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MENTAL CAPACITY IN HONG KONG: INCONSISTENCIES, UNCERTAINTIES, AND THE NEED FOR REFORM

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1. INTRODUCTION

In the area of mental health and capacity law, Hong Kong lags far behind many jurisdictions in terms of its compliance with international human rights standards. To this day, the Hong Kong Government's approach to issues around mental capacity continues to be heavily based upon the medical model of mental illness and disability, which equates functional impairment with the loss of legal capacity and stresses the need for psychiatric intervention and rehabilitation. This is despite resulting inconsistencies with norms set out in the various international human rights treaties applicable to Hong Kong, including the International Covenant on Civil Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR), which had been ratified by the United Kingdom (and whose applicability was extended to the territory) prior to Hong Kong's handover to the People's Republic of China (PRC). Both treaties are now entrenched in the Hong Kong Basic Law, with the ICCPR further domesticated through the Hong Kong Bill of Rights Ordinance (HKBORO). In August 2008, the PRC ratified the Convention on the Rights of Persons with Disabilities (CRPD), whose applicability was again extended to Hong Kong.[1] However, the provisions of the CRPD have not been incorporated into domestic law and are, as such, not directly litigable in local courts.[2]

This chapter looks at various legal provisions regulating mental capacity in Hong Kong and evaluates them against requirements set out by article 12

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[1] C.J. PETERSEN, 'China's Ratification of the Convention on the Rights of Persons with Disabilities: The Implications for Hong Kong' (2008) 38 *Hong Kong Law Journal* 611, 624–25.

[2] Hong Kong takes a dualist approach in its international obligations. See M. RAMSDEN, 'Dualism in the Basic Law: The First 20 Years' (2019) 49 *Hong Kong Law Journal* 239.

of the CRPD, highlighting areas which demonstrate inconsistencies, uncertainties, and a need for reform in light of current international human rights norms and standards. The next section provides an overview of the development of Hong Kong law in the area, highlighting changes in its approach to mental health and capacity through the past decades. Section 3 examines how mental (in)capacity is defined in Hong Kong law while sections 4 to 6 closely examine the regulation of (civil) capacity in three significant areas: medical treatment of those without capacity to consent, substitute decision-making in the forms of guardianship and management of property by the Court, and advance decision-making. Finally, section 7 concludes with broader reflections on the compliance of Hong Kong mental capacity / health law with the norms and values set out under the CRPD and other international human rights treaties.

2. THE DEVELOPMENT OF MENTAL CAPACITY LAW IN HONG KONG

The origins of current laws in relation to mental capacity in Hong Kong date back to the colonial era. Hong Kong became a British colony in 1841 and, apart from a brief period under Japanese occupation from 1941 to 1945, remained so until its sovereignty was transferred to the PRC in July 1997. At the very beginning of colonial rule, English laws were received into Hong Kong by the enactment of several constitutional documents, including the 1843 Hong Kong Letters Patent and the 1843 Royal Instructions.[3] In 1844, the Supreme Court Ordinance was passed to establish the court system in Hong Kong and to formally introduce a wholesale incorporation of English laws, specifically providing that the common law and the laws as enacted in the UK shall apply in Hong Kong, except where they were 'inapplicable to the local circumstances of [Hong Kong] or of its inhabitants'.[4] Even as Hong Kong acquired its own legislature as early as in 1843, it is generally undisputed that, at least up until the handover, laws and policies in Hong Kong were heavily influenced by those adopted in the UK.[5] It has been observed that the

[3] See P. WESLEY-SMITH, 'The Reception of English Law in Hong Kong' (1988) 18 *Hong Kong Law Journal* 183.

[4] Supreme Court Ordinance, 1873.

[5] See *China Field Ltd v. Appeal Tribunal (Buildings) (No 2)* (2009) 12 HKCFAR 342, 351–52: '[Historically], Hong Kong courts had to develop what amounted to a common law of Hong Kong even though it was for the most part identical to English law.'

healthcare laws and policies set in place by the colonial government 'combin[e] a British colonial history [with] a Chinese cultural context'.[6]

In the early days of British Hong Kong, mental health legislation primarily addressed individuals suffering from some form of mental disorder. The first piece of mental health legislation enacted in Hong Kong separately from English law was the 1906 Asylums Ordinance, which replaced the English Lunacy Regulations Act 1853 as the applicable law for the compulsory detention and care of 'persons of unsound mind'. For the purposes of the Asylums Ordinance,

> every person shall be deemed to be of unsound mind who is so far deranged in mind as to render it either *necessary or expedient* that such person, either for his own sake or in the public interests, should be placed and kept under control (emphasis added).[7]

Section 5 of the Ordinance further provides that

> Any medical practitioner, officer of police or any private person, *having reason to believe* that a person is of unsound mind may on the written order of any magistrate or justice of the peace cause such person to be conveyed, using such force as may be necessary, to an asylum (emphasis added).[8]

The Asylums Ordinance underwent a series of amendments until it was replaced by the Mental Hospitals Ordinance in 1950,[9] though little changed in relation to the definition of persons of 'unsound mind' and the low threshold upon which a person might be compulsorily detained. The primary effect of the 1950 Mental Hospitals Ordinance was to put in place more stringent requirements in the regulation of the mental institutions, following the general change in mental health policy that individuals with mental illness ought to be medically attended and not simply locked away in the name of public safety / interest.[10]

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[6] V. SCHOEB, 'Healthcare Service in Hong Kong and Its Challenges: The Role of Health Professionals within a Social Model of Health' [2016] *China Perspectives* 51.

[7] Asylums Ordinance, s. 3.

[8] Asylums Ordinance, s. 5.

[9] The Asylums Ordinance was amended in 1927 and 1935. See D. CHEUNG, 'Mental Health Law in Hong Kong: The Civil Context' (2018) 48 *Hong Kong Law Journal* 461.

[10] For example, the Mental Hospitals Ordinance provided for voluntary admissions and included not only 'custody and care' but also 'treatment' of patients.

