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Liberty behind closed doors ...?

Involuntary placement and medical treatment in psychiatric institutions from the human rights perspective

INTRODUCTION

According to statistics, roughly one in four of the population will experience mental disorder at some time of their lives.¹ A comparatively substantial part of this number (at least one tenth of the population) will need treatment for a serious neuropsychiatric condition.² Unfortunately, when the diagnosis is determined, mental disorder is not the only challenge that the person must face; it often comes along with exclusion, stigmatisation, powerlessness and the vulnerability of the person concerned.³

Because of the mental disorder, persons likewise can be subjected to unwanted interference in their lives, such as involuntary placement in psychiatric institutions and coercive medical treatment. The inability in certain conditions of avoiding such coercive methods demonstrates the necessity of establishing appropriate legal mechanisms, which would protect persons with mental disabilities from unlawful and unjustified interferences in their lives.

Normative framework of reference

Hence the rights of the persons suffering from mental disabilities are regulated in a number of international documents. This includes such legally binding documents as the *European Convention on Human Rights and Fundamental Freedoms* (ECHR), United Nations (UN) *International Covenant on Civil and Political Rights* (ICCPR), UN *Convention on the Rights of Persons with Disabilities* and Council of Europe (CoE) *Convention on Human Rights and Biomedicine*. Within addition to the previously mentioned legally binding instruments, the CoE and the UN have adopted a number of legally non-binding documents: recommendations and principles ("soft law") regarding protection of persons with mental disabilities.

1 Bartlett, P., Lewis, O. & Thorold, O., *Mental Disability and the European Convention on Human Rights* (Martinus Nijhoff Publishers, Leiden 2007) p. 2.

2 Ibid.

3 On the issues of exclusion, vulnerability, powerlessness see Bell, S., 'What does the "right to health" have to offer mental health patients?' (2005) *International Journal of Law and Psychiatry* (IJLP) 141, 153, p. 141; Fennell, P., 'Human rights, bioethics, and mental disorder' (2008) *Medicine and Law* (ML) 95, 107 p. 98-99; Nowak, M., Suntinger, W., 'The Right of Disabled Persons not to be subjected to Torture, Inhuman and Degrading Treatment or Punishment' in Theresia Degener and Yolán Koster-Dreese (eds), *Human Rights and Disabled Persons* (Martinus Nijhoff Publishers, The Netherlands 1995) p. 117-119 and *Herczegfalvy v Austria* (App no 10533/83) (1993) A/242-B, 15 EHRR 437 para. 82.

No doubt, the legally binding documents and, in particular, the *Convention on the Rights of Persons with Disabilities* are important instruments in order to ensure better protection of the rights of persons with disabilities.⁴ Yet, the potential of the "soft law" documents in defining the rights of persons suffering from mental disabilities cannot be underestimated. First of all, "soft law" documents may complement the many legally binding norms, which are written in comparatively general terms. The legally binding documents are prescribing certain rights in broadly applicable ways and often do not relate directly to mental disability and the problematic aspects that it includes. On the other hand, principles and recommendations contain very detailed analysis of the rights and principles regarding medical treatment, involuntary placement, private life protection and other issues related precisely to the persons with mental disabilities.

Secondly, those legally binding documents, which more specifically address rights of persons with mental disabilities, have been adopted later than the "soft law" documents. For instance, the CoE *Convention on Human Rights and Biomedicine* was adopted on 4 April 1997⁵ and the UN *Convention on the Rights of Persons with Disabilities* was only adopted on 13 December 2006,⁶ while, for instance, the UN *Declaration on the Rights of Mentally Retarded Persons* was proclaimed on 20 December 1971.

Research questions and working hypothesis

Taking into account the prescribed advantages of the "soft law" documents in comparison with legally binding documents, one might wonder, whether recommendations and principles could be (or perhaps are) used as an aid to construct the scope of the "hard law", and in particular, the case law of the European Court of Human Rights (ECtHR). To answer to this question, analysis and comparison of both "soft law" and "hard law" is necessary. Nevertheless, the examination of the interrelation between and mutual influence of "soft law" and "hard law" in the context of this research is not a theoretical one. It derives from the practical concern and serves the goal of defining the protection framework of the persons suffering from mental disabilities in the most precise way. The research is oriented to determine the potential of "soft law" and "hard law" documents for protecting one of the most vulnerable categories of persons from unjustified and unlawful interferences in their lives.

Use of both sets of instruments (legally binding and non-binding) concerning involuntary placement and medical treatment in psychiatric institutions is important also for another reason. While the ECHR precisely defines the grounds for involuntary placement in psychiatric institutions and the ECtHR offers a well developed case law, there is no such clear regulation or expanded case law regarding coercive medical treatment. The expanded regulation of involuntary placement in psychiatric

4 So far the Convention has been already ratified by 58 states and the Optional Protocol by 36. Status of ratification of UN Convention on the Rights of Persons with Disabilities, <<http://www.un.org/disabilities/default.asp?navid=18&pid=257>> accessed 26 June 2009.

5 Status of ratification of Convention on Human Rights and Biomedicine, <<http://conventions.coe.int/Treaty/Commun/QueVoulezVous.asp?NT=164&CL=ENG>> accessed 26 June 2009.

6 Convention on the Rights of Persons with Disabilities (adopted 13 December 2006, entered into force 3 May 2008) UNGA Res A/RES/61/106.

institutions raises concerns, whether there should not be also an existing protection framework regarding involuntary medical treatment? Or is involuntary medical treatment being covered by the regulation of involuntary placement in psychiatric institutions due to their close tie-up? To answer these questions, examination of the legally binding norms might not be enough. Determination of the "soft law" requirements, analysing their reflection in the case law of the ECtHR and perhaps looking for ways to fill up the gaps of the ECtHR regarding involuntary placement and medical treatment in psychiatric institutions are thus the goals of this paper.

Outline of the structure

The first part of the paper concentrates on the recommendations and principles regarding persons suffering from mental disability and gives an overview of the "soft law" requirements regarding persons with mental disabilities. It reflects the UN and the CoE guidance on such issues as respect of the interests of the person with mental disabilities, the involuntary placement and medical treatment in psychiatric institutions, procedural guarantees, capacity, role of guardian etc.

The second part then includes two chapters, which are both based on the legally binding rules and case law of the ECtHR. These respectively deal with the issue of involuntary placement in psychiatric institutions, and with medical treatment. The goal of the second part is to give an overview of the norms and case law of the ECtHR regarding involuntary placement and medical treatment in psychiatric institutions, highlight some problematic aspects in this respect, observe the use of "soft law" and measure the coherence and compliance of the rules and case law of the ECtHR with the requirements set in the recommendations and principles reflected in the first part of the paper.

Note on terminology

Before focusing on the research, some additional explanation in respect of use of terminology will be provided, as literature relating to mental health law and legal documents are not consistent in this respect.

In the view of medical development, starting from the first documents related to mental health issues, different terminology has been used to define the status of related persons. For example, the UN in 1971 adopted the *Declaration on the Rights of Mentally Retarded Persons*. From the current perspective, this is not considered as the most precise definition, since not all persons suffering from mental illness are mentally retarded. The term "persons of unsound mind" included in Article 5 of the ECHR has been recognised by mental disability NGOs as being particularly stigmatising and archaic.⁷

International documents, related to the mental health issues and literature reflect inconsistency in respect of use of terminology regarding persons suffering

7 Mental Disability Advocacy Centre, 'The European Convention on Human Rights and the rights of people with mental health problems and/or intellectual disabilities' (2003) <http://www.mdac.info/documents/MDAC_ECHR_training_pack_-_English_2nd_edition.doc> accessed on 10 May 2009.

from mental disabilities. Because of that, terms, used in this paper, are based on definitions given in various documents, which in the eyes of author define status of persons and actions taken by public authorities in the most appropriate way for the purpose of this paper. The terms used are the following ones:

Persons with mental disabilities – this term includes people with mental health problems (those with a diagnosis of 'mental illness' such as bipolar affective disorder, depression or schizophrenia), and people with intellectual disabilities (known as 'learning' disability, 'learning difficulties,' 'development disability,' the old-fashioned 'mental handicap' or the particularly stigmatising 'mental retardation').⁸

Mentally incapable person – an adult, who by reason of an impairment or insufficiency of their personal faculties, is incapable of making, in an autonomous way, decisions concerning any or all of their personal or economic affairs, or understanding, expressing or acting upon such decisions, and who consequently cannot protect their interests.⁹

Involuntary placement – admission and detention for treatment of a person suffering from mental disorder in a hospital, other medical establishment or appropriate place, it being understood that the person in question is capable of consent and does not consent to the placement or the person in question is incapable of consenting and refuses placement.¹⁰

Treatment – management of a person suffering from mental disorder and any intervention (except special treatment) whether of a physical, psychological or social nature having a therapeutic aim.¹¹

PART I

Recommendations and principles regarding persons with mental disabilities

CHAPTER 1

Determining the substance of the principles and recommendations

1.1. Reference to human rights

Frequently in legal doctrine three relationships between mental health and human rights are identified: mental health policy affects human rights, human rights violations affect mental health, and positive promotion of mental health

8 Ibid.

9 CoE Rec No. R (99) 4 of Committee of Ministers to Member States on Principles Concerning the Legal Protection of Incapable Adults and its Explanatory Memorandum (23 February 1999) Part I art 1.

10 CoE "'White paper" on the protection of the human rights and dignity of people suffering from mental disorder, especially those placed as involuntary patients in a psychiatric establishment', drawn up by a Working Party of the Steering Committee on Bioethics, Strasbourg (3 January 2000) Glossary.

11 Ibid.

and human rights are mutually reinforcing.¹² While acknowledging the interrelation and importance of all three aspects, this paper is focused primarily on the first type of relationship.

To determine how a State's policy could affect the human rights of a person suffering from a mental disability, it is crucial initially to emphasize the applicability of human rights to persons with mental disabilities. Applicability of human rights includes two important notions, first of all, foundation of human rights simply because of humanity and secondly, equality in possessing human rights. It follows that 'persons with mental disabilities need not prove that they deserve certain rights or can be trusted to exercise them in socially and culturally acceptable ways. Human rights law provides fundamental protections without qualification or exception'.¹³

Since the early documents regarding the rights of persons with mental disabilities, the principle of human dignity has been strongly highlighted as a foundation for respect of human rights and observance of non-discrimination. Such a notion is established already in Article 1 of the 1977 UN *Declaration on the Rights of Mentally Retarded Persons*, which states that 'the mentally retarded person has, to the maximum degree of feasibility, the same rights as other human beings'.¹⁴ The UN *Principles for the Protection of Persons with Mental Illness* include the principle of fundamental freedoms and basic rights, which prescribes that 'all persons with a mental illness, or who are being treated as such persons, shall be treated with humanity and respect for the inherent dignity of the human person'.¹⁵

Similar notions can be found in almost any other document outlining the rights of persons with mental disabilities.¹⁶ Some documents of the CoE include specific obligations to ensure civil and political rights.¹⁷ They put forward prohibition of torture or inhuman and degrading treatment or punishment, respect for private and family life, freedom of expression and right to marry and

12 Gostin, O. L., 'Human Rights of Persons with Mental Disabilities' (2000) IJLP 125, 159 p.127. See also Fennell, P., 'Human rights, bioethics, and mental disorder' (2008) ML 95, 107 p. 96.

13 Gostin, O. L., 'Human Rights of Persons with Mental Disabilities' (2000) IJLP 125, 159 p.126.

14 Universal Declaration of Human Rights (adopted 10 December 1948 UNGA Res 217 A(III) (UDHR) art 1.

15 Principles for the Protection of Persons with Mental Illness, United Nations General Assembly (UNGA) Resolution (Res) A/Res/46/119 (17 Dec 1991) principle 1.

16 See, for example, CoE Rec No. R (83) 2 of Committee of Ministers to Member States Concerning the Legal Protection of Persons Suffering from Mental Disorder Placed as Involuntary Patients (22 February 1983) art 10 or CoE Rec No. R (99) 4 of Committee of Ministers to Member States on Principles Concerning the Legal Protection of Incapable Adults and its Explanatory Memorandum (23 February 1999) Part II, Principle 1, or CoE Conclusions document Protection and promotion of the human rights of persons with disabilities' of seminar organized by The Commissioner for Human Rights (5-7 February 2003) art 1.

17 See, for example, Coe Rec No. REC (2004) 10 of Committee of Ministers to Member States Concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder and its Explanatory Memorandum (22 September 2004) art 4 or CoE "White paper" on the protection of the human rights and dignity of people suffering from mental disorder, especially those placed as involuntary patients in a psychiatric establishment', drawn up by a Working Party of the Steering Committee on Bioethics, Strasbourg (3 January 2000) art 11 (1).

found a family.¹⁸ Considering the applicability of such rights, the basic notion is that 'restriction of these rights should be an exception rather than the norm'.¹⁹ Respect for privacy and family life has often been particularly emphasised. Documents include both aspects of privacy—as used generally in literature: namely, informational and decisional privacy.²⁰ Reference to the informational privacy is expressly highlighted with an aim to invite member states to stop the practice of censoring correspondence,²¹ ensure patients' rights to send any letter unopened²² and protect data of ex-patients in mental hospitals.²³

Decisional privacy regarding persons with mental disabilities and legally incapable adults is an equally important issue since it concerns freedom to make fundamental decisions about persons' lives and intimate relations without interference by the state.²⁴ In cases where legal capacity is lost, the person is no longer able to make such decisions. It then becomes crucial in these circumstances for the nominated guardian not to ignore the needs of the incapable adult and to take into account his/her wishes and feelings to the greatest possible extent.²⁵

It might seem self-evident that all human rights are and should be guaranteed without exception or discrimination in respect of every individual of society, including the most vulnerable groups. Yet society often becomes confused when it comes to the protection of human rights for persons with mental disabilities. Public attitude is frequently based on stigmatisation and outcasting of persons suffering from the different forms of mental disabilities. The unpredictability of their behaviour and often inability for some persons to fully comprehend their actions and related consequences often motivate public perception that such persons do not possess all the essential elements of human beings. Hence, they are often not seen as individuals endowed with the full humanity. As a result of that, the full applicability of human rights regarding persons with "unsound mind" might seem an unjustified and dispensable requirement.

It can be concluded that the rationale of including human rights reference in all the documents regarding the rights of persons with mental disabilities serves primarily the purpose of stressing the notion of the full value of individuals and the principle of non-discrimination. It can be identified as a strong reiteration or

18 See, in particular, Explanatory Memorandum to the CoE Rec No. REC (2004) 10 of Committee of Ministers to Member States Concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder (22 September 2004) art 4.

19 Ibid.

20 Siegel, W. A., 'Inequality, privacy and mental health' IJLP (2008) 150, 157 p. 154.

21 CoE Rec No. 818 (1977) on the Situation of the Mentally Ill (8 October 1977) art 13 (i).

22 Ibid art 6 (b).

23 See, for example, CoE Rec No. 818 (1977) on the Situation of the Mentally Ill (8 October 1977) art III (i) or CoE Rec No. REC (2004) 10 of Committee of Ministers to Member States Concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder (22 September 2004) art 13.

24 Siegel, W. A., 'Inequality, privacy and mental health' IJLP (2008) 150, 157 p. 154.

25 CoE Rec No. R (99) 4 of Committee of Ministers to Member States on Principles Concerning the Legal Protection of Incapable Adults (23 February 1999) Part II, Principle 8.

statement, that mental disability is not depriving a person from the essence of humanity, and that their human rights should consequently be respected to the same extent as for everyone else.²⁶

1.2. The principle of best interests of incapable adults and/or persons with mental disability

The principle of taking into account the best interests of the persons with mental disabilities could be the one which is most wrongly understood by society and violated most frequently by the relatives and closest persons of the individual concerned.

Societies often tend to approach mental disorders and legal incapacity as a phenomenon against which the general population should be protected in the first place. This approach can be justified in particular cases, when a person endangers society or his/her behaviour appears to represent such risk. At the same time there are many situations when a person with mental disability may endanger himself/herself (for example in cases of suicidal tendencies) and require a treatment basically for his/her own safety (and not for the protection of society).

The principle of best interest is of striking relevance in situations involving legal incapacity issues. The concept of legal incapacity has been conceived and is meant to serve as a protection mechanism for persons who are not able to fully or partly organise and manage issues connected with everyday life. Deprivation of legal capacity has nothing to do with the protection of society's wellbeing, interests or security. The same should be taken into account in case of voluntary or involuntary placement and treatment: the patients best interests should be ensured, not that of the family, community, professionals or the state.²⁷

The initial documents considering mental health issues and human rights did not include precisely defined protection of primary interests of person suffering from mental disabilities. What can be found in early recommendations in the 1970s, is condemnation of the abuse of psychiatry for political purposes and elimination of dissidence whatever its form.²⁸ Later documents incorporate many references stating that in cases of involuntary placement or involuntary treatment a person's interest should be taken into account.²⁹

The most expanded provisions regarding the principle of best interests of incapable person can be found in the CoE Recommendation on principles regarding

26 CoE Conclusions document 'Protection and promotion of the human rights of persons with disabilities' of seminar organized by The Commissioner for Human Rights (5-7 February 2003) art 1.

27 Gudmundur A. & Katarina T., (eds), *A Thematic Guide to Documents on Health and Human Rights* (Martinus Nijhoff Publishers, The Hague 1998) p. 444.

