

# Making Sense of Bournemouth

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## Introduction

The judgment of the European Court of Human Rights (ECtHR) in *HL v UK*<sup>3</sup> has been understood by some commentators as making it unlawful, without the use of formal legal powers, to give treatment in a psychiatric hospital to a person who lacks capacity to consent and over whom the mental health professionals directly involved are exercising complete and effective control. This understanding follows from a reading of the judgment which equates complete and effective control with deprivation of liberty for the purposes of Article 5 of European Convention on Human Rights (ECHR). If this interpretation is correct, the same principle would apply to people living in nursing homes who require a high level of care and supervision and who lack capacity. While the former could be formally detained in hospital (or a 'registered establishment')<sup>4</sup> under the Mental Health Act 1983 (MHA), the Act's detention powers do not extend to other care settings.

This article suggests that to understand the ECtHR's judgment in *HL v UK* it is necessary to take account of the unusual facts of the case. It is suggested that it does not follow from the judgment that the admission of a compliant incapacitated patient will necessarily deprive that person of liberty for the purpose of Article 5. The Government's initial responses<sup>5</sup> to the judgment fails to distinguish admissions which do engage Article 5 from those which do not. It is suggested that the Government should provide guidance to assist mental health professionals and others to make this distinction in individual cases.

## Why was the Bournemouth case brought?

In July 1997, when he was admitted informally to a psychiatric hospital (Bournemouth) under the common law principle of necessity, HL had been living with Mr and Mrs E for three and a half years. He had come to them under an adult fostering scheme as part of the process of closing the long-stay institution where he had lived for over 30 years. Mr and Mrs E do not run a residential care home. HL lives with them as a member of the family. Caring for HL is not easy. He is profoundly autistic, without speech and capable of only very restricted social interactions; he needs help with his self-care and with eating; his behaviour is unpredictable: something as simple as a shopping trip may have to be called off because of his distress or disruptive behaviour; he needs to be with someone at all times and is not good at adjusting to new people or new situations.

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3 *HL v The United Kingdom* (Application no. 45508/99). Judgment 5th October 2004

4 s.34(2) MHA 1983

5 Ms R Winterton, Minister, Department of Health to the Standing Committee on the Mental Capacity Bill on 28 October 2004; Department of Health Advice – 10 December 2004

To look after HL is a major commitment. Mr and Mrs E have seen that he has benefited enormously from their care and has achieved a measure of happiness and fulfilment which is beyond anything they would have believed possible when he first came to live with them in 1994. This is without doubt a community care success story. If authoritative confirmation were needed, it is to be found in the report of the Health Service Ombudsman, which is quoted in the Strasbourg judgement, to the effect that HL has a significantly better quality of life with Mr and Mrs E than he would have in institutional care.<sup>6</sup>

So why did Mr and Mrs E bring the case, beyond the simple fact that in July 1997 HL was removed from their care without their agreement?

- First, because they were convinced that there was no valid clinical justification for taking him to hospital and keeping him there, a view which finds powerful support in the Ombudsman's report.
- Second, because they believed he was unhappy and distressed in hospital, and that he wanted to return home.
- Third, because they knew that institutional care was inferior to what they could offer.
- Fourth, because they had no confidence in the psychiatrist who had arranged HL's admission. They were aware that she had not seen him for many months prior to the incident – a very minor incident – which provided the justification for his admission.
- Fifth, because they believed that the psychiatrist and other members of the local NHS learning disability service had convinced themselves that Mr and Mrs E were not suitable carers. This was despite the contrary opinion of the social services learning disability team, and the truly outstanding care manager, who is referred to in the Strasbourg judgement as AF, and abundant evidence attesting to the exceptional quality of their care, which was to be found in care plans and in the minutes of regular care planning meetings. Mr and Mrs E feared that reasons would be found to justify delaying HL's return home and that eventually a point would be reached where their claims, based on love and affection but also on their conviction that HL wanted to live with them and had benefited from doing so, would be displaced by professional opinions about his best interests, derived from a combination of clinical judgement and self-serving notions of 'good practice'.