In the late 50s and early 60s, following the Guillebaud Report (1956),[11] the UK's approach to mental health began to shift towards deinstitutionalisation.[12] Hong Kong soon followed: the first iteration of the Mental Health Ordinance (MHO) was enacted in 1960 (taking effect in 1962), through which the Government sought to make provisions for all aspects of care and treatment of individuals who, as a result of mental illness or intellectual disabilities, were unable to manage affairs in relation to their person or property, i.e., individuals who were 'mentally incapacitated'. In essence, the MHO empowers the Court to exercise *parens patriae* jurisdiction on the state's behalf, allowing treatment orders to be made and committees to be appointed to manage the financial and personal affairs of mentally incapacitated persons.[13] The MHO has since undergone several phases of amendment, establishing, in its Amendment Ordinance in 1988, the Mental Health Review Tribunal,[14] a quasi-judicial body responsible for the review of applications made by persons subjected to the compulsory regime, including those liable to be detained in a hospital and those in the community.[15] Another significant change took place in the 1996/7 reform, which was the introduction of a full-fledged guardianship regime with its own Guardianship Board,[16] another quasi-judicial body, empowered to make, review, and vary guardianship orders[17] with the aims of 'support[ing], protect[ing] and advocat[ing] the best interests of mentally incapacitated adults' and 'facilitat[ing] the resolution of disputes with relatives and service providers'.[18] Under the current iteration of the MHO, where the Guardianship Board is, inter alia, of the view that an individual's ability to make 'reasonable decisions in respect of all or a substantial proportion of the matters which relate to his personal circumstances' is limited by mental disorder or handicap and 'no other less restrictive or intrusive means are available in the circumstances' to meet the individual's particular needs,[19] it may appoint a private

[11] See, for an overview of the Report, T.E. CHESTER, 'The Guillebaud Report' (1956) 34 *Public Administration* 199.

[12] See, P. NOLAN, 'The History of Community Mental Health Nursing' in B. Hannigan and M. Coffey (eds), *The Handbook of Community Mental Health Nursing*, Routledge, London 2003, pp. 7–18.

[13] R. LEE, 'The Adult Guardianship Dilemma in Hong Kong' (2019) 25 *Trusts & Trustees* 1073, 1074; MHO, pts. IVB, II. See sections 4 and 5 below.

[14] MHO, pt. IVA.

[15] MHO, s. 59B.

[16] MHO, pt. IVB.

[17] MHO, s. 59K(1).

[18] GUARDIANSHIP BOARD (HONG KONG), 'Vision, Mission and Values of the Guardianship Board' <http://www.adultguardianship.org.hk/content.aspx?id=home&lang=en> accessed 14.07.2022.

[19] MHO, s. 59O.

guardian, such as a friend or a relative, or designate the Director of Social Welfare as a public guardian to make decisions on behalf of the individual.[20]

Today, the concept of mental incapacity is associated with a wider range of conditions which may impair a person's cognitive capacities than 'unsound mind', such as dementia, stroke, schizophrenia, other forms of psychiatric or cognitive disorders, intellectual disabilities, or brain damage caused by injury, illness or substance abuse. The sections below discuss how mental (in)capacity is defined under different headings in Hong Kong mental health law and its practical implications.

3. THE DEFINITIONS OF MENTAL (IN)CAPACITY IN HONG KONG LAW

The law on mental (in)capacity in Hong Kong is made up of a complex matrix of judge-made and statutory principles. Given the jurisdiction's continued use of the common law legal system to this day, the starting point for assessing mental capacity in Hong Kong is found in English common law. The law is, however, complicated by the MHO, which provides not one but multiple definitions of capacity to be applied in different contexts. As will be demonstrated, these different tests are predicated upon different understandings of mental capacity and may yield results that are at odds with one another.

In common law, the overarching principle in relation to mental capacity is that every adult is presumed to have capacity to make decisions for themselves—including on medical treatment, care, or other non-medical matters—although this presumption may be rebutted with respect to each specific instance of decision-making.[21] A person may be said to lack capacity if 'some impairment or disturbance of mental functioning' renders him/her unable to make a decision,[22] with this ability assessed through a three-stage test: (1) whether the person is capable of taking in and retaining the relevant information; (2) whether they believe it; and (3) whether they are capable of weighing that information, balancing risks and needs (the *Re C* test).[23] If someone

[20] MHO, s. 59S.
[21] *Re T (Adult: Refusal of Treatment)* [1992] 4 All ER 649 (CA) (Lord Donaldson).
[22] *Re MB* [1997] EWCA Civ 3093 [4].
[23] *Re C (Adult: Refusal of Treatment)* [1994] 1 All ER 819 (QBD).

is deemed capable of making a decision, their choice must be respected, even in life-threatening situations:

> [T]he principle of self-determination requires that respect must be given to the wishes of the patient, so that, if an adult patient of sound mind refuses, however unreasonably, to consent to treatment or care by which his life would or might be prolonged, the doctors responsible must give effect to his wishes, even though they do not consider it to be in his best interests to do so.[24]

Other key principles in relation to the assessment of capacity may also be discerned from the case law:

- The capacity required for a specific decision in question is commensurate with its gravity.[25]
- A person is not deemed to lack capacity merely because their decision appears to be unreasonable or irrational.[26]
- It is not necessary for a person to 'use and weigh every detail', but only the 'salient factors', of the options available in order to demonstrate capacity.[27]
- Even though a person may be unable to use and weigh some of the relevant information, they may nevertheless be able to use and weigh other elements sufficiently enough to be able to make a capacitous decision.[28]
- Where capacity is found to be lacking, having considered the above, the decision must be made in the person's best interests.[29]

In England and Wales, these principles were consolidated into statutory law in 2005 through the Mental Capacity Act (MCA), as it was thought at the time that the uncertainty surrounding the common law framework had left professionals vulnerable to legal actions and delayed access to treatment for patients.[30] Under the MCA, section 1 first reaffirms the presumption of capacity and other key principles. The next sections then lay down the two parts in the capacity assessment: section 2 sets out the 'diagnostic' threshold, requiring

[24] *Re C (Adult: Refusal of Treatment)* [1994] 1 All ER 819 (QBD). See also *Airedale NHS Trust v. Bland* [1993] 1 All ER 821, at 860.
[25] *Re T (Adult: Refusal of Treatment)* [1992] 4 All ER 649 (CA) (Lord Donaldson).
[26] *Re T (Adult: Refusal of Treatment)* [1992] 4 All ER 649 (CA) (Lord Donaldson).
[27] *CC v. KK and STCC* [2012] EWHC 2136 (COP) [69].
[28] *Re SB (A patient; capacity to consent to termination)* [2013] EWHC 1417 (COP) [44]; *WBC (Local Authority) v. Z, X, Y* [2016] EWCOP 4 [12].
[29] *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1 at 55.
[30] E. JACKSON, *Medical Law: Text, Cases, and Materials*, 4th ed., OUP, Oxford 2016, p. 243.

any inability to make a decision to be a result of 'an impairment of, or a disturbance in the functioning of, the mind or brain' while section 3 sets out the 'functional' threshold, i.e., what it means to be 'unable' to make a decision. The section 3 test is similar to the three-stage test found in common law (the *Re C* test):[31] a person is unable to make a decision for themselves if they are unable to understand, retain, use, or weigh information relevant to the decision in the decision-making process *or* if they are unable to communicate that decision. Additionally, it is emphasised that a lack of capacity cannot be established merely by reference to the person's age, appearance, or other 'unjustified assumptions' associated with their condition.[32]