28 CoE Rec No. 818 (1977) on the Situation of the Mentally Ill (8 October 1977) art 10.

29 See, for example, CoE "White paper" on the protection of the human rights and dignity of people suffering from mental disorder, especially those placed as involuntary patients in a psychiatric establishment', drawn up by a Working Party of the Steering Committee on Bioethics, Strasbourg (3 January 2000) art 3, 6 and 11 (7), or Coe Rec No. REC (2004) 10 of Committee of Ministers to Member States Concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder (22 September 2004) art 10.

the legal protection of incapable adults. As a result of incapacity, a person loses the ability to act on behalf of him or herself on legal and often also private matters. The rights attributed to the appointed guardian are thus very broad. In practice, the interests of incapable person are often put aside in acting upon issues such as protection of property, choice of place of residence and treatment in mental hospital. The recommendation thus sets out a duty for representatives and guardians to respect the interests and welfare of the incapable adult. Such duty specially implies the obligation to use and manage property of the incapable person for the benefit of that incapable person.³⁰

1.3. Principles regarding involuntary placement and medical treatment

The main approach for the admission to mental hospital and provision of medical treatment in case of mental disability is that it in principle should be voluntary and only in exceptional cases imposed.³¹ Involuntary placement always needs to be accomplished in accordance with domestic laws and procedure. In case of treatment, the medical personnel should take into account the principle of least restriction, needed to treat the patient 'in the least restrictive environment and with the least restrictive or intrusive treatment appropriate'.³² It also applies to the use of such treatments as restraint and seclusion.³³ In accordance with the UN *Principles for the Protection of Persons with Mental Illness* restraint and seclusion should only be employed 'when it is the only means available to prevent imminent harm to the patient or others'.³⁴

Although these requirements might seem relatively straightforward and comprehensible, in practice, important gaps in interpretations subsist. In subsequent sub-chapters some of such aspects will be highlighted.

1.3.1. Medical treatment and involuntary placement

1. Regarding involuntary placement in psychiatric institutions, recommendations and principles are relatively consistent. The criteria for placement and requirements for the procedure that should be observed are for the most part similar in the "soft law" documents, covering this issue. Thus the CoE Recommendation *Concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder* prescribe that:

30 Coe Rec No. REC (2004) 10 of Committee of Ministers to Member States Concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder (22 September 2004) Part II, Principle 8.

31 See, for example, Coe Rec No. 1235 (1994) on Psychiatry and Human Rights (12 April 1994) art 7 (i) a.

32 Principles for the Protection of Persons with Mental Illness, UNGA Res A/Res/46/119 (17 Dec 1991) principle 9 (1).

33 Coe Rec No. REC (2004) 10 of Committee of Ministers to Member States Concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder (22 September 2004) art 27.

34 Principles for the Protection of Persons with Mental Illness, UNGA Res A/Res/46/119 (17 Dec 1991) principle 11 (11).

... a person may be subjected to involuntary placement only if all the following conditions are met:

- i) the person has a mental disorder;
- ii) the person's condition represents a significant risk of serious harm to his or her health or to other persons; the placement includes a therapeutic purpose;
- iii) no less restrictive means of providing appropriate care are available;
- iv) the opinion of the person concerned has been taken into account.³⁵

The early UN and the CoE Recommendations do not set down the last two requirements but define another ground for involuntary placement that 'states may, however, provide that a patient may also be placed when, because of the serious nature of his mental disorder, the absence of placement would lead to a deterioration of his disorder or prevent the appropriate treatment being given to him'.³⁶ As it was mentioned, the latest documents seem to rely on a notion that the main reason for involuntary placement is protection of the person from causing risk of dangerousness to him/her self or society and do not include ground of involuntary placement due to necessity of medical treatment.

2. In respect of involuntary medical treatment the "soft law" documents are not so consistent and reflect different approaches, depending on the date of adoption. The first documents of the CoE³⁷ prescribe the right to receive medical treatment and care,³⁸ but do not require consent for medical treatment and do not determine criteria for coercive medical treatment. The only exception is related to the 'treatment which is not generally recognized by medical science or presents a serious risk of causing permanent brain damage or adversely altering the personality of the patient'.³⁹ Such treatment can be only provided after receiving informed consent of the patient.

The UN Principles⁴⁰ in this respect are more explicit and set up a general provision that 'no treatment shall be given to a patient without his or her informed consent'.⁴¹ Nevertheless the provision includes number of exceptions which exclude those patients, who 'lack capacity give or withhold informed

35 Coe Rec No. REC (2004) 10 of Committee of Ministers to Member States Concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder (22 September 2004) art 17. See also Principles for the Protection of Persons with Mental Illness, UNGA Res A/Res/46/119 (17 Dec 1991) principle 16.

36 CoE Rec No. R (83) 2 of Committee of Ministers to Member States Concerning the Legal Protection of Persons Suffering from Mental Disorder Placed as Involuntary Patients (22 February 1983) art 3 (b); Coe Rec No. 1235 (1994) on Psychiatry and Human Rights (12 April 1994) art 7 i (a) and Principles for the Protection of Persons with Mental Illness, UNGA Res A/Res/46/119 (17 Dec 1991) Principle 16 (1) ii.

37 CoE Rec No. R (83) 2 of Committee of Ministers to Member States Concerning the Legal Protection of Persons Suffering from Mental Disorder Placed as Involuntary Patients (22 February 1983) and Coe Rec No. 1235 (1994) on Psychiatry and Human Rights (12 April 1994).

38 CoE Rec No. R (83) 2 of Committee of Ministers to Member States Concerning the Legal Protection of Persons Suffering from Mental Disorder Placed as Involuntary Patients (22 February 1983) art 5 (1).

39 Ibid.

40 Principles for the Protection of Persons with Mental Illness, UNGA Res A/Res/46/119 (17 Dec 1991).

41 Ibid principle 11.

consent,' those who have 'personal representative empowered by law to consent to treatment of the patient' and the provision does not apply in cases of urgent medical necessity, determined by 'qualified mental health practitioner'.⁴²

Only the latest CoE documents have clearly highlighted 'the necessity to make a distinction between a legal ground for involuntary medical treatment and the legal ground for involuntary treatment'⁴³ and require recognition that 'the compulsory placement and treatment of an individual are two separate questions requiring separate decisions'.⁴⁴ Also the criteria for involuntary treatment have been determined, which require that the same conditions as for involuntary placement would be met.⁴⁵ The decisions regarding involuntary medical treatment should be 'taken by the court or another competent body' which would 'take into account the opinion of the person concerned' and would 'act in accordance with procedures provided by law'.⁴⁶

In respect of involuntary placement and medical treatment of incapable adults the CoE Recommendation *on Principles Concerning the Legal Protection of Incapable Adults* is more specific than other CoE recommendations and require to take into account the actual capacity of the person to consent or refuse the treatment and not disregard a person's right to refuse treatment only because of the legal incapacity.⁴⁷ Such prescription gives authority to the opinion of some authors that 'the appointment of a guardian does not necessarily mean that the individual lacks the actual or functional capacity to consent to medical treatment'.⁴⁸ It accordingly follows that the guardian or representative should not be endowed with the unconditional right to take any decision considering placement and treatment of the incapable adult.

42 Ibid.

43 CoE "'White paper" on the protection of the human rights and dignity of people suffering from mental disorder, especially those placed as involuntary patients in a psychiatric establishment', drawn up by a Working Party of the Steering Committee on Bioethics, Strasbourg (3 January 2000) art 3.

44 CoE Conclusions document 'Protection and promotion of the human rights of persons with disabilities' of seminar organized by The Commissioner for Human Rights (5-7 February 2003) art 6.

45 Coe Rec No. REC (2004) 10 of Committee of Ministers to Member States Concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder (22 September 2004) art 18: "the person has a mental disorder; the person's condition represents a significant risk of serious harm to his or her health or to other persons; no less intrusive means of providing appropriate care are available and the opinion of the person concerned has been taken into consideration."

46 Ibid art 20 (2).

47 CoE Rec No. R (99) 4 of Committee of Ministers to Member States on Principles Concerning the Legal Protection of Incapable Adults (23 February 1999) Part V, Principle 1 states "Where an adult, even if subjected to a measure of protection, is in fact capable of giving free and informed consent to a given intervention in his health field, the intervention may only be carried out with his or her consent."

48 Bartlett, P., Lewis, O. & Thorold, O., *Mental Disability and the European Convention on Human Rights* (Martinus Nijhoff Publishers, Leiden 2007) p.122.

1.3.2. Special treatments and procreation

Special treatments often are recognized as controversial⁴⁹ and include certain types of therapies which may leave permanent brain damage or change in personality.⁵⁰ Such treatment can include lobotomies,⁵¹ electroconvulsive therapy, psychosurgery or use of hormone implants to alter sexual drive.⁵² Due to the serious consequences such treatment leaves, particular order is demanded for obtaining a person's (or his/her guardian's) consent. It is recommended to states that such treatment should never be used in the context of involuntary placement.⁵³ Mostly international documents demand the person's written consent after providing him or her full information about treatment and the permanent consequences likely to follow.⁵⁴

Member states have been invited by the CoE to seek new ways how to humanize the use of certain therapies.⁵⁵ It has been argued by some authors that the use of certain therapies in a non-modified way (for example, use of electroconvulsive therapy without anaesthetic and muscle relaxants) could be recognized as an inhuman treatment.⁵⁶

Considering sterilization, the UN recommendations have established a prohibition to carry out such acts as a treatment for mental illness.⁵⁷ The CoE recommendations have created ground for protection of persons with mental disorder and their right to procreate⁵⁸ and established the prohibition to use mental disorder as a justification for termination of pregnancy.⁵⁹

49 CoE "'White paper" on the protection of the human rights and dignity of people suffering from mental disorder, especially those placed as involuntary patients in a psychiatric establishment', drawn up by a Working Party of the Steering Committee on Bioethics, Strasbourg (3 January 2000) art 6 (1).

50 CoE Rec No. 818 (1977) on the Situation of the Mentally Ill (8 October 1977) art 13, II (ii).

51 See, for example, Coe Rec No. 1235 (1994) on Psychiatry and Human Rights (12 April 1994) art 7 (ii) b.

52 CoE "'White paper" on the protection of the human rights and dignity of people suffering from mental disorder, especially those placed as involuntary patients in a psychiatric establishment', drawn up by a Working Party of the Steering Committee on Bioethics, Strasbourg (3 January 2000) art 7.

53 Coe Rec No. REC (2004) 10 of Committee of Ministers to Member States Concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder (22 September 2004) art 28 (2).

54 See, for example, Coe Rec No. 1235 (1994) on Psychiatry and Human Rights (12 April 1994) art 7 (ii) b or Coe Rec No. REC (2004) 10 of Committee of Ministers to Member States Concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder (22 September 2004) art 28 (2).

55 Rec No. 818 (1977) on the Situation of the Mentally Ill (8 October 1977) art 13, II (ii).

56 Bartlett, P., Lewis, O. & Thorold, O., *Mental Disability and the European Convention on Human Rights* (Martinus Nijhoff Publishers, Leiden 2007) p. 117.

57 Principles for the Protection of Persons with Mental Illness, UNGA Res A/Res/46/119 (17 Dec 1991) Principle 11 (12).

58 Coe Rec No. REC (2004) 10 of Committee of Ministers to Member States Concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder (22 September 2004) art 30.

59 Ibid art 31.

1.4. Procedural guarantees

Procedural guarantees regarding persons suffering from mental disabilities are established with the purpose of preventing human rights violations in cases of involuntary placement, medical treatment and also incapacity proceedings. Often such guarantees are left unfulfilled and ignored not only due to the vulnerability of the persons concerned, but also because of misinterpretation and lack of knowledge, as to how such guarantees are to be applied (if so), in the event that a person is not endowed with a full capacity or is acting in ways that raises doubts about his/her capacity.

The aspect of full applicability of principle of human rights to persons with mental disabilities, including persons deprived of legal capacity, was already highlighted in the first sub-chapter of the paper. Notwithstanding the requirement that human rights should be enforced equally and without any distinction, the procedural guarantees, which are correspondent in respect of persons suffering from mental disabilities, are applied in very specific circumstances and thus require additional interpretation.

1.4.1. The right to participation and to be heard

The rights to be heard and to participate in all proceedings considering status or interests of the person is the main prerequisite for possibility to influence decisions taken by the court (or any other body of authority) and to ensure that all the other procedural guarantees are being respected during proceedings.

Due to the importance of this issue, the right to be heard is stressed in almost all the documents related to the rights of persons with mental disabilities.⁶⁰ In addition to the general guarantee to be heard, the CoE recommendation also prescribes a principle that 'the person concerned should be seen and consulted'.⁶¹ The main reason for demanding the right to be seen and heard during involuntary placement and incapacity proceedings is to prevent situations, in which court decisions would be taken only on the basis of medical reports⁶² and without any possibility for a person to represent his/her interests.

In cases of inability of a person to represent him or herself, the rights of appointed representative or guardian should be fully respected. Even in the case of involuntary placement, the person has rights to communicate with his or her lawyer or legal representative.⁶³

60 See, for example, CoE Rec No. 818 (1977) on the Situation of the Mentally Ill (8 October 1977) art 13 I (iii); CoE Rec No. REC (2004) 10 of Committee of Ministers to Member States Concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder (22 September 2004) art 25 1 (i) or CoE Rec No. R (99) 4 of Committee of Ministers to Member States on Principles Concerning the Legal Protection of Incapable Adults (23 February 1999) Part III, Principle 13.

61 CoE Rec No. REC (2004) 10 of Committee of Ministers to Member States Concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder (22 September 2004) art 20 1 (ii).

62 CoE Rec No. 818 (1977) on the Situation of the Mentally Ill (8 October 1977) art 13 I (iii).

63 CoE Rec No. REC (2004) 10 of Committee of Ministers to Member States Concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder (22 September 2004) art 23 (1).

The right to participation also entails an obligation to provide related information regarding health issues and proceedings to the person concerned. In conformity with international standards, representatives and guardians are both entitled to receive all the information regarding a person they are accompanying or representing,⁶⁴ but they also both have a parallel duty to provide such information to the person with mental disabilities.⁶⁵

1.4.2. The rights to appeal and review

The rights to appeal and review have been stressed in the recommendations and principles with the same intensity as the rights to participation and to be heard.⁶⁶ In accordance with the CoE recommendations, a person has the right to lodge an appeal against the decisions taken by the judicial or any other appropriate authority regarding his or her involuntary placement and/or medical treatment in psychiatric institutions.⁶⁷ In respect of both decisions, a person is also given the right to review, which should be ensured by 'a court at reasonable intervals'.⁶⁸ In accordance with the CoE recommendation, "'court" includes reference to a court-like body or tribunal'.⁶⁹

Analysis of the "soft law" provisions regarding procedural guarantees reflects the strong interrelatedness, which exists between all of them. It is almost impossible to exercise the right to appeal, if the person has been formerly denied the right to participate and has not been, in general terms, informed about the proceedings underway. In case of capacity proceedings this issue is even more complex, since most domestic laws require legal capacity to submit an appeal. Often persons consequently face a deadlock if their legal capacity has been restricted, being unable to submit an appeal.

To avoid this kind of situation, it is essential to see all procedural guarantees as interrelated and arising one from another. Often it is not possible to ensure one right if the other one is being ignored. The strong statements of international documents considering the rights to appeal, review, to be heard and to participate can be interpreted as requests for states to take seriously into

64 Ibid art 22 (3).

65 See, for example, CoE Rec No. R (99) 4 of Committee of Ministers to Member States on Principles Concerning the Legal Protection of Incapable Adults (23 February 1999) Part II, Principle 9 (3).

66 See, for example, CoE Rec No. R (83) 2 of Committee of Ministers to Member States Concerning the Legal Protection of Persons Suffering from Mental Disorder Placed as Involuntary Patients (22 February 1983) art 4 (4) or Coe Rec No. 1235 (1994) on Psychiatry and Human Rights (12 April 1994) art 7 (i) c.

67 CoE Rec No. REC (2004) 10 of Committee of Ministers to Member States Concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder (22 September 2004) art 25 and CoE Rec No. R (83) 2 of Committee of Ministers to Member States Concerning the Legal Protection of Persons Suffering from Mental Disorder Placed as Involuntary Patients (22 February 1983) art 4.

68 Ibid, see also CoE Rec No. R (83) 2 of Committee of Ministers to Member States Concerning the Legal Protection of Persons Suffering from Mental Disorder Placed as Involuntary Patients (22 February 1983) art 8.

69 Ibid art 2 (3).

account procedural guarantees of the persons with mental disabilities, even if their legal capacity is factually limited or their attitude seemingly unreasonable and inadequate.

1.5. Principle of maximum preservation of capacity

Regarding the mental capacity, two important points should be made. First, it needs to be recognized that there can be different degrees of incapacity and secondly, incapacity may vary from time to time.⁷⁰ From this basic notion it follows that persons should not always be fully deprived of legal capacity and that such deprivation may not necessarily need to be permanent.

This principle is often strongly violated in a number of cases *de facto* but also *de jure*, through provisions existing in many domestic laws.⁷¹ Often states only recognise full deprivation of legal capacity and it is also considered that legal incapacity is an unchangeable condition. While it could be presumed that the existence of such norms on the domestic level result from the negligence, lack of attention and lack of political will to change this particular situation, the impact that such domestic rules leave on peoples' lives is incommensurable.

From the perspective of international standards, domestic laws should recognize the difference between various actions and levels of restrictions of legal capacity. It is defined as the principle of least restriction, which requires the States to adopt the concept of partial capacity. The Explanatory Memorandum to the CoE *Recommendation on principles concerning the legal protection of incapable adults* expresses an opinion that for certain group of rights (for example, the right to vote or the right to consent to or refuse any medical treatment) there never exists any need for full removal of the person's legal capacity.⁷² It would require detecting actual capacity of the person at any time, when such a right by him or her would be practised.

