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Compulsory treatment in the community in Hong Kong: Implications of the current law and practice on the rights of persons with mental illnesses

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This article examines the current legal framework and practice of the conditional discharge of mental health patients in Hong Kong under section 42B of the Mental Health Ordinance from a human rights perspective. Using existing literature and findings from semi-structured qualitative interviews conducted with medical professionals, the author argues that the current regime lacks adequate safeguards for mental health patients, both in law and in actual practice, and suffers from the absence of a clear guiding purpose. As such, the law and practice of conditional discharge would most likely infringe patients' fundamental rights to private and family life and to liberty and personal security. The article concludes with the suggestion that an evidence-based approach is required to determine the purpose of the regime and thus how it may be best designed for that end.

1. Introduction

For those studying or working in the field of medical law in common law jurisdictions, it is trite law that adult patients can refuse any medical treatment as long as they have the relevant decision-making capacity, even if that decision is life-threatening or contrary to their best interests.[1] However, in a stark contrast to this well-established common law rule, many of these same jurisdictions also provide a separate legal framework for persons with mental illnesses[2] who may be detained or treated in hospital without their consent regardless of whether they have capacity to make the medical decision in question.[3] This exceptional legal provision for the deprivation of liberty of persons with mental illnesses clearly engages their human rights, most notably their right to liberty and other rights covered by the United Nations (UN) Convention on the Rights of Persons with Disabilities (CPRD) and the International Covenant on Civil and Political Rights (ICCPR). Any potential interferences with these rights will thus require justification.[4]

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[1] See, for example, *Airedale NHS Trust v Bland* [1993] AC 789 and *Re T (Adult: Refusal of Treatment)* [1993] Fam 95.

[2] 'Mental illness' will be used throughout this study to describe the medical condition of the group of patients potentially affected by the mental health regime, as it is more commonly and generally used in clinical studies and other reports in Hong Kong, while other terms such as 'mental disorder' and 'psychosocial conditions' are used more narrowly. For example, the Review Committee on Mental Health's 'Mental Health Review Report' (April 2017) refers to 'the treatment of mental illness', 'people suffering from mental illness', and 'mental illness in children and adolescents'.

[3] See, for example, England and Wales' Mental Health Act 1983, ss 2 and 3 and Hong Kong's Mental Health Ordinance Cap 136, ss 31 and 36.

[4] For an overview of arguments surrounding the justification for compulsory detention and treatment of mentally ill patients with *capacity*, see Emily Jackson, *Medical Law: Texts, Cases, and Materials* (4th edn, OUP 2016) ch 6.1.

However, what is less researched, and what I would like to address in this study, is the legal provision for compulsory treatment of patients with mental illnesses *in the community* and its impact on such patients' rights. In many common law jurisdictions, including the United Kingdom, the United States, Canada, Australia, and New Zealand, the community treatment order (CTO) is a common legal tool for such treatment. CTOs generally oblige patients to keep in touch with their medical team, take medication, or be subject to certain living arrangements, and a failure to meet such conditions would give the relevant institution the power to recall the patient.[5] In recent years, calls for CTOs in Hong Kong have been made each time a tragedy or act of violence involving individuals with mental illnesses has taken place.[6] The most recent example of this was in the aftermath of an arson incident on an MTR train in February 2017. When a man was arrested for the act, media attention soon focused on his history of mental illnesses, generating a debate on the possibility of introducing CTOs in Hong Kong. This served to reinforce the portrayal of persons with mental illnesses in the mainstream media as dangerous and needing some form of social control imposed on them in order to prevent harm to the public. [7]

Although CTOs have not been introduced in Hong Kong,[8] a system for some sort of compulsory treatment in the community does exist in the form of conditional discharge (CD), under section 42B of the Mental Health Ordinance (MHO), which, not coincidentally, was enacted soon after the violent Anne Anne Kindergarten stabbing perpetrated by a psychiatric outpatient in 1982.[9] Under section 42B, conditions may be imposed on a patient upon discharge from hospital and if the patient has 'a medical history of criminal violence or a disposition to commit such violence'.[10] The conditions may be anything that is 'fit on an order for discharge' and 'reasonable in the circumstances'.[11] A power to recall the patient to the hospital also exists.[12]

What is interesting about compulsory treatment in the community is its instinctive attractiveness to the general public and policymakers as a form of control that is seemingly less restrictive than detention in hospital, but at the same time provides the perfect solution to all the 'problems' individuals with mental illnesses are assumed to

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[5] Tom Burns, 'Community Treatment Orders: State of the Evidence' (2013) 23 East Asian Arch Psychiatry 35.
[6] 鄧琳, '社區強制治療是利是弊？從服務使用者的經驗說起' ('The pros and cons of compulsory community treatment: from the perspective of service users') *Pentoy* (Hong Kong, 27 February 2017) < https://wp.me/p8iPwg-gMc> accessed 1 December 2018 and 麥佩雯, '重提「社區治療令」 立法強制精神病患者治療' ('Bringing up community treatment orders again: legislating for the compulsory treatment of mentally ill patients') *HK01* (Hong Kong, 21 July 2016) <https://www.hk01.com/社區/32647/> accessed 1 December 2018.
[7] — '縱火疑兇再度婚變闖禍' ('Arson suspect causing trouble after second divorce') *Oriental Daily* (Hong Kong, 12 February 2017) <http://orientaldaily.on.cc/cnt/news/20170212/00176_010.html> accessed 1 December 2018 and — '醫生倡立法強制治療' ('Psychiatrist advocates legislating for compulsory treatment') *Apple Daily* (Hong Kong, 12 February 2017) <https://hk.news.appledaily.com/local/daily/article/20170212/19925862> accessed 1 December 2018.
[8] The possible introduction of CTOs in Hong Kong has been considered by the Review Committee on Mental Health but the Committee was 'unable to conclude that the benefit to derive from CTO will more than compensate for the curtailment on civil liberties or that the occurrence of tragic incidents involving mental patients will be reduced as a result'; see Review Committee on Mental Health, 'Mental Health Review Report' (April 2017) ch 5 <http://www.hpdo.gov.hk/en/mhr_background.html> accessed 1 December 2018.
[9] Kam-shing Yip, 'An Analysis of the Anti-Psychiatric Halfway House Movement in Hong Kong' (2003) 30 Administration and Policy in Mental Health 535.
[10] Mental Health Ordinance Cap 136, s 42B(1)(a).
[11] Mental Health Ordinance Cap 136, s 42B(2).
[12] Mental Health Ordinance Cap 136, s 42B(3).

cause in society by keeping them under systematic monitoring so that any 'dangerousness' may be discovered as soon as possible.[13] However, in jurisdictions where CTOs have been introduced, there have been concerns that CTOs may increase stigma towards mental health patients even as they try to reintegrate into society[14] and that CTOs may be counterproductive to recovery as they erode patients' trust in medical professionals and reduce their willingness to seek help.[15] Most notably, there is in fact little evidence of the effectiveness of CTOs in the world, in terms of reducing readmission rates or the duration of readmissions.[16] Sanjay Khurmi and Martin Curtice reflect that CTOs can have both positive and negative effects on human rights. On one hand, CTOs can help patients regain the rights to respect and autonomy that they may not be able to fully exercise when spending prolonged periods in the hospital; on the other hand, if CTOs are used overzealously, they may lead to loss of autonomy and dignity and promote discrimination.[17]