In Hong Kong's case, however, the Government has not followed England's footsteps in putting these common law principles into legislation. Instead, in parallel to the common law test, a separate statutory framework for mental capacity has been developed. Under section 2 of the MHO, the general interpretation provision, 'mental incapacity' means '(a) mental disorder; or (b) mental handicap', which are in turn defined as follows:

> 'mental disorder' means—
> (a) mental illness;
> (b) a state of arrested or incomplete development of mind which amounts to a significant impairment of intelligence and social functioning which is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned;
> (c) psychopathic disorder; or
> (d) any other disorder or disability of mind which does not amount to mental handicap,
>
> and 'mentally disordered' shall be construed accordingly;
> 'mental handicap' means sub-average general intellectual functioning with deficiencies in adaptive behaviour, and 'mentally handicapped' shall be construed accordingly.

There is a separate definition for 'mentally incapacitated person':

> 'mentally incapacitated person' means—
> (a) for the purposes of Part II ['Management of property and affairs of mentally incapacitated persons'], a person who is incapable, by reason of mental incapacity, of managing and administering his property and affairs; or

[31] *Re C (Adult: Refusal of Treatment)* [1994] 1 All ER 819 (QBD).
[32] MCA 2005, s. 2(3).

(b) for all other purposes, a patient or a mentally handicapped person, as the case may be.

In the same sub-section, a 'patient' is defined as 'a person suffering or appearing to be suffering from mental disorder'. This definition of 'mentally incapacitated person' is thus wider than simply someone with 'mental incapacity' as defined above, as 'patient' includes not only those diagnosed with a mental disorder but also those who *appear* to be suffering from a mental disorder.

It should be noted that a finding of 'mental incapacity' or that someone is a 'mentally incapacitated person' under section 2 does not mean that the person is deemed by the law to lack capacity to make a particular decision; rather, it operates similarly to the diagnostic threshold of the common law test (the requirement of the presence of 'some impairment or disturbance of mental functioning'),[33] which delineates the broad category of individuals who may be subject to the second part of the capacity test involving the functional threshold. The function thresholds vary with specific areas of regulation in relation to 'mentally incapacitated persons' and are provided for under different Parts of the Ordinance. For example, section 7 under Part II of the Ordinance ('Management of property and affairs of mentally incapacitated persons') obliges the Court to order an inquiry into whether someone is 'incapable, by reason of mental incapacity, of managing or administering his property and affairs' so as to determine whether a committee should be established to manage the individual's property on his/her behalf. In short, having established that the individual in question is 'mentally *incapacitated*', the Court will have to determine whether they are also thereby *incapable* of making certain decisions.

Similarly, a different functional threshold may be found in section 59ZB under Part IVC ('Medical and dental treatment') which provides for the treatment (other than for mental disorder) of 'a mentally incapacitated person who has attained the age of 18 years and is incapable of giving consent' to said treatment. Consent here refers to the person's ability to 'understand' 'the general nature and effect of the treatment'. This test for capacity in relation to medical treatments appears to be more akin to the general common law test compared to the test for the management of property. Nevertheless, it presents a more simplistic threshold compared to the *Re C* test, which requires the person to be able to retain, believe, *and* weigh information relevant to the decision. While the *Re C* common law test has general applicability to decisions

[33] *Re MB* [1997] EWCA Civ 3093 [4].

in relation to all matters, if a mentally incapacitated person's (as defined by section 2 of the MHO) situation falls under any of the specific areas detailed under the MHO, the relevant section will apply.

This (unnecessary) complexity surrounding the definition of 'mentally incapacitated persons' is partly attributable to the government's desire to adopt a single 'generic name' in the legislation to refer to both those with mental illness and those with mental handicap in drafting the 1997 amendments to the MHO, supposedly for the sake of convenience.[34] In practice, the co-existence of these different definitions of capacity in common and statutory law in Hong Kong has produced a legal framework that is rather too complex for both private individuals and medical and legal professionals to navigate. This may also yield differential treatment amongst those deemed to be a mentally incapacitated and those who are not.

The complication in the framework governing mental capacity is further evidenced by the fact that the Hong Kong Hospital Authority has separately issued guidelines on the subject for medical practitioners. For example, in relation to in-hospital resuscitation decisions, the Hospital Authority has set out the following test for capacity:

> A competent adult is defined as one with decision-making capacity, which consists of the elements of (i) the ability to understand the medical information presented; (ii) the ability to reason and consider this information in relation to his own personal values and goals; and (iii) the ability to communicate meaningfully.[35]

More recently, the Hospital Authority issued the *Guidelines on Life-Sustaining Treatment in the Terminally Ill*, which explicitly adopts the British Medical Association's guidance on capacity and includes understanding the treatment's 'purpose and nature' and 'mak[ing] a free choice'.[36] Both of these tests are evidently distinct from the s.59ZB MHO test of 'understanding the general nature and effect of treatment'. Not only does this myriad of very dissimilar guidelines demonstrate a gap between what the law says and what is done in actual practice, the fact that the Hospital Authority feels the need to

[34] D. CHEUNG (2018), above n. 9, p. 480

[35] As quoted in LAW REFORM COMMISSION OF HONG KONG, *Substitute Decision-Making and Advance Directives in Relation to Medical Treatment* (2006), p. 52 <https://www.hkreform.gov.hk/en/docs/rdecision-e.pdf> accessed 14.07.22.

[36] HOSPITAL AUTHORITY (HONG KONG), *HA Guidelines on Life-Sustaining Treatment in the Terminally Ill* (2020), para. 5 <https://www.ha.org.hk/haho/ho/psrm/LSTEng.pdf> accessed 14.07.22.

issue additional guidance in this area is perhaps a telling sign that the current law is inadequate in providing clarity and certainty to practitioners.

This patchwork of legal and non-legal regulations has consequences for both practical efficacy and conceptual coherence: apart from the difficulty in working out how to interpret and apply the law (and other relevant rules) when there is doubt about an individual's decision-making capacity, the way 'mental incapacity' is structured and assessed under the current legal framework is also conceptually problematic in a number of ways, especially in light of article 12 of the CRPD, which reaffirms persons with disabilities' right to equal recognition before the law. These challenges will be explored in turn in the following sections, focusing on two broadly defined areas in civil mental health law.