Another important aspect of the maximum preservation of capacity concerns connection between admission in psychiatric hospital (voluntary or involuntary) and legal incapacity. In the first recommendations of the Committee of the Ministers of the CoE considering mental health issues, States were invited to 'modify the civil capacity rules applied to mentally ill, in order to ensure that any hospitalisation does not necessarily result in an automatic determination of legal incapacity'.⁷³ Similar notion has also been expressed in a later recommendation of the CoE in 1983.⁷⁴

70 CoE Rec No. R (99) 4 of Committee of Ministers to Member States on Principles Concerning the Legal Protection of Incapable Adults (23 February 1999) Principle 3.

71 For example, The Civil Law of Latvia (*Latvijas Republikas Civillikums*) (1938) only prescribes full deprivation of legal capacity (art 362).

72 CoE Rec No. R (99) 4 of Committee of Ministers to Member States on Principles Concerning the Legal Protection of Incapable Adults (23 February 1999) Principle 3.

73 CoE Rec No. 818 (1977) on the Situation of the Mentally Ill (8 October 1977) art 13, I (iv).

74 Article 9 states: "The placement, by itself, cannot constitute, by operation of law, a reason for the restriction of legal capacity of the patient."

1.6. The role of representative and guardian

It would not be an exaggeration to aver that in relation to the persons with mental disabilities and incapable adults, the role of representatives and guardians is more crucial than in any other case of adult representation. Persons with mental disabilities often are not able to protect their rights adequately, and the case of mental incapacity status of an adult is often emulated to a case of "civil death". All these circumstances create a situation in which representative's or guardianship's acts are accompanied with large discretionary power(s) and authority. It can be used for the benefit of the person concerned, but the vulnerability of persons suffering from mental disabilities can equally open doors for abuse.⁷⁵ Unfortunately, it is not only the "professional guardians" who are violating rights of persons, whose interests should be the main concern of their work; frequently persons with mental disabilities and incapable adults are suffering from abuses by their own family members. To prevent risk of possible abuses, it is crucially important to observe a person's rights to be heard, and to take into account his or her wishes as to the choice of person to represent him or her during the process of guardian appointment.⁷⁶

The UN *Principles for the Protection of Persons with Mental Illness* have paid particular attention to the problem of family member abuses. It suggests that the person, whose capacity is at issue, should be entitled to be represented by a counsel, who is not a member of the family unless the tribunal is satisfied that there is no conflict of interest.⁷⁷ The question, whether family members should be involved and represent a person's interests during capacity proceedings, is not an easy one to answer. Often family members are the ones who know the actual health condition of the person best of all, and, of course, not all family representatives or guardians act in a bad faith or negligence. Still the case law of ECtHR indicates that restrictions on participation of family members during capacity proceedings would in some occasions have helped to prevent numerous violations committed against legally incapable persons.⁷⁸

From the previously mentioned, one can infer that there is no need to create rules which would fully exclude any family member from participation in the capacity proceedings. On the other hand, family members should not be unconditionally endowed with the right of representation. There should be left a possibility to question the participation of family members with due reference to the principle of the best interests of the person concerned.

75 Vulnerability of the persons suffering from mental disabilities has been often highlighted in the CoE recommendations. See for example, CoE Rec No. R (99) 4 of Committee of Ministers to Member States on Principles Concerning the Legal Protection of Incapable Adults, Explanatory Memorandum (23 February 1999) Principle 1 (25).

76 Ibid principle 8 (45).

77 Principles for the Protection of Persons with Mental Illness, UNGA Res A/Res/46/119 (17 Dec 1991) Principle 1 (6).

78 See, for example, case *Shtukaturov v Russia* (App no 44009/05) ECHR 2008.

1.7. Concluding remarks

The first chapter of this paper was devoted to the examination of related "soft law" documents. It formulated principles which are derived from the CoE and UN recommendations and are crucial in respect of protection of persons with mental disabilities. The chapter displayed the multiplicity of issues that principles and recommendations cover. As was reflected, they include all the aspects that persons with mental disabilities have to face and provide best practice suggestions on how to deal with it. It not only covers the social inclusion, integration and rehabilitation issues, but also details the "negative" obligation on States to avoid unnecessary interventions in people's lives.

The examination of the documents reflected the strong emphasis on the respect of human rights of persons suffering from mental disabilities and the crucial importance of taking into account the best interests of the person concerned. It also contributed to the acknowledgment of certain problems regarding involuntary placement, medical treatment, procedural guarantees and incapacity.

The further chapters will thus examine the compliance of "soft law" standards with the human rights principles, established by the treaties and case law. The framework of the "hard law" on such questions as involuntary placement and medical treatment in psychiatric institutions will be provided to draw parallels with the already examined "soft law" approach. Chapters will try to determine to what extent the "soft law" requirements are protected through the legally binding norms. The focus of the research will be on the following issues: the substantive and procedural norms of involuntary placement in psychiatric institutions of capable and incapable persons suffering from mental disabilities, the link between involuntary placement and medical treatment, the need to ensure medical treatment, the importance of consent for medical treatment and medical treatment from the perspective of private life protection and prohibition of inhuman and degrading treatment.

PART II

Human rights principles regarding involuntary placement and medical treatment

CHAPTER 2

Involuntary placement in psychiatric institutions

2.1. The right to liberty

The right to liberty and prohibition of arbitrary or unlawful detention or arrest is prescribed in Articles 3 and 9 of *The Universal Declaration of Human Rights* (UDHR), Article 9 of the UN ICCPR and Article 5 of the ECHR. It is not an absolute right and therefore a person's liberty can be deprived on 'such grounds

and in accordance with such procedures as are established by law'.⁷⁹ Article 5 of the ECHR is more concrete and gives an exhaustive list of grounds,⁸⁰ based on which a person's liberty can be deprived in a lawful way.

To recognize what could amount to a deprivation of liberty, it is important to define first of all, the essence of the right to liberty. The right to liberty should be seen in its narrowest form in the framework of previously quoted articles. These norms do not apply to the general term the *liberty of person*.⁸¹ They relate to the physical liberty of persons,⁸² 'only to very specific aspect of human liberty: the freedom of bodily movement in narrowest sense'.⁸³ At the same time it should be distinguished from the right to freedom of movement which is prescribed in Article 2, Protocol 4 of the ECHR.

It might not always be an easy task to draw a sharp line between these two rights. The guidelines given by the ECtHR in the *Guzzardi* case can be seen as a main, but still very general approach to draw the distinction between the right to liberty and the freedom of movement. The ECtHR has stated that the difference is 'merely one of degree or intensity, and not of nature or substance'.⁸⁴

As follows from the case law of the ECtHR, the Court would examine conditions and obstacles in each separate case. It would pay attention not only to the location (for example, a prison, an island⁸⁵ or hotel room⁸⁶), but also to the type, duration and effects.⁸⁷ The capacity and consent to detention would be also evaluated by the Court in certain cases.⁸⁸ These conditions and obstacles can be also defined as objective and subjective elements of the deprivation of liberty.⁸⁹ An objective element describes the loss of liberty as a 'confinement in a particular restricted space for a not negligible length of time';⁹⁰ while subjective element means that 'a detainee must not have validly consented to the confinement in question (assuming the detainee has the capacity to provide such consent)'.⁹¹ As will be highlighted further in this paper, in a case when a person is

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

80 See *Brand v Netherlands* (App no 49902/99) ECHR 10 November 2004 para. 58 regarding lawful grounds of deprivation of liberty.

81 Nowak, M., *U.N. Covenant on Civil and Political Rights. CCPR Commentary* (2nd revised edn N.P. Engel Publisher, Kehl, Germany 2005) p.212.

82 *Engel and others v Netherlands* (No 1) (App no 5100/71; 5101/71; 5102/71; 5354/72; 5370/72) (1976) A/22, 1 EHRR 647 para 58.

83 Nowak, M., *U.N. Covenant on Civil and Political Rights. CCPR Commentary* (2nd revised edn N.P. Engel Publisher, Kehl, Germany 2005) p.212.

84 *Guzzardi v Italy* (App no 7367/76) (1981) A/39, 3 EHRR 333, para. 93.

85 *Ibid.*

86 *Riera Blume and others v. Spain* (App no 37680/97) ECHR 1999-VII, para. 30.

87 Ovey, Cl., White, R., *The European Convention on Human Rights* (4th edn OUP, Oxford 2006) p.124.

88 For example, as in case *H.L. v UK* (App no 45508/99) ECHR 2004-IX

89 Harris, D.J., O'Boyle, M. & Warbrick, C., *Law of the European Convention on Human Rights* (OUP, Oxford 2009) p.123.

90 *Ibid.*

91 *Ibid.*

deprived of liberty on the grounds of "unsound mind," the subjective element is the one with major importance.

To recognize deprivation of liberty as lawful, two important conditions must be fulfilled: first of all, it should be done on the grounds established by the law (in accordance with the ICCPR) or on the grounds prescribed by Article 5 (under the ECHR) and, secondly, it should be done in compliance with the procedure prescribed by the law.

When it comes to the applicability of both norms in respect of persons with mental disabilities, it is easier to apply the ECHR, since Article 5 provides clear basis for 'the lawful detention of persons of unsound mind'.⁹² As was already mentioned, the ICCPR does not include such listing of grounds. It demands that grounds for deprivation of liberty be established in domestic laws and be compatible with international laws.⁹³ However this does mean that Article 9 is not applicable in case of detention of person with mental disability. As M. Nowak argues, such 'logical-systematic interpretation leads to absurd result, which does not comport with the object and purpose of this provision'.⁹⁴ Therefore he concludes that 'the holding of mentally ill persons [...] is to be understood as arrest or detention, making the guarantees in paras.1, 4 and 5 fully applicable'.⁹⁵

Regarding procedure prescribed in law, norms refer primarily to the domestic laws. Some procedural guarantees are also specifically included in Article 9 of the ICCPR and Article 5 of the ECHR. Not all of these guarantees are applicable in case of detention of person with mental illness. Nevertheless both treaty provisions endow persons with the right to take proceedings before a court without delay to question the lawfulness of detention. In case of unlawful detention a person has an enforceable right to compensation.

2.2. Lawful detention of persons of "unsound mind"

What could be defined as a major difference between detention of person of "unsound mind" and deprivation of liberty based on the other grounds mentioned in Article 5 of the ECHR? One of the most striking differences and also problematic aspects is already mentioned in the question itself. The term "unsound mind" links the fact of detention of persons with mental disabilities not to some external or objective circumstances (as for example, in the case of detention of 'a person for non-compliance with the lawful order of a court'⁹⁶), but to the person him or herself. Such formulation leaves many questions unanswered.

To begin with, Article 5 does not prescribe a definition of the term "person of unsound mind". Nor does it define conditions, in which liberty of the persons of unsound mind could be lawfully restricted. Article 5 is also silent in respect of the

92 Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights, as amended) (ECHR) art 5 (1) e.

93 Nowak, M., *U.N. Covenant on Civil and Political Rights. CCPR Commentary* (2nd revised edn N.P. Engel Publisher, Kehl, Germany 2005) p.224.

94 Ibid p.220.

95 Ibid.

96 Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights, as amended) (ECHR) art 5 (1) b.

requirement of "lawful" detention and thus raises a question, should every detention of a person of "unsound mind", done in accordance with the domestic laws, be recognized as legitimate?

To all these unclear issues the ECtHR had to give explanations, when the first complaint regarding potential unlawful deprivation of liberty in psychiatric hospital on the basis of "unsound mind" was submitted to the Court. *Winterwerp v. the Netherlands* has been the landmark case since the ECtHR delivered its decision in 1979. Up to now the ECtHR has developed significant case law regarding this issue, even though the first case was litigated a comparatively short period of time ago.

In accordance with the ECtHR case law, deprivation of liberty in the event of mental disability, unlike all the other grounds, involves not only the objective element of deprivation of liberty (such as the locking-up of a person in the premises, for example) but also the subjective element, which often plays the most important role. Regarding the placement in psychiatric institutions, the Court has stated that 'a person can only be considered to have been deprived of his liberty if, as an additional subjective element, he has not validly consented to the confinement in question'.⁹⁷ Not only is the actual capacity to realise and dispute detention at stake (as for example in case of *H.L. v. UK*), but also the role of relatives or legal guardians who might take these decisions in place of a person who has lost the legal capacity but might still possess the actual capacity.⁹⁸ Also the problematic situation of factual deprivation of liberty can emerge when a person has been admitted to a psychiatric institution on a voluntary basis, but in reality is kept behind closed doors and is not free to leave.⁹⁹ In this respect the ECtHR in the case of *H.L. v. UK* has stated that, what matters is not so much whether the person is held under "locked" conditions, but the extent to which he or she is in fact subjected to a regime of continuous supervision and control and whether in practice he or she would be free to leave were this to become an issue.

When it comes to analysis, whether detention of person of "unsound mind" has been done in accordance with the framework of the ECHR, formulation of Article 5 demands more concrete interpretation. Already in the *Winterwerp* decision, the Court recognised that the Convention does not state what is to be understood by the words "persons of unsound mind".¹⁰⁰ Nor did the Court give a precise definition in its judgment, by stating that 'this term is not one that can be given a definitive interpretation'.¹⁰¹

Nevertheless the Court further explained the concept of a person of unsound mind:

...it is a term whose meaning is continually evolving as research in psychiatry progresses, an increasing flexibility in treatment is developing and society's attitude to

97 *H.M. v Switzerland* (App no 39187/98) ECHR 2002-II para.46.

98 See, for example, *Shtukurov v Russia* (App no 44009/05) ECHR 2008.

99 See, for example, case *H.L. v UK* (App no 45508/99) ECHR 2004-IX.

100 *Winterwerp v Netherlands* (App no 6301/73) (1979) A/33, 2 EHRR 387 para. 37.

101 *Ibid.*

mental illness changes, in particular so that a greater understanding of the problems of mental patients is becoming more wide-spread.¹⁰²

Even if the *Winterwerp* judgment did not provide a clear interpretation of the term "person of unsound mind", it set out three minimum conditions, which have to be satisfied in order to recognise detention as lawful within the meaning of Article 5 (1). The Court stated that:

Except in emergency cases, the individual concerned must be reliably shown to be of unsound mind, that is to say:

- i) a true mental disorder must be established before a competent authority on the basis of objective medical expertise;
- ii) the mental disorder must be of a kind or degree warranting compulsory confinement; and
- iii) the validity of continued confinement depends upon the persistence of such a disorder.¹⁰³

This three condition test, set up in the *Winterwerp* case, is of a crucial importance, since it has been used by the Court in further cases as a basic guideline to determine whether deprivation of liberty of persons on the ground of "unsound mind" has been done in accordance with Article 5 of the ECHR.

2.2.1. "True" mental disorder

Even though the *Winterwerp* case established the three condition test for the lawful detention of persons of unsound mind, it still requires further explanation and qualification in respect of the facts of each particular case. Further in this sub-chapter special attention will be paid to the notion of *true* mental disorder. The next sub-chapter accordingly will analyse *degree* of a true mental disorder warranting compulsory confinement and in the sub-chapter 2.2.3. problematic aspects regarding *persistence* of medical disorder will be highlighted.

Already in the *Winterwerp* case, the Court tried to give at least some basic notions of what could be recognised as the "true" mental disorder of a degree warranting compulsory confinement. The word "true" is not included in Article 5 of the ECHR. It first appeared in the above quoted excerpt of the *Winterwerp* case, where the ECtHR emphasized that in order for a deprivation of liberty to be lawful within the meaning of Article 5 (1) a "true mental disorder" must be established before a competent authority on the basis of objective medical expertise.¹⁰⁴ Thus it is clear that no arbitrary determination of the state of health of persons is permissible; the interpretation of Article 5 by the Court requires a 'medical declaration to the effect that the person concerned is in a state of mental illness and that it is necessary or desirable to treat him in a psychiatric hospital'.¹⁰⁵

In respect of mental order itself, the *Winterwerp* case sets up the main notion that 'In any event, sub-paragraph (e) of Article 5 (1) obviously cannot be taken

102 Ibid.

103 Ibid para. 39.

104 Ibid.

105 Ibid para. 38.

as permitting the detention of a person simply because his views or behaviour deviate from the norms prevailing in a particular society'.¹⁰⁶ *X. v. Germany* case explained the term of "unsound mind" as not limited only to mental illness, but in its widest sense, including abnormal personality disorder.¹⁰⁷

Determination of diagnosis in cases of mental disability might not always be an easy task even for professional psychiatrists. It is not difficult to imagine that the reaction of persons without any specific education in mental health would not always be an adequate one in relation to the actual state of health of the person related. Society tends to characterise behaviour that is beyond normal and acceptable lines as a mental illness, which demands an immediate action, often in the most restrictive way. Thus the requirement for objective medical expertise is an understandable and substantial safeguard against arbitrariness.¹⁰⁸

When it comes for the ECtHR to decide, whether a person should have been detained as a person of "unsound mind", the Court leaves a broad margin of appreciation for the national authorities, 'since it is in the first place for the national authorities to evaluate the evidence before them in a particular case'.¹⁰⁹ Examples of the ECtHR case law show that the Court relies on national medical reports and is only verifying some procedural aspects of examinations. For example, in the case of *Rakevich v. Russia* the applicant was involuntarily placed in a psychiatric hospital after she 'stayed overnight to study the Bible and share her religious opinions'.¹¹⁰ The Court found that the applicant did not have a documented history of mental disorder before her hospitalisation. Nevertheless the Court 'does not consider that the applicant's detention was arbitrary as the authorities' decision was based on psychiatric evidence that she was mentally ill'.¹¹¹

The Court is hesitant to scrutinise medical evidence in substance, and some authors deem that it would be unlikely that Court would ever start to do so.¹¹² Similar approach is also adopted by the UN Human Rights Committee, which is not analysing medical reports in substance, relying on the opinion of psychiatrists and examining some procedural aspects.¹¹³

2.2.2. Disorder of a degree warranting compulsory confinement

The fact of medically attested mental illness alone (which could be recognized as "true" mental disorder in respect of Article 5 of the ECHR) is not a sufficient

106 Ibid.

107 (App no 10565/83) (1984) 6 DR 182.

