requirements, however. In the 2013 decision of a 7-judge ECtHR chamber in *Plesó v Hungary* (hudoc 2 October 2012, App No 41242/08) the ECtHR took a restrictive approach to the unsoundness of mind justification, applying great scrutiny to the claim that deprivation of liberty was necessary to prevent a person’s health deteriorating, as opposed to preventing imminent harm to others or to one’s own life or limb. (para 66)

In *Plesó*, the Court held that where the deprivation of liberty was for the purpose of improving a person’s condition or avoiding a deterioration, ‘involuntary hospitalisation may indeed be used only as a last resort for want of a less invasive alternative, and only if it carries true health benefits without imposing a disproportionate burden on the person concerned’. (para 66) The Court further held that the proportionality assessment must consider the person’s own views and their ‘inalienable right to self-determination’ (para 66) and that ‘the core Convention right of personal liberty being at stake, the Contracting States’ margin of appreciation cannot be construed as wide in this field’. (para 66) In *Stanev v Bulgaria*, too, the Grand Chamber of the ECtHR held that ‘any protective measure should reflect as far as possible the wishes of persons capable of expressing their will’ and that ‘[f]ailure to seek their opinion could give rise to situations of abuse and hamper the exercise of the rights of vulnerable persons.’ (para 153)

⁷⁵ See for example, *M v Ukraine* App no 2452/04 (ECtHR, 19 April 2012) para 58; *Kedzior v Poland* App no 45026/07 (ECtHR, 16 October 2012) para 63; Human Rights Committee, General Comment No 35, ‘Article 9 (Liberty and security of person)’ (16 December 2014) UN Doc CCPR/C/GC/35. Regarding restraint, see for example, European Prison Rules; *Extract from the 16th General Report [CPT/Inf (2006) 35], published in 2006*, para 51, referring to restraint in psychiatric hospital settings: ‘Every psychiatric establishment should have a comprehensive, carefully developed, policy on restraint. The involvement and support of both staff and management in elaborating the policy is essential. Such a policy should make clear which means of restraint may be used, under what circumstances they may be applied, the practical means of their application, the supervision required and the action to be taken once the measure is terminated. The policy should also contain sections on other important issues such as: staff training; complaints policy; internal and external reporting mechanisms; and debriefing. In the CPT’s opinion, such a comprehensive policy is not only a major support for staff, but is also helpful in ensuring that patients and their guardians or proxies understand the rationale behind a measure of restraint that may be imposed.

⁷⁶ See for example *Quinn v France* (App No 18580/91) Judgment of 22 March 1995; *Labita v Italy* (App No 26772/95) Judgment of 6 April 2000; Irish Human Rights Commission, *Follow-Up Report on State Involvement with Magdalen Laundries* (June 2013), Chapter 3, <https://www.ihrec.ie/app/uploads/download/pdf/20130618164449.pdf>

⁷⁷ See for example, *Creanga v Romania* (App No 29226/03) Judgment of 23 February 2012; *Medvedyev and Others v France* (App No 3394/03) Judgment of 29 March 2010,

⁷⁸ Harris, O’Boyle and Warbrick, *Law of the European Convention on Human Rights* (3rd edn) (Oxford University Press 2014) 304.

⁷⁹ United Nations Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, ‘Approach of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment regarding the rights of persons institutionalized and treated medically without informed consent’, UN Doc CAT/OP/27/2 (26 January 2016), para 5, <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G16/011/96/PDF/G1601196.pdf?OpenElement>

⁸⁰ *DD v Lithuania* App no 13469/06 (ECtHR, 14 February 2012), para 157.

⁸¹ CPT Standards 2015, *Extract from the 8th General Report [CPT/Inf (98) 12], published in 1998*, para 52, referring to Recommendation 1235 (1994) on psychiatry and human rights.

⁸² CPT Standards 2015, *Extract from the 8th General Report [CPT/Inf (98) 12]*, published in 1998, para 52. See also See, for example, regarding the psychiatric detention context: CPT Standards 2015, *Extract from the 8th General Report [CPT/Inf (98) 12]*, published in 1998, para 52; Human Rights Committee, General Comment No 35, 'Article 9 (Liberty and security of person)' (16 December 2014) UN Doc CCPR/C/GC/35 para 19, citing 1061/2002, *Fijalkowska v. Poland*, paras. 8.3–8.4; 754/1997, *A. v. New Zealand*, para. 7.3; general comment No. 31, para. 15

⁸³ See *Fox, Campbell and Hartley v United Kingdom* (App Nos 12244/86; 12245/86; 12383/86) Judgment of 30 August 1990; see also IHRC Follow-Up Report on Magdalen Laundries Chapter 3; see also *M v Ukraine* (App No 2452/04) 19 April 2012, paras 55-67.

⁸⁴ CPT Standards 2015, *Extract from the 16th General Report [CPT/Inf (2006) 35]*, published in 2006, para 44.