### **Proceedings in the Domestic Courts**

Acting as HL's litigation friend, Mr. E commenced judicial review proceedings and issued a writ of habeas corpus. For the case to succeed it was necessary for the court to find both that HL was detained in Bournemouth hospital and that there was no lawful justification for his detention. The Trust asserted that he was not detained, as he was not subject to either physical coercion or legal powers of detention. But if, on the contrary, he was detained the Trust asserted that his detention was lawful by virtue of section 131(1) of the MHA which permitted the informal admission of compliant incapacitated patients under the common law principle of necessity.

The proceedings failed at first instance because the judge found HL was not detained.<sup>7</sup> HL's appeal to the Court of Appeal was allowed. The judges concluded that HL was detained because he was

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<sup>6</sup> See the reference to the Health Service Commissioner's investigation of the case which is summarised in

paragraphs 50 – 51 of the ECtHR's Judgment.

<sup>7</sup> Judgment of Owen J, 9th October 1997.

not free to leave: “*had he attempted to leave the hospital, those in charge of him would not have permitted him to do so*”.<sup>8</sup> The Court decided that only those with capacity to consent could lawfully be given in-patient psychiatric treatment otherwise than under formal Mental Health Act powers: “*They were only allowed to admit him for treatment if they complied with the statutory requirements ... The [hospital’s] powers to act under the common law doctrine of necessity can arise only in relation to situations not catered for by [the Mental Health Act]*”.<sup>9</sup> It followed that HL was, in the Court of Appeal’s judgment, unlawfully detained.

In giving this judgment, the Court of Appeal did not make findings as to the desirability of HL remaining in hospital. The Court’s decision meant that the hospital had to choose either to discharge HL or to admit him formally under the MHA and thus render his detention lawful. They chose the latter. He was then able to exercise his right to apply for his discharge. In December 1997 there was a short hearing before the hospital managers. Their decision was to discharge HL from section 3 with immediate effect and he returned home.

At the instigation of the Department of Health, the Trust appealed against the Court of Appeal’s judgment because of its wide implications. The Department said that if the judgment was allowed to stand, it was possible that an additional 48,000 people would have to be detained under the MHA every year. HL lost in the House of Lords, where it was held that his admission was authorised in common law by the principle of necessity.<sup>10</sup> The law, as stated by the House of Lords, was once more that the compliant mentally incapable psychiatric patient could be admitted and treated under common law without recourse to MHA powers and safeguards, even if the admission amounted to detention.

### **Proceedings in the European Court of Human Rights**

An application was then made to the ECtHR. The issues before the court were:

- Was HL detained for the purposes of Article 5 of the ECHR?
- If so, was his detention in accordance with a procedure prescribed by law, as required by Article 5(1)?
- And was he afforded his right under Article 5(4) to have his detention reviewed by a court, in the light not only of domestic law requirements but also in accordance with the principles established by case law under the Convention on detention of persons of unsound mind?

The ECtHR found that he was detained for the purposes of Article 5; that his detention was not in accordance with a procedure prescribed by law because under the common law principle of necessity there was an absence of procedural safeguards to protect against arbitrary deprivation of liberty; and that he was denied his right under Article 5(4) because there was in 1997 no domestic court which could review the Article 5 lawfulness of his detention.

In relation to admission to psychiatric hospital, the effect of the decision in *HL v UK* is twofold:

- 1) Where a person who lacks capacity is admitted to hospital in circumstances which amount to deprivation of liberty, informal admission under section 131(1) of the MHA will be unlawful, as being in breach of the right in Article 5(1) not to be arbitrarily detained.

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<sup>8</sup> *R v Bournemouth Community and Mental Health NHS Trust, ex parte L* [1998] 2WLR 764, per Lord Woolf MR.

<sup>9</sup> *Ibid.*

<sup>10</sup> *R v Bournemouth Community and Mental Health NHS Trust, ex parte L* [1999] AC 458.

- 2) Pre-Human Rights Act (HRA) judicial review proceedings were not capable of fulfilling the requirements of Article 5(4).

The judgment also has clear implications where someone who lacks capacity is detained elsewhere than in a hospital. Such a person enjoys the same rights under Article 5 as someone who is detained in a hospital but under domestic law the simple expedient of an application for admission under Part II of the MHA is not available to remedy the breach of Article 5(1).