108 *Rakevich v Russia* (App no 58973) ECHR 24 March 2004 para. 32.

109 *Winterwerp v Netherlands* (App no 6301/73) (1979) A/33, 2 EHRR 387 para. 40.

110 (App no 58973) ECHR 24 March 2004 para. 9.

111 *Ibidem*, para. 30. See also the case of *Luberti v Italy* (App no 9019/80) (1984) A/75, 6 EHRR 440 paras. 24–29 or *Winterwerp v Netherlands* (App no 6301/73) (1979) A/33, 2 EHRR 387 para. 42.

112 Bartlett, P., Lewis, O. & Thorold, O., *Mental Disability and the European Convention on Human Rights* (Martinus Nijhoff Publishers, Leiden 2007) p.43.

113 See, for example, CCPR 'A. v New Zealand' (3 August 1999) CCPR/C/66/D/754/1997 para. 7.2.

ground for a lawful deprivation of liberty of person of unsound mind. As was mentioned already before (in sub-chapter 2.2.1) mental disorder must be of a degree warranting compulsory confinement.¹¹⁴

The "degree" of mental disorder has been defined by the Court as 'of such a kind or of such gravity as to make him an actual danger to himself or to others'.¹¹⁵ The Court has not considered it necessary for the lawmaker to exhaustively interpret the term "danger", as it is hardly possible to embrace in the law the whole diversity of conditions which involve psychiatric hazards.¹¹⁶ Also the Court has emphasised that the term "dangerousness" is not a statistical one. In the case of *Thynne v. UK* the Court stated that 'the factors of mental instability and dangerousness are susceptible to change over the passage of time and new issues of lawfulness may thus arise in the course of detention'.¹¹⁷ Thus, for instance, the Court has found violation of Article 5 (1), where domestic courts have failed to prove the prerequisite of dangerousness of the person detained in psychiatric hospitals in the trials which prolong the term of involuntary stay in hospital.¹¹⁸

It should be mentioned that the criteria of 'mental disorder of a kind or degree warranting compulsory confinement' is the subject of increasing debate due to possibility of compulsory treatment in the community,¹¹⁹ which becomes a reality in many jurisdictions.¹²⁰ When compulsory treatment takes place in the community, Article 5 has only limited impact, and Article 8 (right to private life) gains more importance in respect of involuntary medical treatment.¹²¹

The foundation of this debate can be found in the "soft law" requirements, which highly recommend replacing psychiatric institutions with life and treatment in community, thus also contributing to the social inclusion of the person concerned.¹²² Since this notion is not based in the "hard law" of the ECtHR or other treaties, it would be interesting to observe whether it could leave any impact on further case law of the ECtHR by finding violation of Article 5 due to the possibility of providing medical treatment in the least restrictive way in the

114 Criteria set out in the case *Winterwerp v Netherlands* (App no 6301/73) (1979) A/33, 2 EHRR 387.

115 Ibid.

116 *Rakevich v Russia* (App no 58973) ECHR 24 March 2004 para. 32.

117 *Thynne, Wilson and Gunnell v UK* (App no 11787/85, 11978/86, 12009/86) (1991) A/190, 13 EHRR 666 para.76.

118 *Gajcsi v Hungary* (App no 34503/03) ECHR 3 January 2007 para. 21.

119 Compulsory treatment in the community is based on "community treatment orders" – legal mechanisms designed to require people who are not detained to comply with programmes of treatment, generally medication. Bartlett, P., Lewis, O. & Thorold, O., *Mental Disability and the European Convention on Human Rights* (Martinus Nijhoff Publishers, Leiden 2007) p.12.

120 Fennell, P., 'The third way in mental health policy: Negative rights, positive rights, and the Convention' *Journal of Law and Society* (JLS) (1999) 103, 127 p. 111.

121 Fennell, P., 'Human rights, bioethics, and mental disorder' (2008) ML 95, 107 p. 105.

122 See for example, WHO Resource Book on Mental Health, Human Rights and Legislation 'Stop exclusion, dare to care' 2005 <http://www.who.int/world-health-day/previous/2001/files/whd2001_dare_to_care_en.pdf> accessed on 19 April 2009 p.57 or CoE Rec No. 818 (1977) on the Situation of the Mentally Ill (8 October 1977) art 13 II (i).

community and not in the place of detention.¹²³ In the case *Storck v. Germany* the ECtHR has already placed a positive duty under both Article 5 and Article 8, to provide effective supervision and review of interferences with the right to liberty and the right to personal integrity.¹²⁴ This could be viewed as the first step towards a broader outlook on involuntary placement in psychiatric hospitals in connection with Article 8 in respect of personal integrity and protection of privacy.

2.2.3. Persistence of medical disorder

The first two criteria, established in the *Winterwerp* case, provide justification for involuntary placement in a psychiatric institution. This, however, does not mean that once a person's liberty is deprived in accordance with those principles, his or her detention can last for an indefinite time without any reviews or right to challenge ongoing detention. The *Winterwerp* case set up also the third criteria due to which 'the validity of continued confinement depends upon the persistence of such a disorder'.¹²⁵

This principle might seem to be an easy one to apply – once a person is not possessing mental disorder of a degree warranting compulsory confinement, he or she should be discharged from a psychiatric institution. Nevertheless the ECtHR in later cases had to ascertain that determination of persistence of disorder is not always a simple issue. In *Johnson v. UK*, the Court admitted that 'it does not automatically follow from a finding by an expert authority that the mental disorder which justified a patient's compulsory confinement no longer persists, that the latter must be immediately and unconditionally released into community'.¹²⁶ Responsible authorities have a duty to determine 'whether the interests of the patient and the community into which he (or she) is to be released would in fact be best served by this course of action'.¹²⁷

The *Johnson* case is attracting attention with the Court's indistinctive emphasis to the protection and interests of society and the community, not only to the importance of the right to liberty (which has been primarily stressed in most of the cases regarding persons of unsound mind). It also highlights the complexity of aspects deriving from conditional discharge and continuous detention. Conditional discharge is obviously the best option in cases where there is no more necessity for involuntary detention, but where the person is not yet ready for independent life in society and might still possess some low level risk of dangerousness due to the medical illness. This kind of treatment would also cohere with the approach included in the "soft law" documents, mentioned already in the previous sub-chapter (2.2.2.). It would be less restrictive treatment than the deprivation of liberty and would interfere with person's private life protection, rather than the right to liberty. At the same time, case law

123 The concept of treatment in the least restrictive manner has evolved from concerns about finding alternatives to deprivation of liberty by institutionalisation. Korr, S. W., Encandela, A. J., Brieland, D., 'Independence or autonomy: Which is the goal?' IJLP (2005) 290, 299 p. 291.

124 (App no 61603/00) ECHR 2005-V para. 150.

125 *Winterwerp v Netherlands* (App no 6301/73) (1979) A/33, 2 EHRR 387 para. 39.

126 (App no 22520/93) (1999) 27 EHRR 296 1997 para. 61.

127 Ibid.

has already highlighted some problematic aspects regarding conditional discharge. *Johnson* and also the *Kolanis*¹²⁸ case reflect the difficulties which are emerging when authorities are failing to fulfil the conditions, prescribed by domestic courts. Not only is the problem of timing then arising (which is analysed further in sub-chapter 2.3.2.), but also the question of justification of person's continuing detention, especially if he or she is no longer suffering from the mental disorder in a degree warranting compulsory confinement. Nor is it anywhere clearly determined, what kind of treatment a person should receive (or could refuse) in case of conditional discharge.

In the *Kolanis* case the Court stated that prolongation of detention raises a new right to challenge detention.¹²⁹ A different and more problematic situation was examined by the Court in the *Johnson* case where the applicant, contrary to the *Kolanis* case, no longer possessed requirements of a person of unsound mind. Nevertheless, as was mentioned above, the Court did not consider it unreasonable of the domestic authorities to subject *Johnson's* discharge to certain conditions.¹³⁰ Due to the failure of the authorities, those conditions were not fulfilled and the applicant spent three and half years more in detention in psychiatric hospital. The ECtHR found violation of Article 5 (1) in this case due to the unreasonable time the applicant had to wait for conditions for discharge to be fulfilled.

Although the Court established in the *Johnson* case that 'appropriate safeguards are in place' and that 'discharge is not unreasonably delayed',¹³¹ it is not clear for how long the person's detention in a psychiatric hospital could be still justified when conditions of discharge cannot be fulfilled. It seems that the Court should not allow further detention of persons in psychiatric institutions when they no longer possess "unsoundness of mind".¹³² At the same time, if the Court would allow prolonged detention on the basis of possible dangerousness, it should set up clear limits for the criteria and period of time for such detention.¹³³

2.2.4. Procedure prescribed by law

A requirement for detention to be lawful is included in both Article 5 of the ECHR and Article 9 of the ICCPR. The term "lawfulness" means that deprivation of liberty is permissible only when it transpires 'on such grounds and in accordance with such procedures as are established by law'.¹³⁴ Thus where

128 See *Kolanis v UK* (App no 517/02) ECHR 2005-V.

129 Ibid para. 80.

130 The Court stated that "It was not therefore unreasonable for the Tribunal to consider, having regard to the views of Dr Wilson and Dr Cameron, that the applicant should be placed under psychiatric and social-worker supervision and required to undergo a period of rehabilitation in a hostel on account of the fact that "the recurrence of mental illness requiring recall to hospital cannot be excluded." *Johnson v UK* (App no 22520/93) (1999) 27 EHRR 296 1997 para. 64.

131 Ibid para. 63.

132 On this issue see Bartlett, P., Lewis, O. & Thorold, O., *Mental Disability and the European Convention on Human Rights* (Martinus Nijhoff Publishers, Leiden 2007) p.60.

133 Ibid.

134 Nowak, M., *U.N. Covenant on Civil and Political Rights. CCPR Commentary* (2nd revised edn N.P. Engel Publisher, Kehl, Germany 2005) p.223.

lawfulness of detention is at stake, two separate aspects can be challenged. First of all, the applicant can dispute whether domestic law is in compliance with the Convention, and second, whether domestic law has been applied in an appropriate way.¹³⁵

Indeed, although the term "law" refers primarily to the domestic legal systems,¹³⁶ lawfulness does not presuppose conformity only with domestic law. It also demands compliance with the purpose of the restrictions permitted by Article 5 1 (e). The ECtHR has emphasised that any deprivation of liberty should be in keeping with the aim of Article 5, namely to protect the individual from arbitrariness.¹³⁷ When it comes to the applicability of Article 9 (4) of the ICCPR, compatibility with the international law and particularly with the Covenant itself must be observed.¹³⁸

The "quality" of law requirements that flow from the expression "prescribed by law" in Article 10 of the Convention was explained 1979 in the case of *Sunday Times v. UK* by the ECtHR.¹³⁹ In respect of the right to liberty (Article 5) the Court has applied these criteria in other cases such as *Kawka v. Poland*. It stressed that the conditions for deprivation of liberty under domestic law should be clearly defined, the law should be foreseeable in its application and sufficiently precise to allow the person – if needed, after having obtained the appropriate advice – to foresee, to a degree that is reasonable in the circumstances, the consequences which a given action may entail.¹⁴⁰

The ECtHR case law shows that the Court would find violation of Article 5 any time, when deprivation of liberty would lack ground in domestic law.¹⁴¹ But the Court would be cautious to interpret domestic law in substance;¹⁴² it leaves interpretation and applicability of domestic laws in the competence of national authorities. Nevertheless the Court has stated that the term "lawful" covers procedural, as well as substantive rules. The Court would still have to ascertain, whether domestic law itself is in conformity with the Convention, including the general principles expressed or implied therein.¹⁴³

135 Bartlett, P., Lewis, O. & Thorold, O., *Mental Disability and the European Convention on Human Rights* (Martinus Nijhoff Publishers, Leiden 2007), p.47.

136 Nowak, M., *U.N. Covenant on Civil and Political Rights. CCPR Commentary* (2nd revised edn N.P. Engel Publisher, Kehl, Germany 2005) p.224.

137 See, for example, *Bizzotto v Greece* (App no 22126/93) ECHR 1996-V para. 31 or *Aerts v Belgium* (App no 25357/94) ECHR 1998 V para. 46.

138 Nowak, M., *U.N. Covenant on Civil and Political Rights. CCPR Commentary* (2nd revised edn N.P. Engel Publisher, Kehl, Germany 2005) p.224.

139 (App no 6538/74) (1979) A/30, 2 EHRR 245 para. 49.

140 (App no 25874/94) ECHR 8 September 1998 para. 49.

141 For example, in the case of *Kepenerov v Bulgaria* (App no 39269/98) ECHR 3 December 2003 the Court found that the applicant was detained by decision of a prosecutor who did not have power to order his detention and did not seek a prior medical assessment of the need for the applicant's confinement. There was no possibility of obtaining an independent review of its lawfulness. Accordingly, the Court found that the applicant's detention had no basis in domestic law, which, moreover, did not provide the required protection against arbitrariness. (para. 37).

142 See, for example, case of *Hutchison Reid v UK* (App no 50272/99) ECHR 2003-IV.

143 See, for example, case of *Winterwerp v Netherlands* (App no 6301/73) (1979) A/33, 2 EHRR 387 para. 45.

Regarding procedural rules, the Court would find violation of Article 5, where domestic courts would fail to follow the procedure prescribed by domestic law.¹⁴⁴ In respect of applicability of domestic law from the procedural perspective, the Court would require strict compliance of the detention with the procedure prescribed by law to ensure that person's liberty is not deprived in an arbitrary fashion.¹⁴⁵

2.2.5. Lack of therapeutic environment as violation of the right to liberty

The first case in which the ECtHR examined place of detention in respect of right to liberty was *Ashingdane v. UK*. The Applicant was claiming that his detention has been unlawful due to the non-transfer from special security psychiatric hospital to an open hospital. Transfer was suggested by several psychiatric doctors, who observed that his health condition did not require further detention in a special security hospital and continued detention was having in fact an adverse effect on his mental health. The transfer was delayed for nineteen months due to the administrative problems.

Already in *Winterwerp*, the ECtHR stated that the right to medical treatment is not included in Article 5 of the Convention.¹⁴⁶ In *Ashingdane* the Court added that neither conditions in which a person is detained, nor treatment regimes to which a person is subjected to, fall under the scope of Article 5.¹⁴⁷ Nevertheless in *Ashingdane* the Court imposed another important prerequisite to fulfil the criteria of lawfulness, which at least to a certain extent is linked to the treatment and conditions. The Court stressed that 'there must be some relationship between ground of deprivation of liberty and the place and conditions of detention'.¹⁴⁸ From the point of view of the Court, "detention" of a person as a mental health patient will only be "lawful" for the purposes of 4 (1) e, if effected in a hospital, clinic or other appropriate institution.¹⁴⁹

In accordance with this criteria the Court later found violation of Article 5 (1) in *Aerts v. Belgium*, where the person who had committed crime, but had not been found responsible due to his mental disorder, was held, for seven months of his total detention, in the psychiatric wing of an ordinary prison, rather than in a social protection centre designated by the relevant mental health board. The Court considered his detention unlawful due to the fact that the psychiatric wing in question could not be regarded as an institution appropriate for the detention of persons of unsound mind – the proper relationship between aim of detention and conditions in which it took place therefore was deficient.¹⁵⁰

144 See, for example, case of *Nakach v Netherlands* (App no 5379/02) ECHR 30 September 2005.

145 See, for example, case of *Witold Litwa and others v. Poland* (App no 26629/95) ECHR 2000-III paras. 72-73.

146 In *Winterwerp* the Court emphasised, that a mental patient's right to treatment appropriate to his condition cannot as such be derived from Article 5 para. 1 (e) (para 51).

147 (App no 8225/78) (1985) A/93, 7 EHRR 528 para. 44.

148 Ibid.

149 Ibid.

150 (App no 25357/94) ECHR 1998 V para. 49. See also the similar case of *Brand v Netherlands* (App no 49902/99) ECHR 10 November 2004, where the Court found violation of Article 5(1)

Ashingdane established an important link between deprivation of liberty and medical treatment. It affirmed the necessity of following through on the basis for detention — if it is for therapeutic purposes, then the therapy must be provided.¹⁵¹ If no therapeutic environment is ensured in cases where the sole basis of detention is unsoundness of mind, the Court would find violation of Article 5 (1), even if it is not severe enough to amount to inhuman and degrading treatment.¹⁵²

On the other hand, *Ashingdane* is also an example of the ECtHR imposing a lower threshold than the one adopted in the "soft law", at least in respect of the right to liberty. The UN *Principles for the Protection of Persons with Mental Illness* include a requirement to observe the principle of least restriction, which demands treatment of the patient 'in the least restrictive environment and with the least restrictive or intrusive treatment appropriate'.¹⁵³ The ECtHR does not link the right to liberty with the level of security and limitation in psychiatric institutions.¹⁵⁴ It is also doubtful whether placement in more secure regimes than necessary could be qualified as inhuman and degrading treatment, rather than simply recognising (as in *Ashingdane*) that 'the applicant has suffered, in human terms, an injustice in having to endure the stricter regime for nineteen months longer than his mental state required'.¹⁵⁵

From previously quoted case law it can be concluded that a person could be lawfully detained if the place of detention would attain at least some standards of medical institutions. Obviously it also includes some requirements for medical treatment, since it would be difficult to find any other link between deprivation of liberty, relying on the ground of unsound mind, and place of detention. The case law of the ECtHR does not provide more precise explanation regarding the nature of the relationship that should exist. In order to determine whether the duty to ensure therapeutic environment for the person whose liberty has been deprived on the ground of unsound mind has been fulfilled, the Court would have to examine circumstances in each particular case.