⁸⁵ CPT Standards 2015, *Extract from the 16th General Report [CPT/Inf (2006) 35]*, published in 2006, para 44. See also para 45 where the CPT recommends that "[p]sychiatric establishments...consider adopting a rule whereby the authorisation of the use of a mechanical restraint lapses after a certain period of time, unless explicitly extended by a doctor".

⁸⁶ CPT Standards 2015, *Extract from the 16th General Report [CPT/Inf (2006) 35]*, published in 2006, para 52

⁸⁷ CPT Standards 2015, *Extract from the 16th General Report [CPT/Inf (2006) 35]*, published in 2006, para 52: "...Preferably, a specific register should be established to record all instances of recourse to means of restraint. This would be in addition to the records contained within the patient's personal medical file. The entries in the register should include the time at which the measure began and ended; the circumstances of the case; the reasons for resorting to the measure; the name of the doctor who ordered or approved it; and an account of any injuries sustained by patients or staff. Patients should be entitled to attach comments to the register, and should be informed of this; at their request, they should receive a copy of the full entry." The CPT further suggests, at para 53: "Regular reporting to an outside monitoring body, for instance a Health-Care Inspectorate, might be considered as well. The obvious advantage of such a reporting mechanism is that it would facilitate a national or regional overview of restraint practices, thus facilitating efforts to better understand and, consequently, manage their use."

⁸⁸ United Nations Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 'Approach of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment regarding the rights of persons institutionalized and treated medically without informed consent', UN Doc CAT/OP/27/2 (26 January 2016), para 9, <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G16/011/96/PDF/G1601196.pdf?OpenElement>

⁸⁹ *Mihailovs v Latvia* App no 35939/10 (ECtHR, 22 January 2013) para 155; *Stanev v Bulgaria* (2012) 55 EHRR 22 para 168.

⁹⁰ Human Rights Committee, General Comment No 35, 'Article 9 (Liberty and security of person)' (16 December 2014) UN Doc CCPR/C/GC/35 para 19.

⁹¹ *Shtukurov v Russia* (2012) 54 E.H.R.R. 27, para 121, citing *Winterwerp (1983) 5 E.H.R.R. CD305* at [55]; and *Luberti v Italy (1984) 6 E.H.R.R. 440* at [31]; see also *Rakevich v Russia* (58973/00) October 28, 2003 at [43] et seq.

⁹² See *Stanev v Bulgaria*, para 169, citing *Shtukurov (2012) 54 E.H.R.R. 27* at [123].

⁹³ *Stanev v Bulgaria*, para 171(c), citing *Megyeri v Germany (1993) 15 E.H.R.R. 584* at [22].)

See further *Stanev*, para 170: ...In the case of detention on the ground of mental illness, special procedural safeguards may be called for in order to protect the interests of persons who, on account of their mental disabilities, are not fully capable of acting for themselves. (See, among other authorities, *Winterwerp (1979–80) 2 E.H.R.R. 387* at [60].)

⁹⁴ *Kedzior v Poland* App no 45026/07 (ECtHR, 16 October 2012) paras 69, 70; Human Rights Committee, General Comment No 35, 'Article 9 (Liberty and security of person)' (16 December 2014) UN Doc CCPR/C/GC/35 para 19: Deprivation of liberty must be re-evaluated at appropriate intervals with regard to its continuing necessity (citing 754/1997, *A. v. New Zealand*, para. 7.2; see Committee on the Rights of the Child, general comment No. 9, para. 50.)

See also CPT Standards 2015, *Extract from the 8th General Report [CPT/Inf (98) 12]*, published in 1998, para 40. Regular reviews of a patient's state of health and of any medication prescribed is another basic requirement. This will inter alia enable informed decisions to be taken as regards a possible dehospitalisation or transfer to a less restrictive environment.

⁹⁵ Human Rights Committee, General Comment No 35, 'Article 9 (Liberty and security of person)' (16 December 2014) UN Doc CCPR/C/GC/35 para 19, citing 1061/2002, *Fijalkowska v. Poland*, para. 8.3; 1629/2007, *Fardon v. Australia*, para. 7.3; see concluding observations: Russian Federation (CCPR/C/RUS/CO/6, 2009), para. 19; Convention on the Rights of Persons with Disabilities, art. 14, para. 1 (b).

⁹⁶ See Juan E Méndez, 'Introduction', in American University, Washington College of Law, *Torture in Healthcare Settings: Reflections on the Special Rapporteur on Torture's 2013 Thematic Report*, explaining his 2013 UN Report [REF]. See SR on Torture 2013, para 69: The Special Rapporteur believes that the severity of the mental illness is not by itself sufficient to justify detention; the State must also show that detention is necessary to protect the safety of the person or of others.

⁹⁷ Human Rights Committee, General Comment No 35, 'Article 9 (Liberty and security of person)' (16 December 2014) UN Doc CCPR/C/GC/35 para 19, citing concluding observations: Bulgaria (CCPR/C/BGR/CO/3, 2011), para. 10.