Research on the effectiveness and effects of CD in Hong Kong has been scarce. The Review Committee on Mental Health in Hong Kong has published a report which documents the number of patients in psychiatric inpatient wards of the Hospital Authority (HA) who were involuntarily admitted, subject to CD, and readmitted respectively and the length of CD from 2011 to 2015, which may prove useful in providing a statistical picture of the use of the regime in Hong Kong.[18] However, these figures do not tell us anything about CD's effectiveness or effects on patients' enjoyment of rights. Clinical studies have been conducted reviewing the outcomes of patients on CD in terms of violence and suicide rates in Hong Kong,[19] but no scholarship so far has discussed the implications of CD on the rights of persons with mental illnesses, or the legal framework's conformity with international human rights standards.[20]

This study aims to fill that gap in research by looking at the relationship between CD and the rights of persons with mental illnesses in Hong Kong. The main question this study sets out to answer is: *what are the implications of the current law and practice*

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[13] This certainly seemed to be the thinking behind then Legislative Council member Albert Ho's call for CTOs in 2016, as mentioned in 麥佩雯 (n 6): 「雖說現在也有『有條件出院』機制，但現時公立醫院的覆診輪候時間長而疏，公職人員也無權將違反條件的病人強行捉回醫院。好像 2007 年，天耀邨精神病母親將兩子女扔落街後自殺身亡的慘劇。該名母親在事發前一星期才剛覆診，但整個過程僅 5 分鐘。」('Although a conditional discharge mechanism is in place at the moment, the queues for public hospitals are long and public officials have no power to catch patients who have breached their conditions back to the hospital. For example, in the tragedy in 2007 of a mentally ill mother in Tin Yiu Estate who threw her two children out the window and committed suicide afterwards – she only attended a clinical appointment a week before the incident, but the whole appointment lasted only five minutes.')

[14] Judith Laing, 'Rights Versus Risk? Reform of the Mental Health Act 1983' (2000) 8 Medical Law Review 210.

[15] Fiona Caldicott et al, 'Client and Clinician – Law as an Intrusion' in Nigel Eastman and Jill Peay (eds), *Law Without Enforcement: Integrating Mental Health and Justice* (Hart 1999), 75.

[16] Burns (n 5) and Jorun Rugkåsa et al, 'CTOs: what is the state of evidence?' (2014) 49 Social Psychiatry and Psychiatric Epidemiology 1861.

[17] Sanjay Khurmi and Martin Curtice, 'The supervised community treatment order and the Human Rights Act 1998' (2010) 16 Advances in Psychiatric Treatment 263.

[18] Review Committee on Mental Health (n 8).

[19] YC Wong and DWS Chung, 'Characteristics and Outcome Predictors of Conditionally Discharged Mental Patients in Hong Kong' (2006) 16 Hong Kong Journal of Psychiatry 109.

[20] For an example of a discussion of the Hong Kong legal regime for the compulsory detention of mentally ill patients from a constitutional rights perspective, see Daisy Cheung, 'The compulsory psychiatric regime in Hong Kong: Constitutional and ethical perspectives' (2017) 50 International Journal of Law and Psychiatry 24.

of CD under section 42B of the MHO in Hong Kong on the rights of persons with mental illnesses? In doing so, I inquire into the viewpoints of one group of the main participants negotiating the mental health legal regime by conducting semi-structured qualitative interviews with practitioners who are directly involved in the implementation of CD to see how the legal framework is actually practised on the ground, whether there is any discrepancy between the law and such practices, and to what end the CD mechanism is put by practitioners.

In the next two sections, I first look at existing literature on the relevant international and local human rights instruments and the state of evidence for the effectiveness of compulsory treatment in the community in the world. In section 4, I describe and justify the methodology used for the primary research. In section 5, I discuss how the CD regime may impact the rights of persons with mental illnesses on the ground, using the literature reviewed and findings from the primary research conducted. I conclude that the current legal regime primarily suffers from the lack of any clear objective, and also fails to provide adequate protection to patients' right to respect for their private and family life and right to liberty and personal security. Finally, in the last section, I suggest that an evidence-based approach is required in considering any next steps in this area, whether it be reforming the conditional discharge regime or introducing CTOs in Hong Kong.

2. What are the rights affected?

Before examining the CD mechanism in Hong Kong, it is necessary to first set out the background to the present study by looking at the existing literature on international and local human rights instruments relevant to persons with mental illnesses.

2.1 The United Nations Convention on the Rights of Persons with Disabilities

China ratified the UN CRPD on 1st August 2008, also applying it to Hong Kong.[21] The purpose of the CRPD, as stated under article 1, is

> 'to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities [(PwDs)], and to promote respect for their inherent dignity.'

The CRPD is thus a 're-articulation of rights found in other treaties in ways that will make those rights meaningful to [PwDs]' – in other words, a Convention which focuses on non-discrimination.[22] It has been described as a 'paradigm shift' in human rights law for addressing PwDs 'as subjects with rights, rather than objects of charity'.[23] The CRPD raises questions about many mental health regimes across the world, including

[21] Carole J Petersen, 'China's Ratification of the Convention on the Rights of Persons with Disabilities: The Implications for Hong Kong' (2008) 38 HKLJ 611, 624-625.
[22] Peter Bartlett, 'The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law' (2012) 75 MLR 752.
[23] Petersen (n 21) 612.

Hong Kong's, which allow for the compulsory treatment of mentally ill persons with decision-making capacity in relation to their medical treatment, whether in hospital or in the community.

The CRPD rights most likely to be engaged by CD in particular are the right to respect for privacy under article 22 and the right to liberty and security of person on an equal basis with others under article 14. The relevance of these two provisions are expounded below.

(i) The right to respect for privacy

Section 42B of the MHO allows practitioners to impose conditions that are 'fit on an order for discharge' and 'reasonable in the circumstances' on discharged patients, and which are backed by the threat of recall. Patients are therefore compelled to comply with the conditions and may have to unwillingly compromise their private lives if they wish to avoid being compulsorily detained in the hospital. This affects their right to respect for privacy under article 22 of the CRPD, which stipulates that PwDs shall not be 'subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence or other types of communication' 'regardless of place of living of residence or living arrangements'.

As Khurmi and Curtice argue in relation to the similar right to respect for family and private life under article 8 of the European Convention of Human Rights (ECHR), such a right can often be interpreted dynamically and compulsory treatment in the community can have potentially far-reaching effects on patients' enjoyment of this right.[24] Although it is likely that, as the European Court of Human Rights (ECtHR) case law indicates, the right to respect for private life may not be applicable every time an individual's everyday life has been disrupted,[25] it is also clear that conditions imposed by practitioners on the patient under the CD regime, even routine ones such as residing at a certain place or attending at an outpatient clinic, may result in disproportionate interferences with their private life under certain circumstances, for example when the duration of such conditions is indeterminate or when there is no way for the patient to appeal against them.