2.3. Procedural guarantees

When a case challenging detention on the ground of unsound mind is litigated in the ECtHR, the Court would examine separately each of the following aspects: whether the person's liberty is deprived on the grounds listed in the ECHR,

as a result of the significant delay in admission to a custodial clinic and thus the beginning of the treatment of the person concerned.

151 Prior, M. P., 'Mentally disordered offenders and the European Court of Human Rights' IJLP (2007) 546, 557 p. 554.

152 Fennell, P., 'The third way in mental health policy: Negative rights, positive rights, and the Convention' JLS (1999) 103, 127 p. 113.

153 Principles for the Protection of Persons with Mental Illness, UNGA Res A/Res/46/119 (17 Dec 1991) principle 9 (1).

154 In the *Ashingdane v UK* (App no 8225/78) (1985) A/93, 7 EHRR 528 the Court recognised that while the differences between two hospitals were of vital concern for Mr. Ashingdane and for the quality of his life in detention, they were not such as to change the character of his deprivation of liberty as a mental patient (para. 47).

155 Ibid para. 49.

whether domestic law provides a basis for detention, whether procedure, prescribed in the domestic law, has been observed and whether procedural guarantees, included in the ECHR Article 5 (4) are ensured.

In order to recognise detention of the person of unsound mind as lawful, all of these conditions must be fulfilled. In case of the ECHR, para. 4 of Article 5 must be taken into account, which prescribes the right of 'everyone who is deprived of liberty to take proceedings by which the lawfulness of his detention shall be decided speedily by a court'.¹⁵⁶ Similar guarantees are also included in Article 9 of the ICCPR.

2.3.1. The right of access to a court

Individual's right of access to a court is not limited only to the cases when his or her rights are violated; such right exists regardless of whether deprivation of liberty is unlawful.¹⁵⁷ As was already mentioned, the ECtHR would examine possible violation of Article 5 (4) separately from Article 5 (1).

To determine what could constitute violation of the right of access to a court, first of all the concept "court" should be defined. Already in the early decision *De Wilde, Ooms and Versyp v. Belgium* the ECtHR stated that 'the court in respect of Article 5 (4) must be a body of a "judicial character", offering certain procedural guarantees'.¹⁵⁸ To be of a "judicial character", a body must be both impartial and independent both of the executive and the parties to the case.¹⁵⁹

The principle of impartiality imposes on courts the duty 'to decide matters before them impartially, on the basis of facts and in accordance with the law, without any restrictions, improper influences, inducements, pressures, threats or interferences, direct or indirect, from any quarter or for any reason'.¹⁶⁰ The ECtHR has emphasised that independence is one of the most important constitutive elements of the notion of a "court".¹⁶¹ Regarding detention of persons with unsound mind, the Court has stated that it would be inconceivable if Article 5 (4) of the Convention should not equally envisage, as a fundamental requisite, the impartiality of that court.¹⁶²

One of the problematic aspects regarding independence of the courts in cases of involuntary placement in psychiatric institutions is participation of psychiatrists in the proceedings. On the one hand, it could be fairer and more helpful for the judge (or judges) to litigate cases more independently as the lack of medical education might leave no other option than to give exaggerated significance in

156 Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights, as amended) (ECHR) art 5 (4).

157 Nowak, M., *U.N. Covenant on Civil and Political Rights. CCPR Commentary* (2nd revised edn N.P. Engel Publisher, Kehl, Germany 2005) p. 235.

158 (No.1) (App no 2832/66; 2835/66; 2899/66) (1972) A/12, 1 EHRR 373.

159 Harris, D.J., O'Boyle, M. & Warbrick, C., *Law of the European Convention on Human Rights* (OUP, Oxford 2009) p.189.

160 UN Basic Principles on the Independence of the Judiciary UNGA Res 40/32, (29 Nov 1985) and 40/146 (13 Dec 1985).

161 *De Wilde, Ooms and Versyp v Belgium* (No.1) (App no 2832/66; 2835/66; 2899/66) (1972) A/12, 1 EHRR 373 para. 78.

162 *D.N. v. Switzerland* (App no 27154/95) ECHR 2001-III para. 42.

the case to the medical report, prepared by the psychiatrist. On the other hand, participation in proceedings of a psychiatrist, who has previously medically treated the person would be a reason to question a court's impartiality. Thus, for instance, lack of impartiality of tribunal was found in case *D.N. v. Switzerland*, where the applicant called into question the impartiality of the psychiatrist, who had treated her and later acted as a judge on the Administrative Appeals Commission, hearing her case for discharge from psychiatric hospital. The Court concluded that the applicant could legitimately fear that the psychiatrist's opinion carried particular weight in taking the decision. Circumstances, taken as a whole, served objectively to justify the applicant's apprehension that the psychiatrist, sitting as a judge in the Administrative Appeals Commission, lacked the necessary impartiality.¹⁶³

The ECtHR in many cases has stated that the cornerstone guarantee of Article 5 (4) is that 'a detainee must have the right actively to seek judicial review of his detention'.¹⁶⁴ Access to a judge should not depend on the good will of the detaining authority; a patient must have the right to seek judicial review on his or her own motion.¹⁶⁵ Such guarantee of review is not an appeal but an examination of the procedural and substantive conditions, which are essential for the lawfulness of the deprivation of liberty, and constitutes an important safeguard against arbitrary decision.¹⁶⁶

Providing access to the court is a crucial step towards ensuring safeguard for lawful detention, but it would not be enough in respect of Article 5 (4). It also includes procedural guarantees that must be secured during court proceedings. Regarding the extent to which procedural guarantees should be ensured, the ECtHR has stated that 'the judicial proceedings referred to in Article 5 (4) need not, it is true, always be attended by the same guarantees as those required under Article 6 (1) for civil or criminal litigation'.¹⁶⁷ At the same time the right of access to a court gives to the individual concerned 'guarantees appropriate to the kind of deprivation of liberty in question'.¹⁶⁸

In *Winterwerp* the ECtHR particularly emphasised that 'mental illness may entail restricting or modifying the manner of exercise of such a right, but it cannot justify impairing the very essence of the right'.¹⁶⁹ Thus at least the absolute minimum guarantees for a judicial procedure should be provided, which in *Winterwerp* the Court defined as the right of the individual to present his own case, to be heard by a judge and to challenge the medical and social evidence.¹⁷⁰ The ECtHR has expanded the listing of procedural guarantees, and in one of the latest cases (*A and Others v. UK*), the Court gave requirements for the proceedings to be 'adversarial,' to ensure 'equality of arms' between parties and

163 Ibid para. 56.

164 *Rakevich v Russia* (App no 58973) ECHR 24 March 2004 para. 43.

165 See, for example, *Gorshkov v Ukraine* (App no 67531/01) ECHR 8 February 2006 or *Rakevich v Russia* (App no 58973) ECHR 24 March 2004 para 44.

166 *Chahal v UK* (App no 22126/93) (1997) 23 EHRR 413 para. 127.

167 *A. and Others v UK* (App no 3455/05) ECHR 19 February 2009 para. 203.

168 Ibid.

169 (App no 6301/73) (1979) A/33, 2 EHRR 387 para. 60.

170 Ibid.

to take into account that 'an oral hearing may be necessary, for example in cases of detention on remand'.¹⁷¹

The ECtHR's decision in *Winterwerp* case was delivered in 1979. One might expect that States would have adopted the Court's position and ensure at least minimum procedural rights in proceedings of involuntary placement in psychiatric institutions. Unfortunately even the latest cases brought before the Court show that not much has changed (at least in respect of some countries), and often the Court has to go back to the same issues, which were discussed already in *Winterwerp* case.

For example, in *Rakevich v. Russia* the applicant claimed that for 39 days after her detention she had no access to a judge. Neither the applicant nor her lawyers had access to any medical files before, during or after the proceedings. Moreover, the court did not summon a crucial witness.¹⁷² In response to that the Government claimed that 'permitting the applicant to examine the medical evidence would have served no purpose since this information could have aggravated her condition and her illness prevented her from interpreting it correctly'.¹⁷³ It is unsurprising that the Court unanimously held that there has been a violation of Article 5 (4) in this case. Similarly the Court found violation in case *Tam v. Slovakia*, where neither applicant, nor doctor treating him was heard in person by the judge.¹⁷⁴

In the case of *Storck v. Germany* the Court found that applicant for twenty years was placed in different psychiatric institutions without her consent and without any judicial decision authorising her detention. The Court found violation of Article 5 (1) and, taking into account the unlawfulness of the applicant's detention, it did not even consider it necessary to examine any possible violation of Article 5 (4).¹⁷⁵

Notwithstanding the importance of procedural guarantees included in Article 5 (4), they are often ignored in respect of persons with mental disabilities. In many cases persons are not being informed about court proceedings, not being heard in a person by the judge¹⁷⁶ and also the principle of equality of arms is often violated regarding examination of evidence. Case law study reflects that one of the main reasons for such violations is prejudice that persons with mental disabilities are too unreasonable and mentally ill to participate in any proceedings. It might be so in some cases, but even then it is not a justifiable reason for not informing the person about proceedings regarding his or her detention. The ECtHR statement in *Winterwerp*, that illness cannot justify impairing the very essence of the right, should be especially kept in mind in any case, when proceedings take place regarding persons with mental disability.

171 (App no 3455/05) ECHR 19 February 2009 para. 204.

172 (App no 58973) ECHR 24 March 2004 para.38.

173 Ibid para. 40.

174 (App no 50213/99) ECHR 22 June 2004 para. 67.

175 (App no 61603/00) ECHR 2005-V para. 118.

176 See, for example, the case of *Van der Leer v Netherlands* (App no 11509/85) (1990) A/170, 12 EHRR 567, where the Court found violation of Article 5 due to the national judge's failure to hear the applicant before authorising her confinement (para. 23).

2.3.2. Length of proceedings and frequency of reviews

Next to the right of access to a court, Article 5 (4) and Article 9 of the ICCPR also require decisions to be taken speedily and without delay. To fulfil the criteria of lawfulness, frequent review of the case must also be ensured, since: 'a detention which as such is lawful and non-arbitrary might become arbitrary after a certain period of time without proper justification'.¹⁷⁷ It is particularly crucial in respect of persons with "unsound mind" due to the common sense point that mental disorder can be a changing condition.¹⁷⁸

The length of proceedings can be examined from two aspects. First of all, whether (and for how long) the person had to wait for the remedy to be available, and secondly, whether the overall time of proceedings can be considered as reasonable. The ECtHR has never determined precise deadlines, within which a decision should be adopted. A decision regarding possible breach of Article 5 (4) in respect of length of time is taken 'in the light of the circumstances of each case'.¹⁷⁹ Nor has Court stated how frequently patients must be able to exercise the right to periodical review,¹⁸⁰ except by urging that the review of lawfulness should be available at reasonable intervals.¹⁸¹

Examples from the ECtHR case law show that the Court might decide differently on similar time periods in different case conditions. It can be explained with the position that not only time concerns matter, but also other circumstances, such as 'the diligence of the national authorities and any delays brought about by the conduct of the detained person'.¹⁸²

For instance, the Court has found the failure of domestic courts to take decisions speedily due to administrative obstacles as a breach, in the case of *E. v. Norway*, where the court's proceedings regarding the applicant's claim to review of his detention lasted for eight weeks. The Court stated that:

It is incumbent on the judicial authorities to make the necessary administrative arrangements, even during a vacation period, to ensure that urgent matters are dealt with speedily and this is particularly necessary when the individual's personal liberty is at stake.¹⁸³

Likewise in the case of *Luberti v. Italy* the Court found excessive delays in proceedings, due to the manner of conducting proceedings employed by domestic courts. Overall time of proceedings in this case took place for a year and a half.¹⁸⁴

177 Nowak, M., *U.N. Covenant on Civil and Political Rights. CCPR Commentary* (2nd revised edn N.P. Engel Publisher, Kehl, Germany 2005) p. 226.

178 *Winterwerp v Netherlands* (App no 6301/73) (1979) A/33, 2 EHRR 387 para. 55.

179 Harris, D.J., O'Boyle, M. & Warbrick, C., *Law of the European Convention on Human Rights* (OUP, Oxford 2009) p.195.

180 Bartlett, P., Lewis, O. & Thorold, O., *Mental Disability and the European Convention on Human Rights* (Martinus Nijhoff Publishers, Leiden 2007) p.67.

181 *Winterwerp v Netherlands* (App no 6301/73) (1979) A/33, 2 EHRR 387 para. 55.

182 (App no 11701/85) (1994) A/181-A, 17 EHRR 30 para. 64.

183 *Ibid* para. 66.

184 (App no 9019/80) (1984) A/75, 6 EHRR 440 para. 37.

Regarding frequency of reviews the Court has found violation of Article 5 (4) in the case of *Herczegfalvy v. Austria*, where the first two decisions were taken after fifteen months and two years. The ECtHR did not consider that these two intervals would fit in the frame of reasonable timing.¹⁸⁵

An interesting issue appeared in the case of *Kolanis v. UK*, where the applicant was discharged from psychiatric hospital on the condition that she would be supervised by a social worker and a psychiatrist. Since no psychiatrist was found, the applicant was kept over a year longer in hospital. The Court stated:

Where, as in the present case, the Mental Health Review Tribunal finds that a patient's detention in hospital is no longer necessary and that she is eligible for release on conditions, the Court considers that new issues of lawfulness may arise where detention nonetheless continues, due, for example, to difficulties in fulfilling the conditions. It follows that such patients are entitled under Article 5 (4) to have the lawfulness of that continued detention determined by a court with requisite promptness.¹⁸⁶

The Court recognised that over a year the applicant had no opportunity to examine her continuous detention before a court, and thus found violation of Article 5 (4) in respect of timing.¹⁸⁷

2.4. Confinement of incapable adults on the basis of the guardian's decision

Mental capacity is variously defined in different national laws. In accordance with the English Mental Capacity Act 2005, 'a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain'.¹⁸⁸ Inability to make a decision is recognised in cases:

...when a person is unable: (a) to understand the information relevant to the decision, (b) to retain that information, (c) to use or weigh that information as part of the process of making the decision, or (d) to communicate his decision (whether by talking, using sign language or any other means).¹⁸⁹

A person's legal incapacity is not the same as actual incapacity and normally is determined with the decision of the domestic court. To avoid any misconceptions, in the framework of this sub-chapter special attention will be paid to the category of people whose legal incapacity has been recognised by the court.

Aspects of involuntary placement of legally incapable adults from the perspective of the "soft law" documents were already shortly highlighted in chapter 1.3.1. of this paper. When it comes to the case law of the ECtHR, references to the "soft law" documents (and especially to the Recommendation

185 (App no 10533/83) (1993) A/242-B, 15 EHRR 437 paras. 75–78.

186 (App no 517/02) ECHR 2005-V para. 80.

187 Ibid para. 82.

188 English Mental Capacity Act 2005 art 2.

189 Ibid art 3.

No. R (99) 4 of Committee of Ministers to Member States on *Principles Concerning the Legal Protection of Incapable Adults*) are often present in judgments.¹⁹⁰ It would not be an exaggeration to say that this is one of the areas where role of the "soft law" documents is particularly obvious and important.

Legal incapacity makes the status of the person who is detained different from the status of the person who possesses legal capacity. In the case of a legally incapable adult, it is often presumed that with the court's decision depriving the person of legal capacity, he or she loses any rights to express consent or will regarding any issues. The only person who has authority to regulate a person's life is his or her guardian.

In the "soft law" documents and also in related literature with regards mental health law a different approach is highlighted. It is the existence of actual or functional capacity to make a decision which matters. Functional capacity requires examination of the actual ability of the person to make a decision. It has been recognised that 'mental capacity may fluctuate with time, and the same individual may have capacity for some decisions, whilst lacking capacity for others'.¹⁹¹

A similar viewpoint has also been adopted by the ECtHR. The best example to reflect the Court's position is the recent case of *Shtukurov v. Russia*, where the Court examined the lawfulness of the detention of a legally incapable adult. The placement in psychiatric hospitals of the applicant was considered voluntary due to his guardian's expressed consent. The Court noted that, 'indeed, the applicant lacked *de jure* legal capacity to decide for himself. However, this does not necessarily mean that the applicant was *de facto* unable to understand his situation'.¹⁹² Thus the ECtHR placed actual capacity above legal capacity and concluded that the applicant's liberty was deprived in a coercive manner, due to the fact that he did not express consent to the placement. The agreement of the guardian was not sufficient to recognise the placement as voluntary. The Court found that the applicant's detention was involuntary, and since the Government was unable to provide reasons to justify his detention, the Court found violation of Article 5 (1).¹⁹³

2.5. Concluding remarks

The right to liberty is an important safeguard, ensured by a number of international treaties. It becomes applicable every time a person's liberty is restricted and also applies to persons who are suffering from mental disabilities and at some moments of their lives are subjected to deprivation of liberty. Article 9 of the ICCPR, Article 5 of the ECHR and especially case law of the ECtHR all determine criteria for the lawful deprivation of liberty and ensure that a number of guarantees must be fulfilled in the process of deprivation of liberty.