4. CONSENT TO MEDICAL TREATMENT (OTHER THAN FOR MENTAL DISORDER)

As noted above, in determining whether an individual has the requisite mental capacity to consent to medical treatment (other than for mental disorder),[37] there are two relevant tests: (1) the common law test and (2) the test under section 59ZB(2) of the MHO. The general rule is that the common law test applies, unless the person is a 'mentally incapacitated person' under section 2 of the MHO. The s.59ZB(2) and common law tests are not necessarily consistent with each other and, depending on whether a person is deemed to be a 'mentally incapacitated person' under the MHO, vastly different answers to the question of whether someone has legal capacity to make a particular decision may result. While the s.59ZB(2) test, by requiring the individual to 'understand' 'the general nature and effect of the treatment', appears to be a threshold that is easier to meet than the common law test, 'understanding' remains to be interpreted and may presumably take the *Re C* common law definition of *taking in*, *retaining*, *believing*, and *weighing* information relevant to the decision. [38] Of more concern is the fact that none of the key common law principles regarding the application of the capacity test, such as the principle that a person is not to be treated as lacking capacity simply because she makes

[37] The compulsory detention and treatment of individuals for their mental disorder is provided for by Part III of the MHO. As very different considerations are at stake here to those involved in mental capacity assessments—compulsory measures are justified not based on mental incapacity but on treatment/public safety- related considerations—they will not be discussed in this chapter.

[38] *Re C (Adult: Refusal of Treatment)* [1994] 1 All ER 819 (QBD).

an 'unwise' decision, are included in the MHO.[39] Meanwhile, section 2 of the MHO labels all those with mental disabilities as '*mentally* incapacitated', which, of course, is in itself incredibly stigmatising and discriminatory.

Under the current legal framework in Hong Kong, the 'best interests' test is used to determine whether treatment should be carried out in relation to a person deemed to lack capacity, according to both the MHO and common law tests. Section 59ZB(3) requires the Court to ensure the proposed treatment is 'carried out in the best interests' of the individual, while common law allows the Court, in its inherent jurisdiction, to make the declaration that a proposed treatment is in a patient's best interests and therefore lawful for the doctor to administer in their professional duty.[40] Under section 59ZA, 'in the best interests' may mean in the best interests of that person in order to

(a) save the life of the mentally incapacitated person;
(b) prevent the damage or deterioration to the physical or mental health and well-being of that person; or
(c) bring about an improvement in the physical or mental health and well-being of that person[.]

Best interests under the MHO, then, is very much oriented towards the individual's *medical* best interests. In contrast, the common law framework includes not only what an individual's physical and mental wellbeing may require but also other factors, including their wishes, feelings, and values.[41] Still, although the latter encompasses a much broader range of considerations, both regimes amount to *substitute* decision-making on the individual's behalf.

In terms of compliance with CRPD standards and values, the first and most glaring problem in both the common law and MHO regimes is that, by using the presence of 'some impairment or disturbance of mental functioning',[42] mental disorder, or 'mental handicap' as the diagnostic threshold in capacity assessments, the concept of 'mental incapacity' applies to persons with, or who appear to have, mental disabilities in a manner that is clearly discriminatory. This provision runs directly against the principle of equal recognition before the law under article 12 of the CRPD: the Committee on the Rights of Persons with Disabilities (CtteeRPD) has affirmed time and again that 'a person's status as a person with a disability or the existence of an impairment

[39] C.f. MCA 2005, ss. 2–3.
[40] *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1, at 77 (Lord Goff).
[41] In English law, these principles are now consolidated under MCA 2005, s. 4.
[42] *Re MB* [1997] EWCA Civ 3093 [4].

(including a physical or sensory impairment) must never be grounds for denying legal capacity or any of the rights provided for in article 12'.[43]

Nevertheless, even if the diagnostic threshold were removed and only the functional test remained, the approaches in common law and the MHO would still fall short of what is required by article 12 of the CRPD. According to the CtteeRPD, article 12 recognises that everyone has the right to legal capacity.[44] Functional tests disproportionately deny persons with disabilities their legal capacity, as they impose too heavy a burden on the individual to meet the requisite threshold without considering the needs of the person or providing any assistance or support for them to exercise their decision-making skills.[45] The CtteeRPD maintains that, in cases where a capacity assessment must be carried out, such as in the context of medical decisions where informed consent is required, states have an obligation to provide the necessary support and reasonable accommodation to facilitate the individual in question in the exercise of their legal capacity, for example by legally recognising the role of supporters.[46]

To conclude, the consequence of failing the functional tests for capacity in Hong Kong is that the decision in question will be made *for* the person in their best interests. The 'best interests' principle operates to substitute the person's judgment with medical or judicial opinion on what is in their best interests, in violation of article 12 of the CPRD.[47] It is contended that the law should accommodate a 'best interpretation' of such will and preferences, even where it is impracticable to determine the will and preferences of the individual, such as in the case of a person in a persistent vegetative state. In any event, alternative planning tools such as advance directives ought to be available so as to enable individuals to indicate their preferences in advance in the event of loss of capacity.[48]

In the next section, the thorny questions of substitute decision-making and best interests will be further explored in relation to the guardianship system and the Court's power in managing a mentally incapacitated person's property and affairs.

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[43] UN CTTEERPD, 'General comment No. 1 on Article 12: Equal recognition before the law' (2014) UN Doc CRPD/C/GC/1, para. 9.
[44] ibid., para. 9.
[45] ibid., para. 15.
[46] ibid., para. 15.
[47] ibid., para. 21.
[48] The legal status of advance directives in Hong Kong is addressed in section 6 below.

5. GUARDIANSHIP AND MANAGEMENT OF PROPERTY BY THE COURT

As noted above, the MHO establishes a guardianship regime for 'mentally incapacitated persons' who are 18 or above[49] under Part IVB. A guardian is a person appointed to assist the mentally incapacitated adult in 'facilitat[ing] the management of their finances and 'ensur[ing] that their needs for services and medical treatment are met'.[50] It should be noted that guardians can only give consent to treatment on behalf of the mentally incapacitated person to the extent that he/she is 'incapable of understanding the general nature and effect of any such treatment'.[51] A mentally incapacitated adult's property and other financial affairs, such as their bank accounts, stocks, and other investments may also be managed by the Court or a committee established under Part II of the MHO. Often, when a person is found to be mentally incapacitated (for example, due to old age and accompanying deterioration in their mental health), the concurrent appointment of both a guardian and a committee may be deemed necessary under the MHO. Both mechanisms constitute forms of substitute decision-making under international human rights law.