(ii) The right to liberty and security of person

Article 14 of the CRPD requires states to ensure PwDs enjoy the right to liberty and security of person on an equal basis with others and are 'not deprived of their liberty unlawfully or arbitrarily'. Although the provision guarantees only the *security of person*, in the sense of protecting against arbitrary physical detention or restraint of the person, and may therefore seem irrelevant to the discussion of compulsory treatment in the community which in general only *restricts* certain aspects of a patient's liberty in their daily life, the fact that section 42B gives the hospital the power to recall the patient and admit the patient as a formal patient under section 31 certainly involves the possible deprivation of patients' physical liberty and therefore engages the right. Reference may be made here to the seminal ECtHR case on the right to liberty and security, *HL*

[24] Khurmi and Curtice (n 17).
[25] *Sentges v The Netherlands* (2003) App No 27677/02.

v The United Kingdom, where it was held that, although the applicants in that case were detained in the hospital as voluntary patients, they would have been involuntarily committed had they attempted to resist, and the 'absence of procedural safeguards fails to protect against arbitrary deprivations of liberty on grounds of necessity'.[26] Similarly, if the CD regime in Hong Kong allows patients to be recalled to the hospital and involuntarily admitted without providing them with the appropriate safeguards, it may be regarded as leading to arbitrary deprivations of liberty.

The Committee on the Rights of Persons with Disabilities' Guidelines on article 14 states that it 'prohibits the deprivation of liberty on the basis of actual or perceived impairment *even if additional factors or criteria are also used to justify the deprivation of liberty*', including the perceived danger of persons to themselves or to others.[27] This directly challenges the provision under section 42B(1)(a) that a medical history of criminal violence or a disposition to commit such violence qualifies a patient for CD. The Committee questions the legitimacy of the often used 'dangerousness' or 'propensity to violence' criteria, pointing out that persons with intellectual or psychosocial impairments are often considered dangerous when they do not consent to medical treatment, but are not provided with the same protection as others under the criminal legal system.[28] The UN High Commissioner for Human Rights has also stated that

> '[l]egislation authorizing the institutionalization of [PwDs] on the grounds of their disability without their free and informed consent must be abolished…This should not be interpreted to say that [PwDs] cannot be lawfully subject to detention for care and treatment or to preventive detention, but 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*.'[29]

The CRPD may be taken as a starting point for the rights of persons with mental illnesses. As can be seen from the above overview of the relevant literature, human rights bodies and academic commentators often focus on the broader theme of the compulsory detention and treatment of mentally ill patients with capacity, but not the compulsory treatment of such patients *in the community*, when discussing the compliance of domestic mental health regimes with the CRPD. Nevertheless, these commentaries remain valuable to our discussion about the specific question of the implications of CD on the rights of persons with mental illnesses in Hong Kong, by providing a rights-based model of disability as a background against which mental health law issues may be considered.

2.2 The local human rights framework

[26] *HL v The United Kingdom* [2004] ECHR 471, para 124.
[27] UN Committee on the Rights of Persons with Disabilities, 'Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities' (September 2015), para 7 (emphasis added).
[28] ibid.
[29] UN High Commissioner for Human Rights, 'Annual Report of the United Nations High Commissioner for Human Rights and Reports of the Office of the High Commissioner and the Secretary-General' (26 January 2009) UN Doc A/HRC/10/48, para 49 (emphasis added).

The ICCPR is incorporated into Hong Kong constitutional law by virtue of article 39 of the Hong Kong Basic Law and the Hong Kong Bill of Rights (HKBoR).

Article 14 of the HKBoR protects against arbitrary or unlawful interference with privacy, family, home, or correspondence (equivalent to Article 17 of the ICCPR) while article 5 of the HKBoR guarantees the right to liberty and security of person (equivalent to Article 9 of the ICCPR).

In contrast to the CRPD and the Committee on the Rights of Persons with Disabilities' opinion that the deprivation of liberty on the basis of a patient's disability is strictly prohibited, the Human Rights Committee (HRC) takes a less absolute view on the justification of deprivations of PwDs' right to liberty and security of person:

> 'The 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*.'[30]

Nevertheless, the HRC emphasised that these deprivations must be accompanied by 'adequate procedural and substantive safeguards established by law' and 're-evaluated at appropriate intervals' and that individuals must be provided with 'effective remedies for the vindication of their rights'.[31]

Hong Kong courts' approach to claims involving non-absolute fundamental rights corresponds to the HRC's view. When faced with such claims, courts apply a four-step proportionality assessment, as set out in the case of *Hysan Development v Town Planning Board*: (i) whether the intrusive measure pursues a legitimate aim; (ii) whether it is rationally connected with advancing that aim; (iii) whether the measure is no more than necessary for that purpose; and (iv) whether a reasonable balance has been struck between the societal benefits of the encroachment and the inroads made into the constitutionally protected rights of the individual.[32]

The four questions in the *Hysan* test helps frame our evaluation of the CD regime's effects on the rights of persons with mental illnesses. What rights are potentially affected by the CD regime? What are the main purposes of CD? Are they legitimate? Is CD rationally connected to, and a reasonably necessary and proportionate means of achieving these aims? Are there any safeguards against abuse of the process, judicial or otherwise, or measures to minimise the intrusion into patients' fundamental rights? These are some of the important questions that will be considered in this study.

3. Compulsory treatment in the community in practice

[30] UN Human Rights Committee, 'General comment No.35 on Article 9 (Liberty and security of person)' (16 December 2014), para 19 (emphasis added).
[31] ibid.
[32] *Hysan Development Co Ltd v Town Planning Board* (2016) 19 HKCFAR 372, paras 134-135.

In order to be able to draw conclusions about the justifiability of Hong Kong's own brand of community treatment, which is still relatively new and on which there is limited research, it is important to look at the available research on the effectiveness and effects on patients of compulsory treatment in the community in other jurisdictions.

Tom Burns provides a comprehensive picture of the state of evidence regarding CTOs in other common law jurisdictions in his meta-analysis, which cites descriptive and stakeholder trials, database studies, and randomised controlled trials from the United Kingdom, the United States, Australia, and New Zealand, and concludes that there is a 'total absence of any effect' of CTOs in reducing the readmission rates of mentally ill patients. This is a crucial finding as the reduction of readmission rates is often the main rationale for the introduction of CTOs in many jurisdictions.[33] Jorun Rugkåsa et al's similar analysis of the currently available studies comes to the same conclusion that there is no clear clinical advantage to CTOs.[34]

Writing in relation to the England and Wales regime, Reinhard Heun et al suggest that CTOs may have potential negative effects on patients. Threats and coercion may negatively impact the professional-patient relationship, and CTOs may be misused by relatives and carers to force patients to comply with their wishes instead of furthering the patient's best interests. Given these issues and the lack of conclusive evidence supporting the effectiveness of CTOs across the world, Heun et al argue that resources spent on administrating CTOs currently should be used instead on improving the compulsory detention and treatment regime under the Mental Health Act, until there is rigorous research which can identify what CTOs are intended to do and the subgroup of target patients that CTOs may help.[35]

Michael Dunn et al's study looks at the use of CTOs in England from an ethical perspective and gives more complex answers to the question of their effectiveness and effects. While acknowledging that quantitative clinical trials have shown no clinical or social benefits accruing to patients on CTOs compared with those who are not, their qualitative interviews with psychiatrists, patients, and family carers reveal that CTOs may have some other positive benefits on patients, such as providing a route back to a 'normal' life by helping patients take steps to recovery. However, others view CTOs as infantilising and holding patients back from pursuing their life goals, and more about 'containing' the patient in the community rather than supporting them to become independent and autonomous agents.[36]