190 See, for example, case *Shtukurov v Russia* (App no 44009/05) ECHR 2008 para. 59.

191 Raymont, V. and others 'The inter-rater reliability of mental capacity assessments' IJLP (2007) 112, 117 p. 113.

192 (App no 44009/05) ECHR 2008 para. 108.

193 Ibid para. 115.

The analysis of the case law of the ECtHR has reflected the very detailed character of the substantive and procedural issues, related to the deprivation of liberty of persons with mental disabilities, which the ECtHR has dealt with. It seems that the "hard law" is more scrupulous in this respect than the "soft law" documents, analysed in the chapter 1. The main criteria and procedural guarantees for involuntary placement in psychiatric institutions are comparatively similar in both: "soft law" and "hard" law instruments. The differences are appearing (and becoming more obvious in the most recent cases) when the Court has to deal with the issues which are falling out of the "traditional" *Winterwerp* case criteria for deprivation of liberty. Such issues are, for example, treatment in the community, lack of therapeutic environment as a violation of right to liberty or conditional discharge. Even if the "soft law" instruments might not provide detailed regulation in respect of all these issues, they do prescribe certain principles (such as the principle of best interests of the person with mental disabilities, the principle of least restriction and the principle of maximum preservation of capacity). The ECtHR case law has reflected, that while certain principles are used to develop further case law (for example, principle of maximum preservation of capacity¹⁹⁴), some unfortunately are not present in the case law of the ECtHR (for instance, principle of least restriction¹⁹⁵).

The focus of chapter 2 of this paper has been on the problematic aspects of deprivation of liberty in respect of Article 9 of the ICCPR and Article 5 of the ECHR. While acknowledging the importance of the safeguards ensured within these articles, none of them resolve large numbers of problems, which arise behind the closed doors of psychiatric institutions and are usually direct consequences of deprivation of liberty. Applicability of Article 5 and Article 9 is limited to the sole determination, whether a person could have been involuntarily placed in the psychiatric hospital and were the legal guarantees present during this process. Other restrictions are not covered, especially if they are for the person's own good.¹⁹⁶ Thereby, the issue of forced medical treatment, which is the one of crucial importance regarding persons of "unsound mind," is staying outside of the scope of the right to liberty.

Some aspects of involuntary placement due to the need for medical treatment have already been examined in this chapter. Also the issue of lack of medical treatment in respect of the right to liberty has been analysed.¹⁹⁷ The next chapter will accordingly focus on problematic aspects regarding medical treatment from the perspective of private life protection and prohibition of inhuman and degrading treatment. The link between place of detention, treatment, consent and dignity will be often raised, thus, the fact that persons are often placed in psychiatric institutions on involuntary basis, should be kept in mind.

194 See above sub-chapter 2.4.

195 See above sub-chapter 2.2.5.

196 Hale, B., 'Justice and equality in mental health law: The European experience' IJLP (2007) 18, 28 p. 22.

197 See sub-chapter 2.2.5.

CHAPTER 3

Medical treatment

3.1. State's positive duty to provide medical treatment

A State's positive duty to provide medical treatment is directly linked to and deriving from the right to health as a fundamental human right. Although most civil rights, such as the right to liberty, the right to private life and prohibition of inhuman or degrading treatment for the greater part require the State to fulfil its negative duty to refrain from unjustified interventions, the positive duty of the State to ensure certain guarantees and choices in respect of some civil rights is often more present than it might seem to be. It is certain that to some extent 'every right needs for its realization the observance of some positive and some negative duties'.¹⁹⁸ When it comes to involuntary placement and medical treatment in psychiatric institutions, the interrelatedness of both of them is particularly obvious, as a violation of certain "negative duty" human rights may arise from the ignorance of positive obligations.

Concerning medical treatment, many aspects influence compliance or non-compliance with human rights norms. It is the general availability of treatment, possibility of choices of medicaments, the conditions in which treatment is ensured etc. It matters in both circumstances: when a person agrees to receive medical treatment and, perhaps even more, when the person does not agree, i.e. in case of involuntary medical intervention. It can be argued, that 'if the State deprives people of the basic right – the right to refuse treatment – arguably it has a concomitant responsibility to ensure that any treatment is provided in an environment which allows them to fully benefit from'.¹⁹⁹

Unfortunately the issues related to conditions of psychiatric institutions and medical treatments are directly linked to financial considerations and political will. Although interrelated, civil-political rights are more law-driven, and socio-economic rights are policy prompted.²⁰⁰ The data regarding percentage of resources spent by states on medical expenditures, given by the medical health literature, is striking. Some countries spend less than one percent of their budget on the entire health care system²⁰¹ and for the majority of countries less than one per cent of healthcare spending is spent on mental health issues; however, mental disability constitutes roughly 12 per cent of the burden of disease internationally.²⁰²

198 Dhanda, A., 'The right to treatment of persons with psychosocial disabilities and the role of the courts' (2005) IJLP 155, 170 p. 156.

199 Bell, S., 'What does the "right to health" have to offer mental health patients?' (2005) IJLP 141, 153 p. 141.

200 Dhanda, A., 'The right to treatment of persons with psychosocial disabilities and the role of the courts' (2005) IJLP 155, 170 p. 155.

201 Toebes, B., *The Right to Health as a Human Right in International Law* (Intersentia-Hart, Antwerpen, Groningen, Oxford 1999) p. 3.

202 Bartlett, P., Lewis, O. & Thorold, O., *Mental Disability and the European Convention on Human Rights* (Martinus Nijhoff Publishers, Leiden 2007) p. 112.

The question thus remains open – how in these conditions can States provide the treatment, from which a person could actually benefit? Sadly, however these statistics often not only reflect State's negligence towards persons suffering from mental disabilities, but also being a reason for serious violation of human rights. Taking all these issues into account, this chapter will focus on medical treatment in psychiatric institutions from the human rights perspective, disclosing different aspects of unwanted, unavailable and inappropriate medical treatment.

For the purpose of this chapter, the term medical treatment is used and should be understood in its broadest way, as defined by the ECtHR, where medical treatment is not only 'therapy, medication or other clinical treatment to cure or alleviate a person's condition, but also where the person needs control and supervision to prevent him, for example, causing harm to himself or other persons'.²⁰³

3.2. What is at stake?

Medical treatment is closely linked to at least two human rights: the right to private life and prohibition of inhuman and/or degrading treatment. Both of them are derived from two fundamental values: human dignity and personal autonomy. It would not be possible to fully apprehend the importance of observation of such rights and the gravity of violation of them without realising the principles and values which lie behind them.

The interrelation of human dignity and autonomy is a prominent part of human rights: 'to safeguard and develop the human dignity and human freedom for everyone'.²⁰⁴ But, although closely linked, 'the two cannot and must not be used synonymously and interchangeably'.²⁰⁵ For the purpose of this paper, the very simplified distinction would link the human dignity as the fundamental value to the prohibition of inhuman and degrading treatment and autonomy as self-determination, to the right to private life protection.

3.2.1. Human dignity

Notion of human dignity appears in such human rights documents as, the ICCPR and the UDHR, which emphasise that 'all human beings are born free and equal in dignity and rights'.²⁰⁶ The importance of human dignity in respect of the development of the catalogue of human rights cannot be underestimated. The preamble of the ICCPR states that civil and political rights derive from the inherent dignity of the human person.²⁰⁷ It can be thus asserted that 'human rights have been devised to realise and protect human dignity'.²⁰⁸

203 *Hutchison Reid v UK* (App no 50272/99) ECHR 2003-IV para. 52.

204 Marshall, G., 'A Right to Personal Autonomy at the European Court of Human Rights' *European Human Rights Law Review* (EHRLR) (2008) 337, 356 p. 339.

205 Salako, E. S., 'The Council of Europe Convention on Human Rights and Biomedicine: A New Look at International Biomedical Law and Ethics' *ML* (2008) 339, 356 p. 342.

206 Universal Declaration of Human Rights (adopted 10 December 1948 UNGA Res 217 A(III) (UDHR) art 1.

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

208 Donnelly, J., 'Human Rights and Human Dignity: An Analytical Critique of Non-Western Conceptions of Human Rights' *The American Political Science Review* (APSR) (1982) 303, 316 p. 303.

The concept of human dignity, as used in respect of human rights, has no definition on the European level,²⁰⁹ nevertheless, for some authors it has been characterised as 'a constitutional right, as the supreme constitutional principle, or as a constitutional value'.²¹⁰ Human dignity is closely related to the ideas of autonomy and informed choice.²¹¹ But though the two are very close linked, the difference is that dignity is a broader concept of a person's status and needs and 'dignity can be maintained even though autonomy can be lost'.²¹²

Such perception of human dignity makes it possible to link human dignity to the prohibition of inhuman and degrading treatment. The role of human rights is to protect the people against physical suffering and belittling of human dignity.²¹³ The notion of human dignity in respect of inhuman and degrading treatment is also present in the decisions of the ECtHR. Thus, for instance, in *Keenan v. UK* the Court highlighted the need for protection of human dignity in particular of a person with mental disability, by stating:

"...in respect of a person deprived of his liberty, recourse to physical force which has not been made strictly necessary by his own conduct diminishes human dignity and is in principle an infringement of the right set forth in Article 3. Similarly, treatment of a mentally ill person may be incompatible with the standards imposed by Article 3 in the protection of fundamental human dignity, even though that person may not be able, or capable of, pointing to any specific ill-effects."²¹⁴

3.2.2. Personal autonomy as medical self-determination

The notion of personal autonomy (as a part of a person's right to protection of their private life) is neither included in Article 8 of the ECHR, nor in Article 17 of the ICCPR. Nevertheless, the notion of autonomy has not been left unattended by different authors in legal doctrine and it has also been in the centre of attention of the ECtHR.

Personal autonomy is characterised by some authors as right to self-governance,²¹⁵ 'right to self-determination, the right to privacy, liberty right and the right to be left alone'.²¹⁶ Autonomy is the human freedom in its broadest understanding: a positive freedom to make one's own choices and plans, the ability to decide through some sort of rational method: being 'free to'.²¹⁷ The

209 Dupré, C., 'Unlocking Human Dignity: Towards a Theory for the 21st Century' EHRLR (2009) 190, 205 p. 191.

210 Ibid.

211 Malpas, J., 'Human dignity and human being' in Jeff Malpas and Norelle Lickiss (eds), *Perspectives on Human Dignity: A Conversation* (Springer, Australia 2008) p.22.

212 Ibid p. 25.

213 Dupré, C., 'Unlocking Human Dignity: Towards a Theory for the 21st Century' EHRLR (2009) 190, 205 p. 194-195.

214 (App no 27229/95) ECHR 2001-III para. 113.

215 Quinn, G., 'The International Covenant on Civil and Political Rights and Disability: A Conceptual Framework' in Theresia Degener and Yolán Koster-Dreese (eds), *Human Rights and Disabled Persons* (Martinus Nijhoff Publishers, The Netherlands 1995) p. 71.

216 Salako, E. S., 'The Council of Europe Convention on Human Rights and Biomedicine: A New Look at International Biomedical Law and Ethics' ML (2008) 339, 356 p. 341.

217 Marshall, G., 'A Right to Personal Autonomy at the European Court of Human Rights' EHRLR (2008) 337, 356 p. 340.

right to autonomy is essential in cases, when a person exercises his or her right of control over health and medical treatment.²¹⁸

The ECtHR firstly referred to autonomy as a part of Article 8 in the case *Pretty v. UK*, by stating that:

Although no previous case has established as such any right to self-determination as being contained in Article 8 of the Convention, the Court considers that the notion of personal autonomy is an important principle underlying the interpretation of its guarantees.²¹⁹

In this case the applicant was claiming for the right to receive her husband's assistance in suicide. The Court stressed that 'the very essence of the Convention is respect for human dignity and human freedom'.²²⁰ It thus found that prohibition of such assistance, established by domestic laws, 'caused concerns regarding the principle of personal autonomy in the sense of the right to make choices about one's own body'.²²¹

Hence, it can be concluded, that the acknowledgement of a person's autonomy plays a crucial role in respect of medical treatment. It leaves the possibility to refuse unwanted treatment and ultimately rests on the consent of a person, 'a matter no less important in the context of disability than elsewhere'.²²²

3.3. Role of informed consent

From the values of human dignity and autonomy accordingly arises the person's right to accept or refuse medical treatment. The requirement of consent regarding medical treatment is thus not motiveless: it is 'wholly consonant with the ideal of human autonomy'.²²³ The doctrine of informed consent can be viewed as a 'core of the physician-patient relationship'.²²⁴ It is also established in Article 3 of the *Charter of Fundamental Rights of the European Union*, which emphasise everyone's right to physical and mental integrity and requires respect for free and informed consent.²²⁵ The significance of the consent has been highlighted as well in the ECtHR case *Evans v. UK*, where the Court was appraising the applicant's choice and only possibility to become a parent in the genetic sense and her ex-partner's decision not to.²²⁶ The Court, by thirteen

218 Moreham, N.A., 'The Right to Respect for Private Life in the European Convention on Human Rights: A Re-examination' EHRLR (2008) 44, 79 p. 71.

219 (App no 2346/02) ECHR 2002-III para. 61.

220 Ibid para. 65.

221 Ibid para. 66.

222 Quinn, G., 'The International Covenant on Civil and Political Rights and Disability: A Conceptual Framework' in Theresia Degener and Yolán Koster-Dreese (eds), *Human Rights and Disabled Persons* (Martinus Nijhoff Publishers, The Netherlands 1995) p. 72.

223 Ibid p. 85.

224 Salako, E. S., 'The Council of Europe Convention on Human Rights and Biomedicine: A New Look at International Biomedical Law and Ethics' ML (2008) 339, 356 p. 341.

225 Charter of the Fundamental Rights of the European Union (adopted 7 December 2000) 2000/C 364/01 Official Journal of the European Communities C 364/1 (18 Dec 2000) art 3.

226 (App no 6339/05) ECHR 10 April 2007 para. 90.

votes to four, found no violation of Article 8 of the ECHR regarding the policy of the legislator and stated that 'it does not consider that the applicant's right to respect for the decision to become a parent in the genetic sense should be accorded greater weight than J's (ex-partner's) right to respect for his decision not to have a genetically-related child with her'.²²⁷

The European Committee for the Prevention of Torture (CPT) in its 8th General Report has also highlighted the need for informed consent in respect of psychiatric treatment. It emphasizes the following:

Patients should, as a matter of principle, be placed in a position to give their free and informed consent to treatment. The admission of a person to a psychiatric establishment on an involuntary basis should not be construed as authorising treatment without his consent. It follows that every competent patient, whether voluntary or involuntary, should be given the opportunity to refuse treatment or any other medical intervention. Any derogation from this fundamental principle should be based upon law and only relate to clearly and strictly defined exceptional circumstances.²²⁸

Thus, the right to consent includes not only the right to be asked, but also the right to take "bad decision" and right to refuse treatment, however unreasonable it might seem.²²⁹ In respect of persons with mental disabilities, refusal to take medication is often interpreted in a very simplified manner: the fact that a person refuses to be treated, means that he or she does not possess the capacity to take rational decisions.²³⁰ It is surprising how differently questions of choice of treatment are viewed regarding, on the one hand, those having psychological illnesses, and on the other hand, those suffering from mental illnesses. The presumption of autonomy over one's body is deeply rooted in our minds in respect of physical illness treatment. Any involuntary intervention would require a strict examination by the court, and would be an issue of public discussions.²³¹ By contrast, cases of involuntary psychiatric medical treatment are rarely known about outside the walls of psychiatric institutions or raise public attention or indignation.

The reasons for refusing psychiatric medical treatment are not always linked to the psychiatric illness and the consequent actual incapacity. Often adverse effects of medicaments (such as "extrapyramidal symptoms": parkinsonian symptoms, dystonia (abnormal face and body movements), akathisia (restlessness), and tardive dyskinesia (rhythmic involuntary movements particularly of the

227 Ibid.

228 European Committee for the Prevention of Torture (CPT), *8th General Report on the CPT's Activities*, Strasbourg, 1998, CPT/Inf(98) 12, <<http://www.cpt.coe.int/en/annual/rep-08.htm>> accessed 10 June 2009 para 41.

229 Mendelson, D., 'Roman Concept of Mental Capacity to Make End-of-Life Decisions' IJLP (2007) 201, 212 p. 201.

230 On the matter, how "bad decisions" made by capable adults risk being constructed as evidence of incapacity, see Larkin, M., Clifton, E., Visser, R., 'Making Sense of 'Consent' in a Constrained Environment' IJLP (2009) 176, 183 p. 177.

231 For example, the recent domestic case of forced treatment of a child suffering from cancer against the will of his parents gained big public attention in media: ___ 'Lawyer: Mom prepared to allow son to undergo chemotherapy' (CNN news), <<http://edition.cnn.com/2009/US/05/25/minnesota.forced.chemo/index.html>> accessed on 26 May 2009.

tongue, lips, face, hands and feet), or unpleasantness of the treatment are the causes for person's unwillingness to be subjected to treatment.²³² As was already mentioned before (in sub-chapter 3.1.), choice of medicaments may depend on financial considerations. If the state cannot provide medical treatment which is appropriate to a person's health, imposition of treatment to a capable adult is a questionable matter. In this respect, the requirements prescribed in "soft law" documents for involuntary medical treatment of a capable adult, should be taken into account. The CoE Recommendation *Concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder* determines the following criteria: 'the person must have a mental disorder; he or she is representing risk of serious harm to his or her health or other persons; no less intrusive means of providing appropriate care are available; and the opinion of the person concerned has been taken into consideration'.²³³ The following sub-chapter will examine whether such requirements for involuntary medical treatment can also be found in the decisions of the ECtHR.