5.1. GUARDIANSHIP

Section 59M of the MHO sets out the criteria for a mentally incapacitated person to be eligible for reception into guardianship: an application may be made in respect of them if (a) they are suffering from mental disorder or has a mental handicap 'of a nature or degree which warrants' such reception *and* (b) it is 'necessary in the interests of the welfare of the mentally incapacitated person or for the protection of other persons' to do so. In considering the merits of an application, in addition to being satisfied that the above criteria are met,[52] the Guardianship Board must also ensure the mental disorder or handicap in question '*limits* the mentally incapacitated person in making *reasonable* decisions in respect of *all or a substantial proportion of the matters which relate to his personal circumstances* (emphasis added)' and that 'the particular

[49] The guardianship of minors is addressed separately in other legislation, including the Guardianship of Minors Ordinance and the Protection of Children and Juveniles Ordinance.

[50] GUARDIANSHIP BOARD (HONG KONG), 'Vision, Mission and Values of the Guardianship Board', above n. 18. This should not be confused with the Court's power to appoint a committee for the management of property and affairs for mentally incapacitated persons, which is provided for separately under Part II of the MHO and which will be discussed below in section 5.2.

[51] MHO, s. 59R(3)(d).

[52] MHO, s. 59O(3)(a)(d).

needs of the mentally incapacitated person may only be met or attended to by his being received into guardianship', with 'no other less restrictive or intrusive' alternative available.[53]

The first requirement here appears to present a rather low and uncertain threshold at odds with both the common law and s.59ZB(2) tests for capacity, as the individual is only required to be *limited* in their decision-making ability. Although this must be in relation to 'all or a substantial proportion' of their personal matters, it is unclear if there is a threshold for the degree of 'limitation' which is required and what that might be.[54] Moreover, the emphasis on making 'reasonable' decisions is not only strange, as this term does not appear in any other capacity tests under the MHO, but also plainly inconsistent with the now widely accepted principle that individuals cannot be deemed to lack capacity merely because their choices seem 'unwise' or 'unreasonable'.[55] The latter requirement of less restrictive alternatives is presumably to offer greater protection for the autonomy of those eligible to be received into guardianship, but such alternatives are currently lacking in the legislative framework. Nevertheless, it may encourage informal arrangements between the mentally incapacitated person in question and their family and/or carers be attempted first, before a guardianship order is made.[56]

The powers conferred upon a guardian are very broad and touch upon a wide range of matters in relation to the individual's personal care, including the power to require them to reside or attend at specified places and the power to hold, receive, or pay money on behalf of the individual for their maintenance or benefit.[57] The main criticism often lodged against the guardianship system is that, once the individual is deemed eligible for guardianship *at the point of the initial assessment* and an order made, the individual will completely lose the ability to make decisions in many domains of their personal life. In other words, mental (in)capacity becomes an all-or-nothing concept, contrary to the now prevalent idea at common law that capacity is time-specific and dependent upon the nature and gravity of each decision that has to be made.[58] Furthermore, once a person has been received into the largely paternalistic guardianship regime, there is no room for them

[53] MHO, s. 59O(3)(b)(c).
[54] D. CHEUNG (2018), above n. 9, p. 482.
[55] See *Re T (Adult: Refusal of Treatment)* [1992] 4 All ER 649 (CA) and the MCA 2005, s. 1(4).
[56] H.W.M. KWOK and P. SCULLY, 'Guardianship for people with learning disabilities: the current perspective in Hong Kong' (2005) 33 *British Journal of Learning Disabilities* 145, 146.
[57] MHO, s. 59R(3).
[58] D. CHEUNG (2018), above n. 9, p. 482.

to exercise their residual autonomy, there being no formal provisions for their participation in the decision-making process or support for doing so.[59]

Throughout Part IVB of the MHO, a clear tension thus emerges between the two key principles underpinning the guardianship system: the best interests principle and the protection of autonomy. Sections 59K(2) and 59S(1) require the Board and the guardian, respectively, to observe and apply the following in the exercise of their powers: that 'the interests of the mentally incapacitated person … are promoted, *including overriding the views and wishes of that person where [the Board or the proposed guardian] considers such action is in the interests of that person*' and that despite this, 'the views and wishes of the mentally incapacitated person are, in so far as they may be ascertained, respected'. Recall the CtteeRPD's strong interpretation of the CRPD, which requires the adoption of a 'universal legal capacity' approach and under which any form of substitute decision-making, including one based on a best interests assessment, is prohibited.[60] It is explicit in the wording in sections 59K(2) and 59S(1) that, while the views and wishes of the mentally incapacitated person are to be respected where ascertainable, it is only to the extent that they cohere with what is in their best interests, according to the Board or the guardian; if there is any inconsistency between the two, the latter prevails. Hence, even though the best interests test may have 'a strong element of "substituted judgment"'[61] or, in the CtteeRPD's language, an element of the 'best interpretation' of wills and preferences approach,[62] it does not in fact guarantee the individual the opportunity to participate in the decision-making process. Their wishes are, ultimately, only considered as part of a paternalistic assessment of best interests and could be overridden by professional views. This is shown in some of the cases referred to the Guardianship Board, where the individual's wishes and feelings, whilst taken into consideration in the

[59] R. Lee, above n. 13, pp. 1075–77.

[60] UN CTTEERPD (2014), above n. 43, para. 25.

[61] The difference between the best interests and substituted judgment tests is encapsulated in the English case of *Aintree University Hospitals NHS Foundation Trust v. James* [2013] UKSC 67, [24]: 'the best interests test should also contain "a strong element of 'substituted judgment'", taking into account both the past and present wishes and feelings of patient as an individual, and also the factors which he would consider if able to do … This is … still a "best interests" rather than a "substituted judgment" test, but one which accepts that the preferences of the person concerned are an important component in deciding where his best interests lie.'

[62] UN CTTEERPD (2014), above n. 43, para. 21.

proceedings and determinative of the outcome in some cases,[63] may also be discounted in others for being 'unrealistic'[64] or 'grossly disoriented'.[65]

Overall, the current guardianship system in Hong Kong represents what is commonly referred to as 'plenary guardianship',[66] whereby the individual under guardianship loses virtually all their legal capacity to manage their personal and/or financial affairs. Despite the requirement of guardianship being the least restrictive means of meeting the person's needs,[67] there is currently no legal provision for supported decision-making (or even a formal recognition of the principle) for people who are lacking or limited in decision-making capacity. The CtteeRPD has expressed concerns in its Concluding Observations on China that there is a 'complete absence of a system of supported decision-making measures which recognize the rights of persons with disabilities to make their own decisions and to have their autonomy, will and preferences respected' and recommended the implementation of a system of supported-decision making in place of existing guardianship laws and policies.[68]

Besides these deficiencies in protecting the autonomy of the mentally incapacitated person, the current guardianship system also runs the danger of placing the person with disability at risk of physical and psychological neglect and abuse, given the far-reaching powers granted to the guardian. When instances of mistreatment do occur, an application to the Board to review the guardianship order can only be made if they are discovered by others.[69] Given

[63] See, e.g., *Ref No GB/P/4/10*: 'In the instant case, visits by the subject's eldest son would be in the best interests of the subject, who also wishes to be so visited.'; *Ref No GB/P/6/16*: 'Since the subject valued son more than daughters, [the potential guardian] was thinking of restoring the subject to his care and as such it would respect the subject's wish and feelings.'