Kate Francombe Pridham et al's study involving similar qualitative interviews with participants of the CTO regime in Canada echoes these themes. While patients do experience CTOs to be coercive and sometimes disempowering, with severe consequences associated with non-compliance including the threat of compulsory detention in the hospital, they also view them as a 'worthwhile trade off of a certain level of coercion' compared to hospitalisation, with some accepting that CTOs may

[33] Burns (n 5).
[34] Rugkåsa et al (n 16).
[35] Reinhard Heun et al, 'Little evidence for community treatment orders – a battle fought with heavy weapons' (2016) 40 BJPsych Bulletin 115.
[36] Michael Dunn et al, 'An empirical ethical analysis of community treatment orders within mental health services in England' (2016) 11 Clinical Ethics 130.

increase independence. Another notable view expressed by patients is that, despite CTO legislation mandating client and provider collaboration in formulating the treatment plan, they have limited opportunities for meaningful contribution in light of the imbalance of power and information between patients and medical professionals.[37]

In Hong Kong, there has been little local research or data collection regarding the use and effectiveness of CD. According to Dr Eric Cheung, former Hospital Chief Executive of Castle Peak Hospital, there were a total of 1173 patients on CD in Hong Kong as at July 2017.[38] The Mental Health Report published by the Review Committee on Mental Health in April 2017 provides a more comprehensive breakdown of the official figures. According to the Report, both the total number of compulsory admissions and the number of CDs have increased from 2011 to 2015.[39] An average of 144.2 patients were conditionally discharged from hospitals each year.[40] As at 30 June 2015, about 23.5% of patients on CD had been on CD for less than a year, 55% for one to five years, 18% for five to ten years, and 3% for more than ten years.[41] What is notable here and will emerge as a recurrent theme in the later discussion of the implementation of CD in practice is that, as there is no express provision under the MHO for limiting the duration of conditions or the termination of conditions by medical professionals, it is unclear whether or not these patients are in fact still obliged to comply with any conditions, despite the fact that they are legally still on CD. On the face of the current law, a CD order can only be 'terminated' if the patient is recalled to the hospital under section 42B(3) or if the patient successfully applies to the Mental Health Review Tribunal (MHRT) against their CD order under section 59B(2)(b). In this respect, the report only provides data on the number of patients recalled to hospitals each year, which was 23 in 2015.[42] There is no data on how long these patients have been on CD before being recalled, or whether and how many times they had been recalled before.

Looking at clinical research, YC Wong and DWS Chung conducted a retrospective case notes review on the 12-month outcomes of a group of 140 adult patients who were conditionally discharged, comparing patients who were readmitted with those who were not readmitted to identify the risk factors associated with readmission. The study found that the short-term outcomes for patients on CD were satisfactory with low rates of recurrent violence and few attempted suicides.[43] However, these conclusions are drawn based on a very limited number of patients, and do not say anything about the effects of CD itself on patients with mental illnesses, as the study did not attempt

[37] Kate Francombe Pridham et al, 'Exploring experiences with compulsory psychiatric community treatment: A qualitative multi-perspective pilot study in an urban Canadian context' (2018) 57 International Journal of Law and Psychiatry 122.
[38] Eric Cheung, 'Compulsory psychiatric treatment in the community in Hong Kong' (Compulsory Mental Health Treatment in Hong Kong: Which Way Forward? conference, Hong Kong, August 2017) <http://www.cmel.hku.hk/events/compulsory-mental-health-treatment-in-hong-kong-which-way-forward-2/> accessed 1 December 2018.
[39] Review Committee on Mental Health (n 8) 199.
[40] Review Committee on Mental Health (n 8) 198.
[41] Review Committee on Mental Health (n 8) 199.
[42] Review Committee on Mental Health (n 8) 199.
[43] Wong and Chung (n 19)

to compare patients on CD with patients that were on other types of treatment or care plans.

While the rate of readmission is the most widely used outcome measure for the effectiveness of CTOs/CD,[44] it only indicates one aspect of how compulsory treatment in the community possibly affects mentally ill patients' lives. It is thus worthwhile to ask more concretely how other aspects of patients' lives may be affected by such treatment, and whether any interferences with their rights are justified, given the lack of conclusive evidence on the effectiveness of CTOs/CD.

4. METHODOLOGY

4.1 Interviewing mental health professionals

Official data on the use of CD can only tell us how much the regime is used but not what considerations go into the decision of a medical professional to put a patient on CD, what constraints medical professionals may be under when making use of the legal provisions, or their attitudes towards CD. Mental health law's discretionary nature and heavy reliance on professional judgment mean that the application of the law depends largely on each medical professional's practice. [45] Thus, medical professionals' knowledge and interpretation of and attitudes towards CD are crucial in understanding how CD is applied in practice and how that may impact the legal rights of persons with mental illnesses.

Semi-structured qualitative interviews with medical professionals have therefore been conducted as the main empirical research component of the present study. Unlike standardised survey interviewing, the purpose of *qualitative* interviewing is to derive interpretations, not facts which are generalisable, from the respondent.[46] The target group for the interviews were *practising mental health professionals who have the power to determine whether to put patients on CD in Hong Kong*. To locate the suitable respondents, I adopted a snowball sampling strategy, beginning with the first few respondents whom I was able to locate via personal and professional contacts, and then moving on to others who were identified through those respondents' social networks. This part of the study has been approved by the Research Ethics Committee of the Faculty of Law at the University of Hong Kong. Informed consent was sought from the respondent in writing before each interview.

Using a semi-structured interviewing method allowed me to ask predetermined but open-ended questions, and provided sufficient flexibility for me change the order of the questions based on the respondent's responses as the interview went on.[47] This was important because, as I was looking for detailed interpretations of and attitudes

[44] Rugkåsa et al (n 16).
[45] Jill Peay, *Decisions and Dilemmas: Working with Mental Health Law* (Hart 2003) ch 4.
[46] Carol AB Warren, 'Qualitative Interviewing' in Jaber F Gubrium and James A Holstein (eds), *Handbook of Interview Research* (SAGE 2001) ch 4.
[47] Lioness Ayres, 'Semi Structured Interview' in Lisa M Given (ed), *The SAGE Encyclopedia of Qualitative Research Methods* (SAGE 2008) 881.

towards CD of medical professionals, the questions were necessarily open-ended and sometimes follow-up questions had to be asked in order to probe deeper into their responses.

A total of six respondents from four of the five gazetted wards in Hong Kong which receive patients liable to be detained under the MHO were interviewed from March to June 2018. All information resulting from the interviews used in this study has been anonymised to protect respondents' identities.

4.2 Limitations

Only qualitative interviews with a limited number of respondents were carried out in this study, which means that the study is not able to present a more representative and statistically significant picture of the attitudes of participants in the CD regime. However, this study shall not purport to be anything more than an analysis of the current legal framework and practice in terms of the rights of persons with mental illnesses based on a preliminary examination of how the law is currently implemented in practice.

It may be questioned why the views of the other obvious group of participants in the CD regime, i.e. the patients, are not also subjects of the primary investigation carried out by this study. This is because patients' experiences with the regime may vary considerably according to the nature of their medical conditions and their personal circumstances and may not be able to reflect the effects of the law and practice of CD accurately or holistically.