### **The Government's Response to the ECtHR's Judgment**

The Government's response to the decision was published on 10th December 2004.<sup>11</sup> This was followed by proposed amendments to the Mental Capacity Bill.<sup>12</sup> In relation to point 1) above, the Mental Capacity Bill was to be amended to permit the creation of a new legal mechanism for authorising the detention of people who lack capacity, to be known as protective care. It would have applied to: "persons who lack capacity, for the purpose of providing them with treatment or care which is determined, in accordance with the regulations, to be in their best interests". The Government had intended that details of the procedures and safeguards under the protective care regime would be left to regulations made under the Bill, having stated that their drafting would have followed consultation with interested parties to "ensure that there are procedural safeguards which are effective, proportionate and deliverable in practice".<sup>13</sup> However on 17th March 2005 Parliament's Delegated Powers and Regulatory Reform Committee ruled the proposed amendments as unacceptable, presumably concluding it to be inappropriate to leave issues of such fundamental importance to regulations rather than primary legislation. The Mental Capacity Act was passed without any reference to the issues, but the "Bournewood" Consultation document, published by the Department of Health in March, makes it clear that the Government still wishes to bring in its "protective care" provisions.

The Government's response to the Article 5(4) point was to assert, as it did in the Strasbourg proceedings, that the position has changed fundamentally since the passage of the Human Rights Act. According to the Government, judicial review proceedings brought by a person alleging unlawful detention would now require the court, in a case where Article 5 lawfulness rests on the detained person being of "unsound mind", to apply the *Winterwerp* criteria.<sup>14</sup> The regulations to be made under the Mental Capacity Bill would have provided for: "the circumstances in which a person's protective care must, and those in which it may, be referred to a prescribed court (or tribunal) for a decision as to whether it should continue" and "as to rights of persons in protective care to appeal to such court (or tribunal) as may be prescribed".<sup>15</sup> It is not clear which court (or tribunal) is intended to have jurisdiction under the proposed 'protective care' regime. But if judicial review is to be used, there will have to be major changes to the system to allow non-means tested legal aid, to abolish the requirement to get permission, to provide for automatic references, and to allow solicitors without higher rights of audience to advocate on behalf of the detained person. What is clear is that Article 5(4) requires a review of the substance of the medical and other evidence relevant to Article 5(1)

11 *Advice on the Decision of the European Court of Human Rights in the Case of HL v UK (The "Bournewood" Case)*.

12 *Amendments to be moved by Baroness Ashton of Upholland (Minister, Department of Constitutional Affairs) on Report, printed on 22nd February 2005. (<http://www.publications.parliament.uk/pa/ld200405/ldbills/027/amend/am027-a.htm>).*

13 *Paragraph 31 of the Advice, footnote 7 ante.*

14 *Winterwerp v Netherlands (1979-80) 2 E.H.R.R. 387, ECHR.*

15 *It is not clear what is meant here by the reference to a prescribed court or tribunal but the regulations would appear not to have contemplated such cases being heard by mental health review tribunals as constituted under the MHA.*

lawfulness. In effect, the court (or tribunal) would be performing, in respect of a detained person in protective care, the function performed by the mental health review tribunal in reviewing the lawfulness of the detention of patients under the MHA.

### **Providing Additional Safeguards for Compliant Incapacitated Patients**

In principle, a legal regime, albeit falling short of full MHA protection and safeguards, which provides greater protection for mentally incapacitated people who require a high level of care, whether in hospital or elsewhere, is to be welcomed.

There are, however, a number of concerns about the embryonic protective care regime.

- a. There would be two parallel legal frameworks for people lacking capacity who are deprived of their liberty: full MHA protection and protective care. This would necessarily give rise to the difficulty of deciding into which regime a given individual fits.
- b. It is likely that some individuals would, as their mental capacity fluctuates, move between the two regimes, which would make for undesirable complexity and increase the number of court or tribunal hearings.
- c. There is a risk that a two-tier system, where protective care offers lesser safeguards, would perpetuate the present distinction between the long-term mentally incapacitated and others, for example people who experience episodes of acute mental illness, whose capacity fluctuates.
- d. This distinction would be reinforced if the regime for the long-term incapacitated offered fewer rights and safeguards than full MHA protection, and would perpetuate, in a new form, the “Bournemouth Gap”.<sup>16</sup> Of particular importance in this context is the right under section 117 to free after-care, which one assumes would not be extended to people discharged from protective care.