⁹⁸ Human Rights Committee, General Comment No 35, 'Article 9 (Liberty and security of person)' (16 December 2014) UN Doc CCPR/C/GC/35, para 19

⁹⁹ Human Rights Committee, General Comment No 35, 'Article 9 (Liberty and security of person)' (16 December 2014) UN Doc CCPR/C/GC/35 para 19, citing concluding observations: Czech Republic (CCPR/C/CZE/CO/2, 2007), para. 14; see also Committee on the Rights of the Child, general comment No. 9, para. 48.

¹⁰⁰ Human Rights Committee, General Comment No 35, 'Article 9 (Liberty and security of person)' (16 December 2014) UN Doc CCPR/C/GC/35 para 19 citing concluding observations: Latvia (CCPR/C/LVA/CO/3, 2014), para. 16. The Human Rights Committee specifically focuses on 'psychosocial disabilities' in this paragraph but it can surely be applied to all deprivations of liberty in the care context.

See also CPT Standards 2015, *Extract from the 8th General Report [CPT/Inf (98) 12], published in 1998*

57. Although no longer requiring involuntary placement, a patient may nevertheless still need treatment and/or a protected environment in the outside community. In this connection, the CPT has found, in a number of countries, that patients whose mental state no longer required them to be detained in a psychiatric establishment nevertheless remained in such establishments, due to a lack of adequate care/accommodation in the outside community. For persons to remain deprived of their liberty as a result of the absence of appropriate external facilities is a highly questionable state of affairs.

¹⁰¹ United Nations Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 'Approach of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment regarding the rights of persons institutionalized and treated medically without informed consent', UN Doc CAT/OP/27/2 (26 January 2016), para 5, <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G16/011/96/PDF/G1601196.pdf?OpenElement>

¹⁰² UN Human Rights Council, Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E Mendez, UN Doc A/HRC/22/53 (1 February 2013), http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf

¹⁰³ United Nations Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 'Approach of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment regarding the rights of persons institutionalized and treated medically without informed consent', UN Doc CAT/OP/27/2 (26 January 2016), <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G16/011/96/PDF/G1601196.pdf?OpenElement>

¹⁰⁴ UN Human Rights Council, Report of the Independent Expert on the enjoyment of all human rights by older persons, Rosa Kornfeld-Matte, UN Doc A/HRC/30/43 (13 August 2015), <http://www.ohchr.org/EN/Issues/OlderPersons/IE/Pages/Reports.aspx>

¹⁰⁵ United Nations Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 'Approach of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment regarding the rights of persons institutionalized and treated medically without informed consent', UN Doc CAT/OP/27/2 (26 January 2016), para 6, <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G16/011/96/PDF/G1601196.pdf?OpenElement>

¹⁰⁶ United Nations Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 'Approach of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment regarding the rights of persons institutionalized and treated medically without informed consent', UN Doc CAT/OP/27/2 (26 January 2016), para 12, <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G16/011/96/PDF/G1601196.pdf?OpenElement>

¹⁰⁷ UN Human Rights Council, Report of the Independent Expert on the enjoyment of all human rights by older persons, Rosa Kornfeld-Matte, UN Doc A/HRC/30/43 (13 August 2015), para 18, <http://www.ohchr.org/EN/Issues/OlderPersons/IE/Pages/Reports.aspx>

¹⁰⁸ Ibid para 51

¹⁰⁹ Ibid para 25.

¹¹⁰ Ibid para 74.

¹¹¹ UN Committee on the Rights of Persons with Disabilities, General Comment No 1, 'Article 12: Equal recognition before the law' (19 May 2014) UN Doc CRPD/C/GC/1 para 17

¹¹² Ibid.

¹¹³ UN Human Rights Council, Report of the Independent Expert on the enjoyment of all human rights by older persons, Rosa Kornfeld-Matte, UN Doc A/HRC/30/43 (13 August 2015), para 50

¹¹⁴ Ibid.

¹¹⁵ Michèle Charpentier and Maryse Soulières, 'Elder Abuse and Neglect in Institutional Settings: The Resident's Perspective' (2013) 25(4) Journal of Elder Abuse and Neglect 339, 351.

¹¹⁶ UN Human Rights Council, Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E Mendez, UN Doc A/HRC/22/53 (1 February 2013), http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf para 63.

¹¹⁷ Irish Human Rights and Equality Commission, *Ireland and the Optional Protocol to the UN Convention Against Torture* (2017) <https://www.ihrec.ie/our-work/cat/opcat/>

¹¹⁸ Irish Penal Reform Trust, OPCAT ratification campaign: <http://www.iprt.ie/opcat>

¹¹⁹ See Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (adopted 18 December 2002, entered into force 22 June 2006) (2003) 42 ILM 26, Arts 11 and 24.

¹²⁰ Committee Against Torture, Concluding Observations on the second periodic report of Ireland (31 August 2017) UN Doc CAT/C/IRL/CO/2, http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CAT%2fC%2fIRL%2fCO%2f2&Lang=en, para 7.

¹²¹ Ibid para 8.