5. DISCUSSION

In this section, I will first draw on responses from the practitioners interviewed to give a preliminary view of what the CD mechanism under section 42B of the MHO looks like when implemented in practice. Then, using the data collected and reflecting upon the literature, I will discuss in depth the different ways in which CD impacts the rights of persons with mental illnesses on the ground.

Respondents will be represented by R1, R2, R3, etc. and the various hospitals where they practise will be represented by H-A, H-B, H-C, etc.

5.1 Conditional discharge in practice

(i) Conditionally discharging the patient

Practitioners were first asked to describe the steps of implementing CD in practice, i.e. from considering CD as an option for a particular patient to actually discharging them, and they all gave similar responses. Respondents first noted the eligibility requirement that the patient must be compulsorily detained in the hospital and have a medical history of or propensity to violence. Respondents also mentioned that, at their

respective hospitals, it is necessary to hold a multidisciplinary, or 'ward-round' meeting involving other personnel such as specialist psychiatrists, nurses, and social workers to discuss the particular patient's case before conditionally discharging them. The general impression given by respondents is that initiating CD is a simple and straightforward procedure.

More complicated is the question of what conditions may be imposed. Under section 42B(2), a practitioner may impose 'such conditions as he thinks fit' upon discharge, and the only statutory requirement is that the conditions be 'reasonable in the circumstances'. R1 confirmed that, in practice, there are no limitations on what conditions practitioners may impose on patients. When asked what sort of conditions they have imposed or encountered in practice besides the examples given under section 42B(2), many respondents immediately responded with a few of what they termed 'strange' or even 'weird' conditions. Both R1 and R3 gave the requirement to 'not abuse substance' as an example of a 'weird' and 'difficult to monitor' condition that they have seen imposed on patients by other practitioners, as

> 'it is very difficult to monitor whether someone has abused drugs. We're not the Correctional Services, and we have no legal powers to compulsorily test their urine.' (R1)

R1 further expressed their view on the absence of clear boundaries of what conditions practitioners may impose on patients, which results in some conditions imposed not necessarily being directed at the patient's supposed disposition to violence or even the patient's medical condition:

> 'Theoretically you can put down anything as a condition now and it's like imposing injunctions. I remember the case of a doctor imposing a condition on a patient not to see someone. Psychiatrists have the power to impose injunction-like conditions but without the same intensity of scrutiny that judges may face.'

The seeming arbitrariness of conditions that practitioners can prescribe may be the result of the lack of consensus on, or even so much as any discussion about what the purpose of CD should be – this will be discussed in more depth below.

(2) Monitoring compliance and recalling the patient

The question of what conditions may be imposed on patients goes hand in hand with the questions of how compliance with the conditions is monitored and when patients may be recalled to the hospital. In relation to monitoring compliance, respondents all gave a similar overview of how community psychiatric nurses (CPNs) and social workers are assigned to each patient's case and would inform the practitioner should anything unusual arise in the patient's condition. Practitioners can themselves observe the patient when they visit the hospital, although different respondents feel differently about how much these brief visits enable them to have a thorough examination of the patients. R1, for example, felt that practitioners do not have the support or resources to adequately engage with the patients on these occasions, while R4 and R5, from the

same hospital, felt that the role practitioners play in the monitoring process is satisfactory.

Under section 42B(3), the patient may be recalled to the hospital when (a) they have failed to comply with any condition *and* (b) it is necessary in the interests of their health or safety or for the protection of others for them to be recalled. This seems to be an aspect of CD that has proven confusing for practitioners and whose implementation depends much upon each practitioner or hospital's own interpretation of the law. Most respondents seemed to think that the only requirement at law for a patient to be recalled is when the patient has breached a condition, although in practice they effectively do consider other factors including whether it is necessary in the interests of the patient's health or safety or for the protection of others to recall them. R1's response encapsulates this interpretation of the law:

> 'Although theoretically patients may be recalled once they have breached any condition, practically speaking, patients are hardly always recalled once they have breached just any condition – for example, if the patient doesn't reside at the place specified in the condition, what will recalling the patient to the hospital do, besides intimidate them and threaten them to comply with the conditions? Therefore, it is not as straightforward as immediately recalling a patient once they've violated a condition – we have to look at the clinical picture before making the decision to recall the patient, such as whether there is any deterioration in their mental state.'

This sense of confusion is shared by R3:

> 'Many psychiatrists don't know when to recall patients to the hospital, because some may think that once a patient breaches a condition they have to be recalled, but others may think that patients should only be recalled if they have breached a condition and also shown some signs of relapse. No one really knows.'

Rather than being unaware of the legal requirement under section 42B(3)(b), it is more likely that practitioners see the power to decide what is 'necessary' under the section as a medical discretion that is so wide so as to be unlimited in practice. It is thus possible that different practitioners will have different considerations and different weights assigned to such considerations in exercising this discretion. R3 shared the factors that they usually consider when deciding what conditions to impose on a patient and whether to recall a patient once a condition has been breached:

> 'I look at whether CD will really work for a particular patient – some patients just wouldn't understand the conditions or follow them, and I won't consider CD in these cases because the treatment outcome will not be improved by CD. However, for some patients, even though we know they won't or can't follow the conditions, CD allows us to recall them to the hospital when they have an early relapse and would therefore still be helpful to them that way.'

R3 further made recommendations for reform in this respect, that section 42B should require not only a risk of violence on the patient's part but also signs of early relapse, which may not otherwise suffice for compulsory admission to the hospital under section 31 of the MHO, for the recalling of conditionally discharged patients. It is interesting to note, however, that the test of whether the patient shows any signs of relapse is still a question that is very much open to each practitioner's interpretation and may therefore prove potentially problematic.

(iii) Terminating conditional discharge

Terminating CD is where most respondents reported difficulty because of the lack of any provision in the statute. As has been mentioned above, the only circumstances in which an order is 'terminated' are when the patient is recalled to the hospital or when the patient successfully applies to the MHRT. There is no legal provision for practitioners to stipulate a time for the order to expire when putting the patient on CD or to formally terminate the order afterwards, when it is felt that it is no longer necessary for the patient to be complying with it. Different respondents suggested different ways of working around the problem.

R1 described how patients' conditions may sometimes be *de facto* terminated by simply being forgotten by practitioners and hospitals for various reasons:

> 'There are definitely cases where monitoring gradually ceased because the patient's condition had been stable for a long time, or because no one remembered that they were on CD because they had switched hospitals too many times and their medical records had been buried somewhere.'

This, of course, is an accidental rather than a practical or systematic way of 'terminating' a patient's CD status. R3 on the other hand detailed a workaround used by H-C to terminate conditions administratively, which has also been reported to be the practice in other hospitals:

> 'Legally we have no way of cancelling a CD…but administratively, we simply "delete" all the terms on the CD,[48] so that it becomes an empty one. It is quite silly, but we haven't found any other way to really solve the problem.'

Of course, it must be noted that 'emptying' a CD order this way does not take the patient off the order, and the patient will remain labelled as being on CD (albeit an empty one) on their file, which may be stigmatising for them: clinically, their doctors have decided that their medical condition no longer requires them to be following any conditions while in the community but bureaucratically, they are on record as someone who may only be safely discharged into the community on a compulsory order.