One reason the Government proposes a new framework of protective care is presumably to deal with those people who are detained elsewhere than in hospital and therefore fall outside MHA detention powers. It is suggested, however, that the necessary legal safeguards could instead be provided by an enhanced MHA guardianship regime. Where the effect of placing someone under guardianship is to deprive them of their liberty, the admission and discharge criteria would have to comply with Article 5, which would mean in such cases applying the same legal test for any detection element of guardianship as for admission to hospital under the MHA. Arguably, this could be achieved without amending the MHA because by virtue of section 3 of the HRA, primary legislation must so far as is possible be “read and given effect in a way that is compatible with the Convention rights”.<sup>17</sup> There would, however, following *R (MH) v (1) Secretary of State for Health (2) Mental Health Review Tribunal*,<sup>18</sup> have to be a system for automatic referral of deprivation of liberty guardianship cases to the mental health review tribunal in order to comply with Article 5(4).

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<sup>16</sup> This refers to what was said by Lord Steyn in his speech in the House of Lords: “Given that [compliant incapacitated patients] are diagnostically indistinguishable from compulsory patients, there is no reason to withhold the specific and effective protections of [the MHA] from a large class of vulnerable mentally incapacitated individuals.”

<sup>17</sup> See *Ghaidan v Godin-Mendoza* [2004] 2 AC 557.

<sup>18</sup> See *R (MH) v (1) Secretary of State for Health (2) Mental Health Review Tribunal* [2004] EWCA Civ 1609, where it was held that Article 5(4) requires there to be a mechanism to ensure that the case of a patient detained under s2 and judged to be incompetent is referred, within the 28 day period, to the mental health review tribunal.

## Deprivation of Liberty

Prior to the decision in *HL v UK*, those proposing additional safeguards for mentally incapacitated adults did not generally make a connection between deprivation of liberty and reciprocal rights and safeguards. This is true, for example, of the Law Commission's recommendation, in its report on Mental Incapacity, that some of the protective aspects of the MHA regime, such as the consent to treatment provisions, should be extended to informal mentally incapacitated patients.<sup>19</sup> The same approach was also found in the Mental Capacity Bill which, as originally drafted, was not concerned with deprivation of liberty. What is different now, following *HL v UK*, is that deprivation of liberty has unavoidably become the touchstone for certain rights and safeguards, specifically those guaranteed by Article 5. It is therefore essential in every case to decide whether or not the person concerned is being deprived of liberty. In this regard the Government's guidance, which goes little further than quoting excerpts from the ECtHR's judgment, is of very little assistance. The amendments put down by the Government to the Mental Capacity Bill defined detention as: "any deprivation of liberty within the meaning of Article 5(1) of the Human Rights Convention".

The starting point under Article 5, in determining whether a person is being deprived of their liberty, is "the specific situation of the individual".<sup>20</sup> HL's situation during his 5 months in Bournemouth hospital included the following factors:

- He did not have any family members who could be consulted about the admission.
- Immediately before admission, he had been living in a family home with his carers, Mr and Mrs E, for over three years.
- His carers were opposed to the admission and at all times wanted him to return home to live with them (which he eventually did).
- Initially they were banned from visiting him.
- He had a significantly better quality of life with Mr and Mrs E than Bournemouth hospital could offer.
- His care co-ordinator, an experienced social worker, believed he did not need to be in hospital and would have been better off at home.

The guidance issued on 10th December 2004 emphasises the statement in the Court's judgment that: "the key factor in the present case [is] that the health care professionals treating and managing the applicant exercised complete and effective control over his care and movements...". Other commentators have also tended to treat this statement as the ratio decidendi of the case.<sup>21</sup> The paradox is that if this is what the ECtHR meant by deprivation of liberty then, because of the nature of his condition, it is difficult to envisage circumstances in which HL is free. Wherever he is, whether at home, in hospital or anywhere else, someone has to take responsibility for HL's care and, if necessary in the interests of his own safety, control his movements. When he is at home with

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19 *Mental Incapacity, The Law Commission, Report 231, March 1995.*

20 This is taken from the judgment in *HL v UK*.

21 The following is taken from Morgan Cole, solicitors Mental Health Law Bulletin 13, dated 13th October 2004: "On the issue of detention, the ECtHR held

that during his time in hospital the patient had been under continuous supervision and control and was not free to leave the hospital. It made no difference whether the ward in which he was treated was locked or lockable. The patient had therefore been deprived of his liberty for the purposes of Article 5(1)."