[64] *Ref No GB/P/1/18*: 'As the subject still harbours the unrealistic wish to return to Dongguan for an independent living, it is obvious that a guardian should be appointed to decide on his long-term care plan'.

[65] *Ref No GB/P/2/15*: 'The Board observes that the subject is grossly disoriented and has marked cognitive deficits including extremely poor memory. Hence, the subject's will and wishes, expressed verbally at the hearing, would carry little weight in the assessment of future welfare plan.'

[66] L. SERIES and A. NILSSON, 'Article 12 CRPD Equal recognition before the law' in L. BENTEKAS, M.A. STEIN, and D. ANASTASIOU (eds), *The UN Convention on the Rights of Persons with Disabilities: A Commentary*, OUP, Oxford 2018, p. 377.

[67] MHO, s. 59O(3)(c).

[68] UN CTTEERPD, 'Concluding observations on the initial report of China' (2012) UN Doc CRPD/C/CHN/CO/1, paras. 21–22.

[69] Section 59U of the MHO allows the mentally incapacitated person in question, the guardian of that person, the Director of Social Welfare, and any other person who 'has a genuine interest in the welfare of the mentally incapacitated person', such as a relative, to submit requests to the Guardian Board for the review of guardianship orders.

the fact that those subject to the guardianship regime are left in an extremely vulnerable position by virtue of both their mental state and the lack of safeguards offered by the law, this raises concerns about potential violations of the rights to physical and mental integrity and freedom from exploitation, violence and abuse under articles 16 and 17 of the CRPD.

5.2. MANAGEMENT OF PROPERTY AND AFFAIRS BY THE COURT OR A COMMITTEE

The MHO provides another mechanism for substitute decision-making under Part II ('Management of Property and Affairs of Mentally Incapacitated Persons'), which runs independently from, but often operates concurrently, with the guardianship regime. Here, the Court may, on application, order an inquiry into whether an individual is 'incapable, by reason of mental incapacity, of managing and administering his property and affairs'.[70] Most commonly, a relative or next-of-kin will be the applicant, but where no such application has been made by the relative, an application may also be made by the Director of Social Welfare, the Official Solicitor, or any guardian of the person. This latter course is especially common in cases of financial abuse.[71] Two medical reports of the concerned person by registered medical practitioners are required in the application.[72]

Generally speaking, having decided the person is 'incapable' of managing and administering their property and affairs, the Court may, under section 10A, 'do or secure the doing of all such things as appear necessary or expedient' for the maintenance or other benefit of that person or members of their family, having regard 'as a paramount consideration, to the requirements of the mentally incapacitated person'. Section 10B further specifies the extensive powers the Court may exercise, including the control, transfer, sale, acquisition of property, dissolution of partnership, carrying out of contract, and conduct of legal proceedings. Moreover, it may 'appoint a committee of the estate', which shall 'do all such things in relation to the property and affairs of the mentally incapacitated person' as the Court orders or authorises it to do, in exercise of the powers mentioned above. The Hong Kong Judiciary has additionally published a Guidance Note, spelling out clearly, for the reference of those appointed to a committee, what their duties are. The first of these is to

[70] MHO, s. 7(1).
[71] S.G. CHAN, *A Practical Guide to Mental Health Law in Hong Kong*, Hong Kong University Press, Hong Kong 2019, p. 39.
[72] MHO, s. 7(5).

'act in the best interest of the [mentally incapacitated person] at all times' and to 'make sure that the [mentally incapacitated person's] money is being used to give him/her the best quality of life'.[73]

As with guardians, once the Court or a committee is charged with responsibility for a person found to lack capacity under Part II, their duty is to act in the best interests of the individual concerned—the individual's will and preferences are only taken into account as part of a best interests assessment. And, as with guardianship, the determination of mental capacity here consists in a one-off assessment covering a potentially unlimited realm of decisions relating to one's property and financial affairs. As such, the wide-ranging powers for the Court and appointed committees under Part II are likely to be inconsistent with article 12.5 of the CRPD, which requires states to 'take all appropriate and effective measures to ensure the equal right of persons with disabilities to own or inherit property' and 'control their own financial affairs'. As with our observations above in relation to medical decisions, the right to legal capacity requires a corresponding duty on governments to provide support in relation to decision-making, recognising that legal capacity should rest with the individual in question regardless of their decision-making skills, and to formally acknowledge the role of supporters.

6. DECISION-MAKING IN CASES OF FUTURE INCAPACITY

Sometimes, a person may wish to make provisions for the future possibility that they might 'lose' their mental and legal capacity to make certain decisions. For example, instead of waiting for provisions under Parts IVB and II of the MHO to kick in when they become mentally incapacitated, they may want to choose someone beforehand to (continue to) act on their behalf with respect to their property and financial affairs in the case that it happens. The Enduring Powers of Attorney Ordinance (EPAO) provides for the creation of *enduring* powers of attorney (EPAs), which can continue after the individual in question (the 'donor') becomes 'mentally incapable'.[74] 'Mentally incapable' here takes its meaning from the Powers of Attorney Ordinance,[75] which

[73] HONG KONG JUDICIARY, 'Guidance Note to Persons appointed as Committee of Estate of a Mentally Incapacitated Person' <https://www.judiciary.hk/en/court_services_facilities/guidance_note.html> accessed 14.07.22.
[74] EPAO, s. 4(1).
[75] EPAO, s. 2.

provides that a person is 'mentally incapable or suffering from mental incapacity' if—

> (a) he is suffering from mental disorder or mental handicap and—
> (i) is unable to understand the effect of the power of attorney; or
> (ii) is unable by reason of his mental disorder or mental handicap to make a decision to grant a power of attorney; or
> (b) he is unable to communicate to any other person who has made a reasonable effort to understand him, any intention or wish to grant a power of attorney.[76]