(iv) Compatibility with the Hospital Authority's care label system

[48] Under s 42B(5) of the MHO, practitioners may vary the conditions imposed upon a patient by notice.

The problem of the lack of provision for the formal termination of conditions is coupled with another problem that is not apparent on the face of the MHO – the potential incompatibility of the CD regime with the HA's internal care label system (formerly the 'Priority Follow-Up' system), which runs parallel to, but is not directly linked to or aligned with the CD regime. All respondents mentioned this system when speaking about different aspects of the CD regime.

Upon admission to HA hospitals, psychiatric patients are classified as requiring one of three levels of care, namely 'conventional care', 'special care', and 'intensive care'. According to the respondents, only patients under the latter two 'care labels' are put on CD in general. The difficulty here emerges when these patients' conditions have become stable for some time and their statuses have downgraded from 'intensive care' to 'special care' and eventually to 'conventional care', based upon a regular review procedure, which may happen every six months or every year depending on the respective hospital's own practice. In R3's words:

> 'The most violent patient may lose all these care labels after ten years, but because there isn't a mechanism for practitioners to formally terminate their CD, they will still have the label of CD attached to them legally. This leads to a clinically awkward situation – is the doctor still obliged to keep track of these patients, whose conditions are supposed to have stabilised for long?'

> 'The problem here is that CD is a legal framework while the care label system is an administrative one, so the two are not necessarily compatible. However, for the purpose of hospitals' internal case management, they are also necessarily intertwined. Practitioners may then become confused when it comes to managing patients who are technically on CD but not under special/intensive care.'

Some respondents, however, did not find this potential incompatibility a problem, and instead thought that the regular review procedure under the care label system, although not legally recognised, represented an adequate substitute to compensate for the lack of an automatic review mechanism under section 42B. According to both R5 and R6, at the same multidisciplinary meeting where the care status of the patient is reviewed, and which is held annually at H-A and H-D, the patient's CD status will also be discussed, and if the relevant personnel view that the patient no longer needs to be subject to the conditions, they will 'empty' the CD of those conditions as mentioned above. Although the label of CD will still be attached to the patient in such cases, they did not see this as problematic.

5.2 The purpose(s) of conditional discharge

When CD was first introduced in Hong Kong, it was done so largely in response to a violent incident involving a psychiatric outpatient and with an apparently preventive rationale.[49] Indeed, while compulsory treatment in the community in other countries,

[49] Yip (n 9).

such as CTOs in England and Wales, are aimed at providing treatment to mentally ill patients which is necessary for *either their own health or safety or for the protection of others*,[50] section 42B explicitly targets only patients who have a history or risk of criminal violence but not self-harm. Over time, of course, it is possible that the purpose of CD has shifted, and the views of medical professionals on the purpose of CD are instrumental in shaping how CD is implemented in practice and how it affects patients' rights. This is especially so given the broad powers conferred upon medical professionals and hospitals by the MHO in how to navigate the legal framework, such as what conditions may be imposed upon patients and when patients may be recalled to the hospital.

Respondents were therefore asked what they thought the purpose of CD was and whether the current CD regime has achieved that purpose in their opinion. The responses were diverse.

R1 expressed a strong view that, not only was CD historically set up to serve the aim of preventing discharged patients with risks of violence from harming others, but it also remains largely preventive in nature to this day. When asked if CD has any therapeutic or rehabilitative element, R1's response was completely negative:

> 'Oh, no, CD really doesn't focus on recovery. From its conception to today's practice, there isn't much of a recovery element in it at all. What I mean by "recovery" is not just in terms of the remission of symptoms, but also to reintegrate the patient into society…and the aim of CD is certainly not that.'

Other respondents, however, had much different views. While acknowledging the preventive element of CD in protecting the safety of others from patients who may pose a violent risk to the public, some also found that it serves the interests of patients themselves. R2 described what they thought was CD's main purpose as

> 'mainly to allow those who may pose a danger to the public for psychiatric reasons to not have to be subject to long-term hospitalisation, as they would have done many years ago, and instead live in the community, but also at the same time to protect the safety of others.'

When further asked if they thought that CD benefits patients in terms of their recovery or reintegration into society, R2 was affirmative:

> 'I think so. At the end of the day when patients are subjected to CD they feel like there's a "law" they have to follow…of course they may not feel willing to do so in the beginning, but eventually some would feel like their lives have become more stable, and when they don't have to be admitted to the hospital they can go find a job.'

[50] Mental Health Act 1983, s 17A(5).

This view corresponds to the responses given by some patients in Dunn et al's study that they felt that CTOs helped them get back on track towards a 'normal life'.[51] R5 proposed a similar view that CD is 'educational', in that it serves as a tool to ease patients into complying voluntarily with a regular treatment plan. Moreover, they see CD as effective in a practical sense:

> 'CD is a good legal tool in taking care of particular patients' needs, if only because putting a patient on CD means allocating a group of nurses and social workers to follow up on their case closely.'

This particular view was echoed by R6, who viewed CD as a 'team effort' which encourages the participation of both mental health care professionals and the patient in a 'goal-setting' exercise to facilitate the patient's recovery and rehabilitation.

R3, who had discussed the importance of taking signs of early relapse into consideration in deciding whether to recall patients to the hospital, viewed the purpose of CD as 'allowing patients to receive early treatment' and denied that it had any preventive or reintegrative aim:

> 'Deterring criminal acts is not something we do, that is for the Correctional Services.'

> 'Patients' reintegration into society is quite irrelevant in making CD decisions. If we have to discharge a patient, we will have to, and if we have to keep detaining them, we will have to do that too. CD is only a matter of whether we need to make it easier for a particular patient to receive early treatment should they relapse after the discharge.'

R3 was also of the opinion that CD has been effective in achieving that purpose, although they acknowledged that the effectiveness of CD depends on how well individual practitioners make use of the regime.

Despite many of the respondents' assertions that CD is more than simply preventive but rather contributes to the patient's wellbeing, it must be remembered here that there has not been much research in the area to show the effectiveness of specifically CD or more generally compulsory treatment in the community in facilitating patients' recovery. Moreover, although well-meaning practitioners may try to involve patients in the decision-making process as much as possible, CD is ultimately a compulsory regime which compels patients to comply with prescribed conditions, backed up by the threat of recall.

5.3 The rights of persons with mental illnesses

Although the primary purpose the UN CRPD, the main international treaty on PwDs' rights, is to reformulate rights that are already recognised elsewhere in a way that focuses on eliminating discrimination against PwDs, this study will not be focusing on

[51] Dunn et al (n 36).

non-discrimination. This is because, as the Committee on the Rights of Persons with Disabilities takes an absolute position that psychiatric regimes must not restrict the rights of PwDs on the basis of their disabilities, even if additional criteria are also used,[52] the answer to any question about whether the current legal framework governing compulsory treatment of psychiatric patients in Hong Kong is compliant with the non-discrimination aspect of the CRPD is inevitably negative. Moreover, the general arguments for and against using having a mental illness as a criterion for compulsory treatment in general have already been explored in much of the literature.[53] This study instead looks at Hong Kong's CD regime specifically and asks how it may affect the human rights of persons with mental illnesses, as compulsory treatment in the community is often neglected in general discussions about how compulsory psychiatric regimes affect such persons' rights.