Mr and Mrs E they do not allow him out on his own, and if he went off they would bring him back. But this level of control is consistent in HL's case with a care regime which maximises his freedom and autonomy, for example by providing opportunities for him to attend social gatherings and to participate in a range of everyday activities such as shopping and going out for a meal. Whatever distinguished life for HL in Bournemouth hospital from life at home with Mr and Mrs E, it cannot be that in one situation but not the other he was subject to the exercise of "complete and effective control over his care and movements". The answer must lie elsewhere.

The judgment continues: "...His responsible medical officer (Dr M) was clear that, had the applicant resisted admission or tried to leave thereafter, she would have prevented him from doing so and would have considered his involuntary committal under section 3 of the 1983 Act. The correspondence between the applicant's carers and Dr M ... reflects both the carers' wish to have the applicant immediately released to their care and, equally, the clear intention of Dr M and the other relevant health care professionals to exercise strict control over his assessment, treatment, contacts and, notably, movement and residence: the applicant would only be released from the hospital to the care of Mr and Mrs E as and when those professionals considered it appropriate."

It could be argued that the relevant distinction here is between Mr and Mrs E as private individuals and the Bournemouth mental health professionals as agents of state power. In both situations he is detained but only the latter is relevant for the purposes of Article 5. However, if this were so, then Mr and Mrs E's objections to the admission and their wish for HL to return to their care as soon as possible would surely be irrelevant to the question whether or not he was deprived of his liberty at Bournemouth. But the clear implication of the judgment is that in going from Mr and Mrs E's care to Bournemouth, HL lost his liberty.

How then can the specific situation of HL in Bournemouth hospital be distinguished from his situation at home, so that the former, but not the latter, amounts to deprivation of liberty? This can only be done by asserting the primacy of home and family life over institutional care. In effect, home and family life stand for liberty and institutional care must always be seen as a potential deprivation of liberty. Whether in any particular case it will amount to deprivation of liberty will depend on the particular circumstances, and of course this formulation does not seek to suggest that life at home is inevitably better, or freer, than life in an institution.

When it is read in conjunction with earlier decisions of the ECtHR, three factors stand out in HL's case. First, that his admission to hospital was effected against the wishes of those with whom he shared his home and family life. Second, that there was at all times an alternative to institutional care. Third, that the quality of his life in hospital was not only worse than that with his carers but more restrictive than it needed to have been even in an institutional setting.

Two previous ECtHR judgments were referred to extensively in *HL v UK*. *Nielsen*<sup>22</sup> concerned the admission to a psychiatric ward of a 12 year old boy. That this was arranged with his mother's consent appears to have been the decisive factor in the decision of the majority that he was not deprived of his liberty. While in *HM v Switzerland*,<sup>23</sup> which concerned the admission of an elderly woman to a nursing home, the most important consideration appears to have been that what was done was for her own good, there being no alternative to the protective care offered by the nursing home, which in the *HL v UK* judgment was described as "an open institution which allowed freedom

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22 *Nielsen v Denmark* (1989) 11 E.H.R.R. 175

23 *HM v Switzerland* (2004) 38 E.H.R.R. 17

of movement and encouraged contacts with the outside world". The important point is that in both cases the Court found, notwithstanding that what was done was imposed on the individual concerned, there was no deprivation of liberty. It is instructive to read the dissenting judgments in the latter case, which found that Article 5 was engaged. They rest on the proposition that: "*she [HM] was not permitted to leave the institution and go home, and that if she did, she would have been brought back to the nursing home ...*". That line of reasoning, which in HL's case would lead to the conclusion that he is detained when at home with Mr and Mrs E, was rejected by the majority in *HM v Switzerland*. They emphasised that the reason HM had been removed from her home was because she had refused to co-operate with the agency which provided help to people in their own homes and that "*the living conditions and standards of hygiene and of medical care at the applicant's home were unsatisfactory ...*". In those circumstances, the Court found that "*the applicant's placement in the nursing home did not amount to a deprivation of liberty within Article 5(1), but was a responsible measure taken by the competent authorities in the applicant's interests*".