To create an EPA, the donor has to have the requisite mental capacity as defined above, i.e., they have to be able to understand the effect of the power of attorney and able to communicate an intention or wish to grant such a power.[77] The instrument creating the EPA must be signed before a registered medical practitioner and a solicitor: the former must certify that they were *satisfied* the donor was mentally capable and the latter must certify that the donor *appeared* to be mentally capable.[78] Once executed (which could be either before or after the donor becomes 'mentally incapable'), the attorney is under fiduciary duty towards the donor, which means that, inter alia, they have to exercise their powers 'honestly and with due diligence'.[79] They may have authority only over particular matters, property, or financial affairs as specified by the donor.[80] An enduring power may be revoked by the donor, when they have capacity or after they have recovered their capacity, or by a Court on the appointment of a committee under Part II of the MHO to manage the donor's affairs.[81]

Theoretically, the EPA regime in Hong Kong can be a useful way for individuals to extend their autonomous choice in matters related to their property and financial affairs, allowing them to begin communicating their wishes with a *chosen* representative before becoming incapacitated and minimising the legal hassle needed to appoint a guardian after the fact.[82] Practically, however, it has been argued that the complicated procedural requirements in the creation of an EPA, given the formality requirements and the requirement for the donor to list every particular matter or property they would like to grant

[76] Powers of Attorney Ordinance, s 1A(1).
[77] EPAO, s. 5(1)
[78] EPAO, s. 5(2)(a)(d)(e).
[79] EPAO, s. 12.
[80] EPAO, s. 8(1).
[81] EPAO, s.13(1)(a)(e).
[82] L. Ho, 'Financial Planning for Mental Incapacity: Antiquated Law in a Modern Financial Centre' (2014) 44 *Hong Kong Law Journal*, 795, 796.

the attorney power over, discourage the community which need it the most—the elderly—from making use of the mechanism, whilst there is a lack of formal legal safeguards once the donor becomes incapacitated.[83]

As noted above, section 8(1)(a) of the EPAO stipulates that an EPA 'must not confer on the attorney any authority other than authority to act in relation to the property of the donor and his financial affairs'. EPAs therefore cannot be used to authorise an attorney to make medical treatment or other care decisions for donors in the case of mental incapacity, even though these decisions hold, arguably, more significance than property and finances to many elderly donors.[84]

There is currently no legislative provision for the making of advance decisions in the context of medical care and treatment in Hong Kong. Under the common law, however, it is possible for an individual with the requisite decision-making capacity to give advance refusal to life-sustaining treatment for when they no longer have such capacity, as the Law Reform Commission (LRC) comments:

> An individual's right of self-determination is embodied in his capacity to give advance instructions as to his medical treatment, including a refusal of such treatment. This is interwoven with the fundamental principle of consent[.][85]

English authority confirms this:

> A medical practitioner must comply with clear instructions given by an adult of sound mind as to the treatment to be given or not given in certain circumstances, whether those instructions are rational or irrational. ... This principle applies even if, by the time the specified circumstances obtain, the patient is unconscious or no longer of sound mind.[86]

In 2006, the LRC put forward recommendations to promote the use of advance directives (ADs)—(usually written) instructions about a person's future medical care, made by that person when they have the relevant capacity, which

[83] ibid., p. 799. See also LAW REFORM COMMISSION OF HONG KONG, *Report on Enduring Powers of Attorney: Personal Care* (2011) <https://www.hkreform.gov.hk/en/docs/repa2_e.pdf> accessed 14.07.22.
[84] L. Ho, above n. 82, p. 804.
[85] LAW REFORM COMMISSION OF HONG KONG (2006), above n. 35, para. 4.41.
[86] *Airedale NHS Trust v. Bland* [1993] 1 All ER 821, at 835–36 (Sir Bingham MR).

only enter into effect when they lose the ability to make the relevant decision(s).[87] At this point in time, the LRC considered various approaches, including extending or changing the scope of EPAs, expanding the functions of the Guardianship Board, and legislating for ADs, but ultimately favoured retaining the existing law and promoting ADs through non-legislative means. Its reasoning was that the common law approach had the advantage of flexibility, and that the community was not familiar enough with the concept of ADs for legislative measures to be introduced. The ultimate goal was to achieve wider use of advance directives through public awareness campaigns and non-statutory guidelines and thereby enhance patient autonomy and provide greater certainty for medical professionals.[88] One such document is the Hospital Authority's guidance for clinicians on advance directives for adults, first published in 2010 and last updated in 2020, which reiterates the common law position that an adult may make an advance refusal of life-sustaining treatment and sets out a model form for making an AD, as put forward by the LRC, so that patients may give directions with more ease and certainty.[89]

In 2019, the Hong Kong Government put forward *legislative* proposals for end-of-life care and ADs for public consultation, noting a rise in awareness about ADs amongst professionals and the public over the years and acknowledging that the lack of legislation for ADs posed concerns about legal uncertainties around the validity of ADs, especially in interaction with other mental capacity / health-related legislation, which made it difficult for patients and professionals to make use of the mechanism.[90] Amongst the proposals were plans to promote advance care planning (ACP), 'a process of communication among a patient, his/her healthcare providers, family members or caregivers regarding the kind of care that will be considered appropriate when he/she can no longer make a decision'.[91] Whilst ADs are supposedly grounded in the principle of informed consent, there is generally a lack of attention to the process of deliberation / communication and how the patient's autonomy is realised through that process. Through the broader process of ACP, patients and

[87] See, e.g., MCA 2005, s. 24.

[88] LAW REFORM COMMISSION OF HONG KONG (2006), above n. 35, ch. 8.

[89] HOSPITAL AUTHORITY (HONG KONG), *Guidance for HA Clinicians on Advance Directives in Adults* (2020) <https://www.ha.org.hk/haho/ho/psrm/ADguidelineEng.pdf> accessed 14.07.22.

[90] FOOD AND HEALTH BUREAU (HONG KONG) (NOW HEALTH BUREAU), *End-of-Life Care: Legislative Proposals on Advance Directives and Dying in Place—Consultation Document* (2019) <https://www.healthbureau.gov.hk/download/press_and_publications/consultation/190900_eolcare/e_EOL_care_legisiative_proposals.pdf> accessed 14.07.22.