(i) Legitimate aim and rationality

The first question in the proportionality analysis is whether the impugned measure serves and is rationally connected to a legitimate aim. Strictly speaking, the wording of section 42B(1) implies that the primary rationale of CD is to manage the condition of patients who have the disposition to commit criminal violence when discharging them from the hospital. Unlike CTO regimes in some jurisdictions, the patient's own health and safety is not a rationale for imposing conditions on the patient upon discharge under the MHO.[54] However, given the wide discretion conferred upon practitioners by the legal regime, CD may serve different purposes according to each practitioner's interpretation and how they implement the law in practice: when they choose to impose conditions on patients upon discharge, what conditions they choose to impose, and whether and when they decide to recall the patient after a breach of any condition. These purposes include to protect the safety of others, to facilitate the patient's treatment and thus recovery and rehabilitation, and to help the patient reintegrate into society, all of which seem uncontroversial. The protection of public safety and health is often one of the legitimate aims enumerated under the HKBoR that may justify the restriction of a qualified right,[55] and facilitating a patient's recovery, rehabilitation, and reintegration is clearly a legitimate goal to pursue in the context of mental health.

The CD regime can be said to be rationally connected to each of these aims. The very legal provisions under section 42B are designed for practitioners to impose conditions on target patients that will supposedly reduce the risk of their committing violence

[52] See section 2.1.
[53] See, for example, John Dawson, 'A realistic approach to assessing mental health laws' compliance with the UNCRPD' (2015) 40 International Journal of Law and Psychiatry 70 and Melvyn Freeman et al, 'Reversing hard won victories in the name of human rights: a critique of the General Comment on Article 12 of the UN Convention on the Rights of Persons with Disabilities' (2015) 2 The Lancet Psychiatry 844, both of which question whether upholding the rights of mentally ill patients on an absolutely equal basis with other patients is practical or beneficial to the patients, contrary to the Committee's view. Although the view of the Committee may certainly be challenged, in making such an argument, the entire mental health system, i.e. both compulsory treatment in the hospital and compulsory treatment in the community for patients with capacity, will have to be taken into account, which would be beyond the scope of this study.
[54] For example, one of the criteria for CTOs in England and Wales under the Mental Health Act 1983, s 17A(5) is that it is necessary for the patient's health or safety that they should receive medical treatment.
[55] See, for example, the right to freedom of thought, conscience, and religion under art 15 and the right to peaceful assembly under art 17 of the HKBoR.

which is induced by their mental illnesses while in the community. At the same time, complying with conditions such as taking medication and visiting outpatient clinics for regular check-ups may plausibly contribute to patients' recovery and rehabilitation, and ultimately their reintegration into society. This is certainly the belief of many of the practitioners interviewed: R2 viewed that, as the patient's propensity to commit violence supposedly stems from their mental illness, any condition properly imposed should address the patient's medical condition as well as their outward behaviour.

(ii) Necessity and fair balance

While it may seem obvious that the CD regime *may* be able to contribute to several distinct legitimate aims, what is not as clear is the extent to which the current legal provisions may interfere with patients' rights and freedoms and whether the detriment so caused is proportionate to the possible benefits brought about by these aims.

As already discussed, although compulsory treatment in the community is often neglected in discussions about the impact of compulsory psychiatric regimes on human rights, it has, in fact, the potential to interfere with at least two of the patient's fundamental rights, namely their right to respect for their private and family life and their right to liberty and security of person. The extent of these potential interferences depends on both the legal provisions themselves and the actual practice of the practitioners, as so much discretion is given to them in deciding how to negotiate the CD legal framework. Whether the interferences are no more than necessary for achieving the legitimate aims in turn depends much on whether there are any safeguards to protect patients against excessive intrusion into their rights and freedoms.

Under section 42B(2), practitioners may impose such conditions which are reasonable in the circumstances as they think fit. While conditions like residence at a specified place and attending at an outpatient clinic may seem to be reasonable requirements which can help facilitate the medical team's communication with the patient or are targeted directly at the patient's medical condition, respondents also reported that they have seen conditions that are much more restrictive or even 'injunction-like', and which in their view are not directly related to the patient's propensity to violence or medical condition, such as not allowing them to contact someone. Despite the common perception that compulsory treatment in the community necessarily gives patients more freedom than detention in the hospital, it may also restrict their rights in other ways, most notably by intruding into their personal and familial spheres of privacy. This is exacerbated by the fact that, unlike compulsory detention in the hospital under sections 31, 32, and 36 of the MHO, CD orders have no 'expiry dates' and there is no judicial oversight or mechanism for patients to ask to have their case referred to a judge before an order is made. Practitioners have reflected that patients do not often receive information regarding the possibility of appeal to the MHRT and that it is indeed rare for patients to launch such applications.

After a patient has been conditionally discharged, they may be recalled under section 42B(3) once they have breached a condition and if the practitioner is of the opinion that it is 'necessary in the interests of the patient's health or safety, or for the protection

of other persons' to recall them. There are no uniform guidelines for practitioners and hospitals to follow regarding the second requirement and the considerations taken into account by practitioners and the weight given to them depend very much on each practitioner's interpretation of the MHO and what they think CD should achieve. Again, there is no way for the patient to request to see a judge at this point before being recalled and, as is the situation with other patients admitted to the hospital under section 31, launching an application at the MHRT will inevitably take more time than the observation period of seven days and is thus an ineffective recourse. As a result, patients may theoretically be recalled to the hospital once they have (whether innocuously or deliberately) breached any condition and consequently lose their liberty without any effective channel of having their voices heard, as long as their practitioner considers that recall is necessary.

Of course, one response to the broad powers given to medical professionals and the lack of legal safeguards is that, in practice, practitioners, being constrained by their own professional ethics, will not abuse their powers to arbitrarily intrude upon patients' privacy or deprive them of their liberty by imposing far-fetched conditions on them or recalling them when it is not necessary to do so. But the question is whether or not that is adequate. Although medical law in general gives much medical discretion to professionals as is necessary, for example, in deciding what is in the best interests of a patient without capacity, it has also come a long way from the traditional, purely paternalistic doctor-knows-best approach. As seen from the CRPD and mental health reforms in jurisdictions all over the world, medical discretion is today often checked by judicial or other safeguards, under an approach which sees patients as rights-holders rather than passive recipients of medical services, and whose rights must be protected against overly defensive medical practices.[56] Practitioners' powers under section 42B, however, do not seem to be subject to any effective safeguards at all. As R3 expressed in their interview:

> 'I do think psychiatrists have an awful lot of power [under the CD regime]. The protection of patients' rights really depends on the integrity of the individual psychiatrist. Some psychiatrists can be very authoritarian and keen to impose CD defensively simply to avoid blame should any tragedy occurs.'