In the Mental Capacity Act the Government is introducing a legal framework for decisions affecting mentally incapable adults which is comparable to the idea of parental responsibility. Under the Act, the general authority confers power to make decisions and take actions affecting the well-being of a mentally incapable adult. Unlike the Danish law which was considered in *Nielsen*, the general authority does not confer the power to consent to medical treatment, or to admission to hospital, on behalf of a mentally incapable adult. But for most practical purposes this is not important. The Act answers an obvious social need, that someone has to make decisions on behalf of those who are not capable of deciding for themselves, and it presumes that on the whole people who care for mentally incapable adults will act in their best interests. In those circumstances, it is surely not unreasonable to suggest that the agreement of family members, or the main carers, is a significant factor in deciding whether what is being done in a given instance amounts to *the state* depriving someone of their liberty. It does not look like an instance of healthcare professionals exercising "*complete and effective control*" but rather of those professionals acting in co-operation with the people who would otherwise be caring for the person concerned. Clearly, for this to be valid the family or carers would genuinely have to agree that admission to hospital or a nursing home really was the most appropriate way forward in all the circumstances. Further, if what is being done in admitting a mentally incapable adult to a psychiatric hospital or nursing home is a response to a situation, such as arose in *HM v Switzerland*, where it is no longer safe for the person concerned to be living at home, it may be that this would give rise to a presumption that the admission does not deprive the person concerned of their liberty. This may be because they are not capable of enjoying their liberty, as in the case of someone with advanced dementia who requires total care, or it may be because the liberty which the Convention exists to protect does not include the liberty to neglect oneself to the detriment of one's health and safety.<sup>24</sup> That the institution to which the person is admitted is open and the care regime aims to maximise the incapacitated person's autonomy, would also tend to point to the conclusion that the admission does not constitute a deprivation of liberty.<sup>25</sup>

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24 Cf. *Re F (Adult: Court's Jurisdiction)* [2000] 2 FLR, 512 per Sedley LJ at p. 532: "*The purpose [of Article 8], in my view, is to assure within proper limits the entitlement of individuals to the benefit of what is benign and positive in family life. It is not to allow other individuals, however closely related and well-intentioned, to create or perpetuate situations which jeopardise their welfare.*"



## **Conclusion**

If the Government fails to provide guidance about the circumstances in which Article 5 is engaged where a mentally incapacitated adult is admitted to psychiatric hospital or to a nursing home, the result may be that a narrow interpretation of the law, which simply equates a sufficient degree of restriction of liberty with detention, will prevail. This interpretation will be justified by those who advise NHS Trusts and the like as demonstrating the greatest possible respect for human rights, by erring on the side of regarding someone as being detained in cases of doubt, and as protecting hospitals and nursing homes from actions under the Human Rights Act for unlawful detention.<sup>26</sup> An outcome far more to be desired would be for the Government to advise providers on how deprivation of liberty can be avoided, for example by ensuring that institutional care is only used if properly supported home care is not possible; by involving families and carers in deciding where and how the incapacitated person should be cared for; and by making sure that institutions are sufficiently well resourced to be able to provide as much freedom for residents in their daily lives as they can manage and enjoy. The additional safeguards required by the decision in *HL v UK* will then be correctly focused on those cases where there is, as in *HL's* case, what can properly be regarded as a deprivation of liberty.

What is now needed is Government guidance on the circumstances in which the actions of public authorities such as NHS Trusts amount to depriving a person who lacks capacity of their liberty. The role of guidance would be to assist practitioners and carers decide in any particular case whether what was proposed or implemented in respect of a mentally incapacitated adult engaged Article 5. The guidance would have to go beyond the words “complete and effective control” to embrace wider issues which arise from the institutional care of mentally incapacitated adults. Guidance which correctly defines the scope of the *HL v UK* ruling would be widely welcomed and would be timely in the context of the Mental Capacity Act which is intended to enhance the legal protection of people who lack capacity.

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25 See ‘Conditional Discharges – ‘Discharge’ from What?’ Robert Robinson *JMHL* July 2003 at pp 102 – 105 for a consideration of the Court of Appeal’s judgment in *R (on the application of the Secretary of State for the Home Department) v MHRT and PH (Interested Party)* [2002] *EWCA Civ* 1868, a case which clearly demonstrates the need to distinguish

between restriction on liberty from deprivation of liberty.

26 This approach would not necessarily protect NHS Trusts, as they would not only have to show that they followed the correct legal procedure, but also that deprivation of liberty was warranted by the person’s mental disorder.