In relation to consent to medical treatment another aspect plays an important role: determination of the actual capacity to take a decision regarding medical treatment. It is a broadly accepted view (in "soft law" documents²³⁴ and also relevant literature sources²³⁵) that in each case, a person's functional (and not legal) mental capacity to take a decision regarding treatment should be evaluated. For instance, psychiatric research proves there can be cases when a person might be dangerous to him or herself and thus require involuntary detention, but might still possess capacity to give or withhold valid consent for treatment.²³⁶ Thus it is not enough to rely on the severity of the mental disorder or even the legal incapacity of the person concerned; psychiatrists should determine the actual capacity of a person and keep 'a clear focus on the patient's ability to understand the consequences of a given treatment decision'.²³⁷

3.4. Involuntary medical treatment as interference in private life

The recognition of the importance of consent regarding medical treatment accordingly raises the questions: what happens if a person's disagreement to

232 Bartlett, P., Lewis, O. & Thorold, O., *Mental Disability and the European Convention on Human Rights* (Martinus Nijhoff Publishers, Leiden 2007) p. 119. – 121. On this matter see also the *Wilkinson v. UK*, Decision as to the admissibility (App no 14659/02) ECHR 28 February 2006, where the applicants had expressly refused medical treatment due to the side-effects.

233 Coe Rec No. REC (2004) 10 of Committee of Ministers to Member States Concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder (22 September 2004) art 18.

234 CoE Rec No. R (99) 4 of Committee of Ministers to Member States on Principles Concerning the Legal Protection of Incapable Adults (23 February 1999) Part IV, Principle 22 (1).

235 On this matter see, for example, Larkin, M., Clifton, E., Visser, R., 'Making Sense of 'Consent' in a Constrained Environment' IJLP (2009) 176, 183 p. 176 or Bartlett, P., Lewis, O. & Thorold, O., *Mental Disability and the European Convention on Human Rights* (Martinus Nijhoff Publishers, Leiden 2007) p. 123.

236 Rutledge, E. and others, 'Functional mental capacity is not independent of the severity of psychosis' IJLP (2008) 9, 18 p. 10.

237 Larkin, M., Clifton, E., Visser, R., 'Making Sense of 'Consent' in a Constrained Environment' IJLP (2009) 176, 183 p. 177.

treatment is not respected? Can medical treatment ever be imposed, or is the person's right to refuse medical treatment an absolute one?

In one of the first cases regarding involuntary medical treatment in a psychiatric hospital (*Herczegfalvy v. Austria*) the ECtHR did not recognise forced medical treatment as an interference in a person's private life.²³⁸ As the ECtHR case law developed, however, the Court eventually established the link between imposed medical treatment and protection of private life. In the case of *Matter v. Slovakia* the Court found that 'the forcible examination of the applicant in a hospital [...] amounted to an interference with his right to respect for his private life as guaranteed by Article 8 (1)'.²³⁹

In the case of *Pretty v. UK* the Court required the 'consent of a mentally competent adult patient'²⁴⁰ to recognise involuntary medical treatment as an interference with the person's private life. Such requirement is not included in the latter case *Y.F. v. Turkey*, where the Court emphasised that any compulsory intervention, even if it is of minor importance, falls under the scope of Article 8 of the ECHR.²⁴¹ The *Y.F. v. Turkey* decision is very important in respect of persons suffering from mental disabilities, as it 'clearly covers involuntary psychiatric treatment'.²⁴²

3.4.1. Justification for interference

The right to private life is not an absolute right. Thus, once the link between involuntary medical treatment in a psychiatric hospital and intervention in private life is established, the State's scope of responsibility and the criteria for lawful intervention in a person's private life should be determined.

First of all, it should be clarified that Article 8 imposes two types of obligation on a State: 'a negative one to avoid interfering with any of the rights outlined in Article 8 (1) unless the conditions in Article 8 (2) are satisfied and a positive obligation to protect individual's private lives, particularly against interference by others'.²⁴³ This implies that the State would be responsible not only for unlawful interventions in individuals' lives by public authorities, but also by other private persons, if the State has failed to 'adopt measures designed to secure respect for private life even in the sphere of relations of individuals themselves'.²⁴⁴ It is essential regarding involuntary medical treatment, as it extends the applicability of Article 8 not only to public psychiatric hospitals, but also to the private clinics.²⁴⁵

238 (App no 10533/83) (1993) A/242-B, 15 EHRR 437, para. 86.

239 (App no 31534/96) ECHR 5 July 1999 para. 64.

249 (App no 2346/02) ECHR 2002-III para. 63.

241 (App no 24209/94) ECHR 2003-IX, para. 33.

242 Bartlett, P., Lewis, O. & Thorold, O., *Mental Disability and the European Convention on Human Rights* (Martinus Nijhoff Publishers, Leiden 2007) p. 129.

243 Moreham, N.A., 'The Right to Respect for Private Life in the European Convention on Human Rights: A Re-examination' EHRLR (2008) 44, 79 p. 46.

244 *Van Kück v Germany* (App no 35968/97) ECHR 2003-VII para. 70.

245 In the case of *Storck v. Germany* the Court stated that "the State remained under a duty to exercise supervision and control over private psychiatric institutions." Para. 149.

The ECtHR has dealt with the State's positive obligations regarding involuntary medical treatment in the *Storck v. Germany* case. In this case the Court found that the applicant was given medical treatment against her will in a private clinic, and concluded that 'as the State was found not to have complied with its positive obligation under Article 8 (1) to protect the applicant against interferences with her private life by private individuals, this finding entails a violation of Article 8 (1)'.²⁴⁶

The criteria for the lawfulness of interference in a person's private life are established in para.2 of Article 8: it must be done 'in accordance with law,' must serve a legitimate aim (such as the protection of health or morals, or the protection of the rights and freedoms of others) and it must be 'necessary in a democratic society'.²⁴⁷

3.4.1.1. In accordance with the law

The first criterion of lawfulness has been already analysed in sub-chapter 2.2.4. To recap, it can be summarised as follows: firstly, the law must exist (on a domestic level) and, secondly, the 'law must provide protection against arbitrary interference with an individual's right under Article 8 and be sufficiently clear...'.²⁴⁸

The ECtHR has found violation of the requirement for the intervention to be done "in accordance with law" in cases where applicants were subjected to forced gynaecological examinations to protect security forces from false allegations of sexual assault.²⁴⁹ The Court found that:

Under Turkish law, any interference with a person's physical integrity is prohibited except in the event of medical necessity and in circumstances defined by law. In the instant case, the Government have not presented any arguments to the effect that the interference at issue was based on and in compliance with any statutory or other legal rule.²⁵⁰

While in the before mentioned case involuntary medical treatment clearly lacked grounds in the domestic law, the Court has also found violation of Article 8 where medical treatment was forcibly imposed on the applicant 'whose confinement in the clinic for medical treatment was not authorised by a court order'.²⁵¹ The Court considered that such interference in the applicant's right to respect for private life 'was not lawful within the meaning of Article 8 para. 2'.²⁵² This case (*Storck v. Germany*) is an interesting example of the close interrelation in which the Court examines involuntary medical treatment and unlawful deprivation of liberty.

246 (App no 61603/00) ECHR 2005-V para. 151.

247 Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights, as amended) (ECHR) art 8 (2).

248 *Bykov v Russia* (App no 4378/02) ECHR 10 March 2009 para. 76.

249 See, for example, *Y.F. v Turkey* (App no 24209/94) ECHR 2003-IX and *Juhnke v Turkey* (App no 52515/99) ECHR 13 August 2008 para. 81.

250 *Juhnke v Turkey* (App no 52515/99) ECHR 13 August 2008 para. 79.

251 *Storck v Germany* (App no 61603/00) ECHR 2005-V para. 152.

252 Ibid.

Yet some questions remain unanswered. It remains unclear whether domestic court orders must include also authorisation for medical treatment or if the ECtHR is presuming that authorisation for involuntary placement also permits forced medical treatment. Since in the *Storck case* the applicant lacked any court order for hospitalisation, it is unfortunately not possible to identify the Court's position in this respect. What follows from the *Storck case* is that the Court regrettably did not require two separate authorisations: one for involuntary placement and the other for medical treatment, as demanded by the "soft law" documents.²⁵³ However, it can be concluded that, as the ECtHR has recognised involuntary medical treatment as interference in a person's private life, States are obliged to establish legal grounds for such interference and, as was mentioned in the beginning of the sub-chapter, the law prescribing such interference must be "sufficiently clear." Hence, it is a questionable matter, whether one authorisation by the domestic courts for involuntary placement and medical treatment would meet the ECtHR established requirements. It could be so, if the law met the necessary clarity requirements in respect of authorisation. Still, to avoid the presumption of forced medical treatment in respect of authorisation of involuntary placement, the most appropriate solution might be to take into account the "soft law" requirements and prescribe two different authorisations for involuntary placement and treatment.²⁵⁴

3.4.1.2. Necessary in a democratic society

In a case where the ECtHR finds that a person's liberty is deprived in a lawful manner and involuntary medical treatment is based on domestic law, this is still not sufficient on its own to recognise intervention in the person's private life as justifiable under Article 8. The ECtHR still has to examine whether the second criterion of Article 8 is fulfilled: intervention in the private life serves a legitimate aim and is necessary in a democratic society. As to the notion of necessity, the ECtHR has stated that the "interference must answer a 'pressing social need' and, in particular, it must be proportionate to the legitimate aim pursued".²⁵⁵

As was mentioned before in sub-chapter 3.3., the CoE Recommendation *Concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder* prescribes criteria for involuntary medical treatment which are identical to those for involuntary placement in psychiatric institution.²⁵⁶ A comparison of the ECtHR case law with the "soft law" requirements reflects that the Court is not taking the same approach in every case as established in the

253 On this issue see chapter 1.3.1.

254 As has been rightly pointed out: "The fact that there may be a long informal tradition of compulsory treatment of people with mental disabilities will not be sufficiently in accord with domestic law unless it is buttressed by the formal legal structure, providing sufficient clarity and safeguards." Bartlett, P., Lewis, O. & Thorold, O. *Mental Disability and the European Convention on Human Rights* (Martinus Nijhoff Publishers, Leiden 2007) p. 130.

255 *S. and Marper v UK* (App no 30562/04) ECHR 4 December 2008 para. 101.

256 The criteria are the following: "the person must have mental disorder; he or she is representing risk of serious harm to his or her health or other persons, no less intrusive means of providing appropriate care are available and the opinion of the person concerned has been taken into consideration."

"soft law" documents. For example, the ECtHR has rightly found no violation of Article 8 in a case of forced examinations of the applicant in a hospital for the purpose of determining whether or not his legal capacity could be restored. Even though the applicant was not "representing risk of serious harm to his health or other persons," the Court noted that the interference complained of had a legal basis and the Court found no reason to doubt that it pursued the legitimate aim of protecting the applicant's own rights and health. Thus the Court had to examine whether the interference was 'necessary in a democratic society'.²⁵⁷ Due to the complexity of the issue, the Court found it reasonable for the domestic court to obtain an expert's opinion on the applicant's mental health. As the domestic court tried to examine the applicant on a voluntary basis and invited the applicant twice to submit to the examination in the mental hospital, the ECtHR did not regard interference as disproportionate to the legitimate aims pursued. Thus no violation of Article 8 was found.²⁵⁸

The opposite conclusion was reached by the Court in the case of *Glass v. UK*. In this case the applicant's son was medically treated in defiance of her objections. The Court decided that the requirement of necessity in a democratic society was breached by the absence of authorisation by a court to determine whether administration of powerful medication was in the best interests of the child. Accordingly, the Court found violation of Article 8 (2).²⁵⁹ In this case the Court's position can be linked to the "soft law" documents, as the Court also evaluated the proportionality of the use of medicaments, which is also the requirement of the "soft law" documents to ensure forced treatment only if no 'less intrusive means of providing appropriate care are available'.²⁶⁰

The link between a patient's capacity to consent to treatment and the test of proportionality regarding intervention in private life has been highlighted in the ECtHR decision on admissibility in *Wilkinson v. UK*. In the mentioned case the applicant was given anti-psychotic medication by the responsible medical officer against his will. The Court thus examined whether the applicant possessed the necessary capacity to take a decision regarding his medical treatment. After establishing that the applicant did not possess the necessary capacity, the Court used the test of medical necessity established in the *Herczegfalvy* case²⁶¹ to determine whether the applicant's treatment fell under the scope of medical necessity. The Court did not examine the medical treatment of Wilkinson in substance as it considered that 'in many areas of medicine, not least psychiatry, decisions as to treatment are complex matters of judgment'.²⁶² Finally the Court evaluated procedural aspects of the decision-making regarding the applicant's

257 Ibid paras. 64-65.

258 Ibid para. 72.

259 (App no 61827/00) ECHR 2004-II para. 83.

260 Coe Rec No. REC (2004) 10 of Committee of Ministers to Member States Concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder (22 September 2004) art 18.

261 On this matter see sub-chapter 3.5.2.

262 *Wilkinson v. UK*, Decision as to the admissibility (App no 14659/02) ECHR 28 February 2006.

medical treatment and concluded that the interference with his right to respect for his private life has not been shown to be disproportionate.²⁶³

The ECtHR case law regarding involuntary medical treatment as interference in a person's private life reflects that in cases where the person who is subjected to forced treatment possesses legal capacity, the Court uses an evaluation test, which is similar to the one prescribed in the "soft law" documents. On the other hand, where the Court finds that the person does not possess the necessary capacity for decision-making (as for example, in the decision on admissibility in *Wilkinson v. UK*), it uses another test for evaluation of possible breach of Article 8. The test was set by the ECtHR in the *Herczegfalvy v. Austria* case in respect of a possible Article 3 breach and will be analysed in the further sub-chapter 3.5.2.

3.5. Medical treatment as inhuman and/or degrading treatment

Involuntary medical treatment can result in more than just a breach of a person's right to private life. In certain conditions the treatment might reach the severity threshold of Article 3 of the ECHR or Article 7 of the ICCPR. The ECtHR case law shows that both Articles 3 and 8 are often used by the applicants in their complaints regarding forced medical treatment. Even though some links can be found between these Articles (such as, for instance, usage of the *Herczegfalvy* case test to evaluate necessity of medical treatment), the values protected and possible justifications (or non-justifications) of interventions, are different.

The treatment might fall under the scope of Article 8 if it does not reach the severity of Article 3 treatment,²⁶⁴ but it is doubtful whether Article 3 could be violated in respect of forced medical treatment, without also breaching a person's right to private life protection.²⁶⁵ To determine whether ill-treatment reaches the level of severity to fall under Article 3 of the ECHR, 'all circumstances of the case, such as the duration of the treatment, its physical and mental effects and, in some cases, the sex, age and state of health of the victim,' should be taken into account.²⁶⁶

As to the categorisation of ill-treatment prohibited by Article 3 of the ECtHR (torture, inhuman and/or degrading treatment), or Article 7 of the ICCPR (also prohibits cruel treatment and punishment) the Court has stated that 'it appears that it was the intention that the Convention should, by means of this distinction, attach a special stigma to deliberate inhuman treatment causing very serious and cruel suffering'.²⁶⁷ Torture has been defined by the ECtHR as 'deliberate inhuman treatment causing very serious cruel suffering'.²⁶⁸ In contrast with torture,

263 Ibid.

264 *Bensaid v UK* (App no 44599/98) ECHR 2001-I para. 46.

265 Harris, D.J., O'Boyle, M. & Warbrick, C., *Law of the European Convention on Human Rights* (OUP, Oxford 2009) p. 72. On the relationship between articles 8 and 5 see also Cooper, J., *Cruelty – an analysis of Article 3* (Sweet & Maxwell, London 2003) p. 195.

266 *Kafkaris v Cyprus* (App no 21906/04) ECHR 12 February 2008 para. 95.

267 *Selmouni v France* (App no 25803/94) ECHR 1999-V para. 96.

268 *Ireland v UK* (App no 5100/71; 5101/71; 5102/71; 5354/72; 5370/72) (1978) A/25, 2 EHRR 25 para. 167.

inhuman treatment need not be intended to cause suffering.²⁶⁹ The Court has considered treatment to be inhuman "because, *inter alia*, it was premeditated, was applied for hours at a stretch and caused either actual bodily injury or intense physical or mental suffering."²⁷⁰

Degrading treatment requires determination of 'whether its object is to humiliate and debase the person concerned and whether, as far as the consequences are concerned, it adversely affected his or her personality in a manner incompatible with Article 3'.²⁷¹ It can also be characterised as a treatment that 'arouses feelings of fear, anguish and inferiority capable of humiliating or debasing the person and possibly breaking his or her physical or moral resistance or as driving the person to act against his or her will or conscience'.²⁷² However, the ECtHR has found treatment as degrading even if there has not been a positive intention to humiliate or debase the person concerned.²⁷³

The ECtHR has often emphasised the fundamental values enshrined in Article 3, and thus grounds in absolute terms the prohibition of torture, inhuman and/or degrading treatment.²⁷⁴ The ECtHR has re-emphasised the absolute character of the prohibition of ill-treatment in the recent case of *A. and Others v. UK*, by stating that 'Even in the most difficult of circumstances, such as the fight against terrorism, and irrespective of the conduct of the person concerned, the Convention prohibits in absolute terms torture and inhuman or degrading treatment and punishment'.²⁷⁵ Such nature of Article 3 means that, first, it cannot be derogated from in time of war or public emergency and, second, it is expressed in unqualified terms.²⁷⁶ It accordingly implies that 'conduct, which comes within Article 3, cannot be justified or excused';²⁷⁷ justifications for intervention in a person's private life, provided by Article 8 (2), would not be permissible in respect of Article 3.