Another response to the question of whether the CD regime provides sufficient safeguards for patients' rights is that, despite the lack of provisions for automatic reviews of the patient's CD status and the termination of CD under the MHO, in practice, hospitals do follow a somewhat standardised review procedure under the HA care label system, where they may also review the patient's CD status and 'terminate' it by emptying the order if necessary. However, this does not seem to be an adequate solution to the problem of the lack of legal provisions in these two aspects. First of all, as has been mentioned above, emptying the CD order does not remove the label of CD from the patient's file. Not only is such an incomplete 'termination' 'clinically awkward' for practitioners and hospitals, it can also be stigmatising for the patient in being labelled incorrectly as being at risk of violence. Secondly, practice seems to vary

[56] See section 2.1.

considerably between hospitals and even between practitioners in the same hospital. For example, while both practitioners at H-A and H-D have reported that such reviews are carried out every year, R2 from H-B reported that their hospital's policy is to carry out reviews half-yearly. Within the same hospital, while some respondents saw the care label system as a solid substitute for a statutorily provided review mechanism, others were of the opinion that it may instead create inconsistencies between the patient's status under the law and their status under the administrative system which can be confusing for the medical team. It is therefore not clear whether and how well this administrative practice in fact serves the purpose of reviewing CD cases. Finally, given CD's potential of causing serious interferences with patients' rights, there is no reason why there should not be uniformly prescribed procedures in the law itself to ensure that there is no unnecessary restriction of patients' rights and freedoms by the continued imposition of CD, similar to what the MHO currently provides for compulsorily detained patients. CD orders have neither a limited time period after which they must expire, unless applications for extensions have been made, similar to sections 31 and 32 of the MHO, nor a legally prescribed mechanism under which the patient's CD status may be regularly reviewed, if they are to run indefinitely as they do now. While CTOs in England and Wales, for example, expire upon the end of an initial six-month period unless extended and require an application for extension every year thereafter,[57] some CD orders in Hong Kong have run on for more than 10 years[58] with hardly any scrutiny of a similar level.

It is now clear that the implications of the CD regime on the rights of patients are twofold. Firstly, in terms of the conditions themselves, having to follow conditions that possibly reach into every aspect of one's everyday life can have a huge impact on the patient's right to respect for their private and family life, especially when they are aware of the severe threat of being compulsorily admitted to the hospital if they do not comply and when they are unable to foresee the end of such extensive control. Secondly, the recalling mechanism as it currently stands may result in arbitrary deprivations of patients' liberty. Like the *HL* case, although patients on CD are not presently being deprived of their liberty, the reality is that, should they ever resist to comply with the conditions, they are effectively under the control of medical practitioners who may then admit them to the hospital against their wishes, subject only to the elusive criterion of whether the responsible practitioner considers the recall to be necessary.

CD' s potential impact on patients' rights must be balanced against the benefits that CD purports to advance. The difficulty here is that CD is widely interpreted by practitioners to have different aims, which do not necessarily complement each other. On one hand, many practitioners' intuitive response to the question of the purpose of CD was that it is therapeutic or at least for the patient's own health and safety. On the other hand, some have expressed the opposite view that CD is purely preventive in nature and should only apply to a narrow group of patients under limited circumstances, or CD would be counterproductive to patient trust and recovery in the long run:

> 'For those on CD, if they feel like they are only being forced to comply with the conditions, they will do it only to check off the box. Honestly, what can

[57] Mental Health Act 1983, s 20A.
[58] Review Committee on Mental Health (n 8) 199.

> you make them do? If you want to engage them and encourage them in their recovery, and there is no incentive for them to do it, then they may resist even more.' (R1)

At the moment, there is simply not enough research done on CD in Hong Kong to give a definite answer to how much CD is able to contribute to the protection of public safety or patients' recovery. Existing studies have not been targeted at finding out about the effectiveness of CD in relation to these aims,[59] and studies from other jurisdictions on compulsory treatment in the community provide no conclusive evidence supporting its effectiveness in terms of reducing readmission rates or bringing any clinical benefits.[60] Additionally, one has to consider the fact the current CD legal framework does not actually purport to pursue the goal of improving the patient's health in their best interests or provide the tools to do so, even if practitioners try their best to utilise CD to that end. For all the talk about CD being a 'team effort' (R6) in which patients may participate – which in itself is unrealistic given the inevitable imbalance of power and information between patients and medical professionals[61] – the power ultimately lies with the medical practitioner to alter the conditions and recall the patient to the hospital, with the patient having no effective way to protest if they do not agree with their treatment.

The rights to privacy and liberty are two of the most fundamental rights an individual is entitled to and are especially important for persons with mental illnesses, given the history of mental health law often enabling the deprivation, instead of protection, of these rights in the name of treating individuals' medical conditions or containing their 'dangerousness'.[62] Any interference with the rights of persons with mental illnesses must therefore be carefully scrutinised. Given the lack of safeguards for their rights when conditionally discharged, coupled with the lack of consensus on the rationale(s) underlying CD and the lack of concrete evidence of its effectiveness in relation to each of the goals, it may certainly be argued that the interference with the rights of persons with mental illnesses caused by the current CD regime in Hong Kong is disproportionate to any preventive or therapeutic aim it may achieve.

6 CONCLUSION

In this study, I have examined the CD regime in Hong Kong and the existing literature on the rights of persons with mental illnesses and community treatment in the community, both in Hong Kong and in other jurisdictions. Most importantly, I discussed how the law and practice of CD impacts the rights of persons with mental illnesses, in light of findings arising from qualitative interviews with medical professionals who are directly involved in negotiating the legal framework. The law gives practitioners much discretion in the implementation of CD on the ground without sufficient guidance or

[59] See Wong and Chung (n 19).
[60] See section 2.3.
[61] Francombe Pridham et al (n 37).
[62] The detention of 'persons of unsound mind' continues to be an exception to the right to liberty and security under art 5 of the European Convention on Human Rights.

safeguards to ensure that patients' rights will not be unnecessarily restricted. Two fundamental problems in the law may be identified: firstly, it is not clear what CD is supposed to achieve with the result that practitioners can have very different interpretations of the law; secondly, there are significantly fewer judicial and other safeguards in the CD than the compulsory detention framework, for example a mechanism for referral to a judge before an order is made or a regular review procedure. This is possibly because of the common perception that compulsory treatment in the community has only minimal impact on the rights and freedoms of patients. That is, however, a misperception, as the conditions imposed have the potential of intruding upon patients' private lives and the possibility of recall to the hospital means that patients' liberties may be deprived if they do not comply with the conditions.

What any proponents of keeping and perhaps reforming CD need to do first of all is to decide what it is that CD should set out to do. The current legal regime which is explicitly preventive is at odds with what many practitioners think CD should do and what they in fact use it for, and is thus not realising its full potential and at the same time not providing patients with sufficient protection of their human rights, putting much responsibility on practitioners in making judgments not only in relation to an individual patient's treatment but also how to interpret and implement the law more generally. Once there is a consensus on what CD should and should not do, more clinical research should be conducted on the effectiveness of compulsory community treatment in achieving those aims and how best it may do so. If the mechanism's purpose is to prevent patients with risks of violence from harming others, then the extent of the intrusion into their rights and freedoms caused by the measure must be minimalised, as local and international human rights laws require; if the mechanism's purpose is to allow patients access to treatment in the community and to ultimately help them in their long-term recovery, then it should apply to a wider group of patients, including those who require treatment or have self-harm risks, and the conditions that may be imposed on patients should be steered towards this therapeutic aim only.

This study hopes to start a conversation and to encourage more clinical research to be done in the area of community treatment in the community, especially given the often sensationalised nature of the conversation around mental health in Hong Kong. The rights of persons with mental illnesses should no longer be neglected because of unfounded prejudices; instead, an evidence-based mental health regime is needed to protect their rights while allowing them access to the healthcare they need.