[91] ibid., para. 2.2.

family members may hopefully become better prepared for future health crises, when emotional, in-the-moment treatment decisions will have to be made.[92] The final legislative proposals provides that

> any mentally competent person who is aged 18 or above [could] make an [AD] to refuse life-sustaining treatment (including artificial nutrition and hydration) under pre-specified conditions.[93]

These pre-specified conditions include terminal illness, persistent vegetative state or state of irreversible coma, and other end-stage irreversible life-limiting condition.[94] Two witnesses with no interest in the estate of the person making the AD, one of whom should be a medical practitioner, are required in the creation or modification of an AD. Moreover, the medical practitioner should be satisfied that the person 'has capability to make an [AD] and has been informed of the nature and effect of the [AD] and the consequences of refusing the treatments specified'.[95] The 'capability' to make an AD here is not further elaborated upon, and it is notable that the requirement is only for the person to have been *informed* about the relevant matters but not to *understand* (as in the MHO test for medical treatment) or further deliberate (as additionally required the common law test) them.[96] It is unclear whether this will remain the case when the proposal is eventually introduced in the legislature. It has also been suggested during the consultation exercise that there should be an all-encompassing legislation for mental incapacity, which would cover issues including ADs, healthcare decision-making by attorneys, and guardianship, but the Government has explicitly rejected this, as they see the subject as too controversial at this time.[97] As Daisy Cheung has argued, for a new statutory AD regime to be effective in creating legal certainty and encouraging

[92] H.S. PERKINS, 'Controlling Death: The False Promise of Advance Directives' (2007) 147 *Annals of Internal Medicine* 51; R.L. SUDORE and T.R. FRIED, 'Redefining the "Planning" in Advance Care Planning: Preparing for End-of-Life Decision Making' (2010) 153 *Annals of Internal Medicine* 256. See also HOSPITAL AUTHORITY (HONG KONG) (2019), above n. 36.

[93] FOOD AND HEALTH BUREAU (HONG KONG) (NOW HEALTH BUREAU), *End-of-Life Care: Moving Forward: Legislative Proposals on Advance Directives and Dying in Place—Consultation Report* (2020) para. 4.2 <https://www.healthbureau.gov.hk/download/press_and_publications/consultation/190900_eolcare/e_EOL_consultation_report.pdf> accessed 14.07.22.

[94] ibid., para. 4.3.

[95] ibid., para. 4.7

[96] ibid., para. 5.8).

[97] ibid., para. 5.8).

individuals to plan their end-of-life care in advance, it might indeed be necessary to first reform the current law on mental (in)capacity to clear up existing uncertainties and inconsistencies.[98]

7. CONCLUSION

To conclude, Hong Kong's laws in relation to mental capacity continue to severely lag behind international human rights standards. Many provisions and concepts within the MHO—last amended substantially two decades ago—are outdated[99] and inconsistent with both article 12 of the CRPD and the spirit of the treaty as a whole. These include, first of all, the lack of a coherent, uniform test for mental capacity in statutory law and the troubling conflation of mental disorder and mental incapacity. Where an individual is found to lack capacity, substitute decision-making based on welfare or best interests, whether by courts or by a party appointed to care for the individual, is always employed. In other words, once an individual is deemed to have impaired decision-making skills, they may lose their legal capacity entirely, with no room or support to participate in the decision-making process, contrary to the principle of universal legal capacity and states' obligation to take appropriate measures to provide support for the exercise of legal capacity under the CRPD. These mechanisms for substitute decision-making fail to recognise the right of persons with disabilities to equal treatment and recognition before the law, amounting to an 'imposition of dependence' which 'negates human aspiration, respect, and choice'.[100]

As many have rightly observed, reforms in mental health / capacity law in Hong Kong have been long overdue, especially in light of the enactment of the Hong Kong Bill of Rights Ordinance in 1992 and the Disability Discrimination Ordinance in 1997, the incorporation of the ICCPR into Hong

[98] D. CHEUNG, 'The importance of supporting legislation: mental capacity law in Hong Kong' at *Living Will, Living Well? Advance Directives Across Asia Workshop*, Centre for Medical Ethics and Law, University of Hong Kong, Hong Kong 2020.

[99] The terminology of 'mental handicap', for example, is no longer used in the scholarship and legislation in many jurisdictions to describe intellectual disabilities. See, e.g., A. TER HAAR, 'Attitudes and words referring to mental handicap' (1993) 16 *International Journal of Rehabilitation Research* 77; P.J. DEVLIEGER, 'From handicap to disability: language use and cultural meaning in the United States' (1999) 21 *Disability and Rehabilitation* 346; P. FOREMAN, 'Language and disability' (2005) 30 *Journal of Intellectual and Developmental Disability* 57.

[100] A. DHANDA, 'Legal capacity in the disability rights convention: Stranglehold of the past or lodestar for the future?' (2007) 34 *Syracuse Journal of International Law and Commerce* 429, 446.

Kong constitutional law in the form of the Basic Law, and the ratification of the CRPD by China in 2008.[101] The need for reform is especially striking given the myriad of practical and conceptual problems presented by the current law in terms of both the care of persons deemed to be mentally incapacitated and the compulsory psychiatric regime.[102] However, given the continued stigmatisation of mental illness and discrimination against persons with disabilities, there is little political momentum for the Government to initiate any such proposals. As the population in Hong Kong continues to age, it is further estimated that individuals suffering from different forms of cognitive impairment will grow rapidly.[103] Reforms are therefore not only necessary but pressing, which may begin with rethinking and consolidating the current piecemeal and incongruent tests for mental capacity in various contexts into a uniform approach that does not strip individuals of their legal capacity based on their decision-making skills or replace their views and preferences with what is considered by others as their best interests. At the same time, a system of supported decision-making should be implemented to empower individuals in the exercise their legal capacity.

[101] C.J. PETERSEN, 'Unfinished Business: Reforming Hong Kong's Mental Health Ordinance to Comply with International Norms' at *Compulsory Mental Health Treatment in Hong Kong: Which Way Forward? Conference*, Centre for Medical Ethics and Law, University of Hong Kong, Hong Kong 2017 <https://www.cmel.hku.hk/upload/files/CMentalHealth-Day-1-Presentation-3-Professor-Carole-Petersen-ppt.pdf> accessed 14.07.22.

[102] D. CHEUNG ET. AL., 'Articulating future directions of law reform for compulsory mental health admission and treatment in Hong Kong' (2020) 68 *International Journal of Law and Psychiatry* 101513 <https://doi.org/10.1016/j.ijlp.2019.101513> accessed 14.07.22.

[103] R. YU ET. AL., 'Trends in Prevalence and Mortality of Dementia in Elderly Hong Kong Population: Projections, Disease Burden, and Implications for Long-Term Care' [2012] *International Journal of Alzheimer's Disease* 406852 <https://doi.org/10.1155/2012/406852> accessed 14.07.22; GUARDIANSHIP BOARD (HONG KONG), *Enigma of Guardianship: An exploration into the challenges of aging population through the lens of mental incapacity* (Chinese only) (2019) <http://www.adultguardianship.org.hk/ebook/Enigma-of-Guardianship.pdf> accessed 14.07.22.