Regarding persons with mental disabilities, in a number of cases the ECtHR has established that a lack of psychiatric medical care amounts to inhuman and/or degrading treatment. In order to evaluate the ECtHR assessments regarding coercive medical treatment under Article 3, firstly the issue of *lack* of medical treatment will be highlighted, as the case law of the ECtHR is clearer on this issue and provides appraisals, which might also be useful for the evaluation of *forced* medical treatment in regard to inhuman and/or degrading treatment.

269 Ibid.

270 *Kudla v. Poland* (App no 30210/96) ECHR 2000-XI para. 92.

271 *Keenan v UK* (App no 27229/95) ECHR 2001-III para. 110.

272 Ibid.

273 *Price v UK* (App no 33394/96) ECHR 2001-VII para. 30.

274 *Selmouni v France* (App no 25803/94) ECHR 1999-V para. 95.

275 (App no 3455/05) ECHR 19 February 2009 para. 126.

276 Harris, D.J., O'Boyle, M. & Warbrick, C., *Law of the European Convention on Human Rights* (OUP, Oxford 2009) p. 70.

277 Hale, B., 'Justice and equality in mental health law: The European experience' IJLP (2007) 18, 28 p. 22.

3.5.1. Lack of medical care

Lack of medical care as violation of the right to liberty in respect of persons with mental disabilities has already been highlighted in sub-chapter 2.2.5. To recap, the ECtHR requires 'some relationship between the ground of permitted deprivation of liberty relied on and the place and conditions of detention'.²⁷⁸ It should be kept in mind that a lack of therapeutic environment as a violation of the right to liberty applies only to those persons whose liberty has been deprived in accordance with Article 5 (4). When it comes to violation of Article 3 as a consequence of a lack of medical treatment, victims are usually not persons whose liberty has been deprived due to unsoundness of mind. Mostly these are prisoners or detainees whose mental health condition requires medical treatment.

Thus in common with the general phenomena,²⁷⁹ violations of Article 3 as a consequence of lack of medical treatment are mostly appearing in closed institutions. As to the extent and the circumstances in which treatment must be ensured, the ECtHR has stated that the mere fact of detention of a person requiring medical treatment is not a sufficient ground for finding a violation of Article 3.²⁸⁰ However, the Court has stated that:

Although Article 3 cannot be construed as laying down a general obligation to release detainees on health grounds, it nonetheless imposes an obligation on the State to protect the physical and mental well-being of persons deprived of their liberty, for example by providing them with the requisite medical assistance.²⁸¹

In accordance with the ECtHR case law, the level of medical treatment that States are obliged to ensure must fulfil the requirement of being compatible with the protection of human dignity.²⁸² Thus, for instance, in the *Keenan v. UK* case the ECtHR emphasised the need to take into consideration the vulnerability and inability of persons with mental disabilities, in some cases, to complain coherently or at all about how they are being affected by any particular treatment.²⁸³ Such treatment 'may be incompatible with the standards imposed by Article 3 in the protection of fundamental human dignity, even though that person may not be able, or capable of, pointing to any specific ill-effects'.²⁸⁴ Also in the recent case of *Renolde v. France*, the Court found violation of Article 3 as a result of incompatibility of treatment of the applicant's brother with the standards imposed by Article 3 in the protection of human dignity.²⁸⁵

278 *Aerts v Belgium* (App no 25357/94) ECHR 1998 V para. 46.

279 Nowak, M., Suntinger, W., 'The Right of Disabled Persons not to be subjected to Torture, Inhuman and Degrading Treatment or Punishment' in Theresia Degener and Yolán Koster-Dreese (eds), *Human Rights and Disabled Persons* (Martinus Nijhoff Publishers, The Netherlands 1995) p. 123.

280 *Moussel v France* (App no 67263/01) ECHR 21 May 2003 para. 38.

281 *A. and Others v UK* (App no 3455/05) ECHR 19 February 2009 para. 128.

282 *Paladi v Moldova* (App no 39806/05) ECHR 10 March 2009 para. 71.

283 (App no 27229/95) ECHR 2001-III para. 111.

284 *Ibid* para. 113.

285 *Renolde v France* (App no 5608/05) ECHR 16 October 2008 para. 129.

Regarding the standards which should be ensured, the Court has stated that the vulnerability and serious mental disturbances of the prisoners demand 'taking special measures geared to their condition in order to ensure compatibility with the requirements of humane treatment'.²⁸⁶ The ECtHR found that such requirements had not been fulfilled in this case where the applicant's brother, who suffered from a mental disturbance, was subjected to 45 days' detention in a punishment cell, which resulted in his suicide.²⁸⁷ Similarly the Court has found standards incompatible with the requirements of human dignity in the before mentioned *Keenan v. UK* case where the son of the applicant, who was diagnosed as suffering from paranoid schizophrenia, committed suicide in a prison after being placed in segregation in the punishment block for 7 days. 9 days before his release his sentence was extended by 28 additional days.²⁸⁸ On the other hand, the Court found no violation of Article 3 in the case of *Kudla v. Poland*, where the applicant also complained about the lack of medical care in prison for his depression, which resulted in his suicide attempt.²⁸⁹ The ECtHR established that, contrary to Keenan's case, 'the applicant regularly sought, and obtained, medical attention' by different doctors;²⁹⁰ and in respect of the circumstances of the case, the suicide attempt by the applicant 'did not appear to have resulted from or have been linked to any discernible shortcoming on the part of the authorities'.²⁹¹

The ECtHR case law regarding lack of medical care as inhuman and/or degrading treatment shows the high threshold set by Article 3. Not every deficiency of medical treatment would reach this threshold and it is the lack of access to qualified medical personnel and lack of supervision of a person suffering from mental illness (as in the case *Keenan v. UK*²⁹²) rather than the unavailability of medication that would be the reason for finding the circumstances falling under the scope of inhuman and/or degrading treatment.²⁹³ It seems that the appropriate number of prison workers and educational activities are of major importance in ensuring treatment compatible with the protection of human dignity. Similar opinion has also been expressed by the CPT in the 3rd General Report, where it emphasised 'the role to be played by prison management in the early detection of prisoners suffering from a psychiatric ailment with a view to enabling appropriate adjustments to be made to their environment'.²⁹⁴ Taking

286 Ibid.

287 Ibid.

288 (App no 27229/95) ECHR 2001-III.

289 (App no 30210/96) ECHR 2000-XI.

290 Ibid para. 96.

291 Ibid.

292 In *Keenan* the Court found that there had been a lack of effective monitoring of Mark Keenan's condition. Also the Court established that "the lack of informed psychiatric input into his assessment and treatment disclose significant defects in the medical care provided to a mentally ill person known to be a suicide risk." *Keenan v UK* (App no 27229/95) ECHR 2001-III para. 116.

293 See on this matter also the case of *Khudobin v Russia* (App no 59696/00) ECHR 26 January 2007.

294 CPT, 3rd General Report on the CPT's Activities, Strasbourg, 1993, CPT/Inf(93) 12, <<http://www.cpt.coe.int/en/annual/rep-03.htm>> accessed 20 June 2009 para. 42.

into account the importance of the role of prison workers, the CPT stresses the need to provide 'appropriate health training for certain members of the custodial staff'.²⁹⁵

3.5.2. Involuntary medical treatment

One of the leading ECtHR cases regarding involuntary medical treatment in psychiatric institutions is the *Herczegfalvy v. Austria*²⁹⁶ case, where the Court established the concept of medical necessity. In the *Herczegfalvy* case the Court stated that:

A measure which is therapeutically necessary from the point of view of established principles of medicine cannot in principle be regarded as inhuman and degrading. The Court must nevertheless satisfy itself that a medical necessity has been convincingly shown to exist.²⁹⁷

1. The *Herczegfalvy* case has caused many discussions in respect of qualification of Article 3 and applicability of the principle of medical necessity. First of all, the difficulties of determining what constitutes "established principles of medicine" have been highlighted. Some authors argue that the *Herczegfalvy* test is based too much on medical examinations and that reliance on such theory 'turns a question of fundamental human rights into a question of clinical practice'.²⁹⁸ It has also been pointed out that there is no case law from the ECtHR to explain what the "established principles of medicine" are.²⁹⁹ So far the Court has determined that "'medical necessity" is not limited to life-saving treatment. It can also cover treatment, such as anti-psychotic medication, imposed as part of a therapeutic regime'.³⁰⁰ Nevertheless, issues of provided medical treatment in substance do not generally fall within the scope of "medical necessity". The Court considers that 'in many areas of medicine, not least psychiatry, decisions as to treatment are complex matters of judgment. Medical experts can legitimately disagree and such disagreement is not, in itself, demonstrative of an absence of medical necessity for the relevant treatment'.³⁰¹ The only condition the ECtHR has set is that 'patients nevertheless remain under the protection of Article 3 (art. 3), whose requirements permit of no derogation'.³⁰² Unfortunately, the Court has not provided any further explanations of how such requirement would function in respect of use of certain medical treatments.

295 Ibid.

296 (App no 10533/83) (1993) A/242-B, 15 EHRR 437.

297 Ibid para. 82. See also one of the latest cases, where the Court has referred to the principle of medical necessity in respect of involuntary gynecological examination: *Juhnke v Turkey* (App no 52515/99) ECHR 13 August 2008 para. 71.

298 Bartlett, P., Lewis, O. & Thorold, O., *Mental Disability and the European Convention on Human Rights* (Martinus Nijhoff Publishers, Leiden 2007) p. 129.

299 Ibid para. 116.

300 *Buckley Buckley v UK*, Decision as to the admissibility (App no 28323/95) (1997) 23 EHRR 101 para. 4.

301 *Wilkinson v. UK*, Decision as to the admissibility (App no 14659/02) ECHR 28 February 2006.

302 *Herczegfalvy v Austria* (App no 10533/83) (1993) A/242-B, 15 EHRR 437 para. 82.

The Court's approach reflects the restricted extent to which the Court is examining cases regarding involuntary medical treatment of incapable adults. It follows from the ECtHR case law that the Court would leave a broad margin of appreciation to States in assessing whether there is a need for medical treatment. The Court cannot examine the existence of such a need in substance and it generally is satisfied where the national institutions have relied on expert opinions.

2. Secondly, in respect of the *Herczegfalvy* decision, authors often express regret that the Court failed to qualify force-feeding, compulsory medical treatment, tying up to a security bed and use of handcuffs for more than two weeks as violations of Article 3.³⁰³ It has been noted that 'the European Commission on Human Rights had previously found that the combination of these treatments amounted to inhuman and degrading treatment'.³⁰⁴ It can also be observed from other cases, where the ECtHR has found that intervention was not motivated by medical necessity, that the Court is examining obstacles in a stricter manner. For instance, the ECtHR has found violation of Article 3 in a case where the applicant was subjected to force-administered medicine through a tube in order to provoke vomiting and thus retrieve swallowed evidence. The Court stated that 'the manner in which the impugned measure was carried out was liable to arouse in the applicant feelings of fear, anguish and inferiority that were capable of humiliating and debasing him'.³⁰⁵ The Court considered that such treatment was not absolutely necessary in the relevant circumstances and 'the prosecuting authorities could simply have waited for the drugs to pass out of the system naturally'.³⁰⁶

By contrast, such evaluation of necessity of medical treatment is entirely absent in the Court's assessments in the *Herczegfalvy* case. The ECtHR approach has been subjected to critique by some authors, which draw attention to possible discrimination in respect of medical treatment of incapable adults. It has been questioned: 'Why should it be acceptable to treat an incapacitated person in a way which would be degrading if done to capacitated?'³⁰⁷ The ECtHR has itself stated in already mentioned *Keenan* case regarding lack of medical care, that the treatment 'may be incompatible with the standards imposed by Article 3 in the protection of fundamental human dignity, *even though that person may not be able, or capable of, pointing to any specific ill-effects*'.³⁰⁸ It is surprising why the

303 See, for example, Hale, B., 'Justice and equality in mental health law: The European experience' IJLP (2007) 18, 28 p. 23 or Nowak, M., Suntinger, W., 'The Right of Disabled Persons not to be subjected to Torture, Inhuman and Degrading Treatment or Punishment' in Theresia Degener and Yolán Koster-Dreese (eds), *Human Rights and Disabled Persons* (Martinus Nijhoff Publishers, The Netherlands 1995) p. 118.

304 Nowak, M., Suntinger, W., 'The Right of Disabled Persons not to be subjected to Torture, Inhuman and Degrading Treatment or Punishment' in Theresia Degener and Yolán Koster-Dreese (eds), *Human Rights and Disabled Persons* (Martinus Nijhoff Publishers, The Netherlands 1995) p. 118

305 *Jalloh v Germany* (App no 54810/00) ECHR 2006-IX para. 82.

306 *Ibid* para. 77.

307 Hale, B., 'Justice and equality in mental health law: The European experience' IJLP (2007) 18, 28 p. 24.

308 *Ibid* para. 113.

Court is not using the same approach regarding coercive medical treatment and is not emphasising the protection of human dignity of the incapable person.

3. The rule established by the ECtHR that treatment that is imposed due to proved medical necessity cannot constitute inhuman and degrading treatment, causes some concerns regarding its absolute character, as medical treatment can be provided in different manners. For instance, the use of electro-convulsive therapy (ECT) might be "therapeutically necessary from the point of view of established principles of medicine", but it can be performed in either a modified³⁰⁹ or an unmodified way. The unmodified ECT has been recognised by the CPT as a 'method that can no longer be considered as acceptable in modern psychiatric practice'.³¹⁰ Taking into account 'the risk of fractures and other untoward medical consequences, the process as such is degrading for both the patients and the staff concerned. Consequently, ECT should always be administered in a modified form'.³¹¹ One can wonder whether the ECtHR would recognise unmodified ECT as a treatment which falls under the requirement of medical necessity and thus does not breach Article 3. The problem is apparent not only regarding ECT; some authors argue that such treatments as "mega-dosing" or psychosurgery are other examples of treatments, which in the case of qualification as purely medical necessity would be a cause of wonder and criticism.³¹²

4. Regarding the current case law of the ECtHR it can be observed that the Court does not take the same approach as required by the "soft law" documents with regards examination of involuntary medical treatment concerning incapable adults in respect of Article 3. It does not take into account the principle of least restrictive treatment but sticks to the general rule that a measure which is therapeutically necessary from the point of view of established principles of medicine cannot in principle be regarded as inhuman and degrading.³¹³ Accordingly, the primary attention of the Court is on the Government's ability to prove medical necessity of treatment and only then should they turn to the method of treatment itself. Thus, for instance, because of proven medical necessity, the Court found no violation of Article 3 in the above mentioned *Herczegfalvy* case regarding forcibly administered food and neuroleptics. In *Nevmerzhitsky v. Ukraine* the Government was unable to provide medical justification for force-feeding of the applicant and accordingly the Court found violation of Article 3.³¹⁴

Thus it can be observed, that the applications regarding involuntary medical treatment in respect of Article 3 are for the greater part unsuccessful. While the

309 Modified electro-convulsive therapy is used after administration of anaesthetics and muscle relaxants: Bartlett, P., Lewis, O. & Thorold, O., *Mental Disability and the European Convention on Human Rights* (Martinus Nijhoff Publishers, Leiden 2007) p. 116.

310 CPT, 8th General Report on the CPT's Activities, Strasbourg, 1998, CPT/Inf(98) 12, <<http://www.cpt.coe.int/en/annual/rep-08.htm>> accessed 10 June 2009 para. 39.

311 Ibid.

312 Bartlett, P., Lewis, O. & Thorold, O., *Mental Disability and the European Convention on Human Rights* (Martinus Nijhoff Publishers, Leiden 2007) p. 117.

313 See, for instance, *Buckley v UK*, Decision as to the admissibility (App no 28323/95) (1997) 23 EHRR 101; *Wilkinson v. UK*, Decision as to the admissibility (App no 14659/02) ECHR 28 February 2006.

314 (App no 54825/00) ECHR 2005-II para. 98.

reasons for such litigation results might be different, and considering some of the problematic aspects which were also highlighted in this sub-chapter, the striking aspect of the case law of the ECtHR is that the CPT already in its 8th General Report has observed that 'the deliberate ill-treatment of patients in psychiatric establishments does occur from time to time'.³¹⁵ Nevertheless, according to the case law of the ECtHR, no violations of Article 3 in respect of involuntary medical treatment in psychiatric institutions so far have been found.

3.5.3. Restraint and seclusion

Use of restraint³¹⁶ and seclusion³¹⁷ in respect of persons with mental disabilities has been recognised by many authors as controversial³¹⁸ and as a violation of the individual's liberty and dignity.³¹⁹ Thus, use of such methods requires introduction and observation of certain procedural guarantees and the taking into account of measures of proportionality.³²⁰ In this respect the CoE *Recommendation concerning the ethical and organisational aspects of health care in prisons* also urges respect for the principle of least restriction, by determining that 'in those cases where the use of close confinement of mental patients cannot be avoided, it should be reduced to an absolute minimum'.³²¹ Regarding physical restraint, the Recommendation permits use of it only under 'exceptional circumstances for a brief period in cases of severely ill patients, while the calming action of appropriate medication begins to take effect'.³²²

The CPT has indicated the problematic aspect of excessive use of restraint in many visited establishments and thus devoted part of its 16th General Report to this issue.³²³ Even though the CPT agrees that the use of restraint is necessary in certain circumstances, it determines that:

Certain mechanical restraints, which are still to be found in some psychiatric hospitals visited by the CPT, are totally unsuitable for such a purpose and could well be considered as degrading. Handcuffs, metal chains and cage-beds clearly fall within this category;

315 CPT, 8th General Report on the CPT's Activities, Strasbourg, 1998, CPT/Inf(98) 12, <<http://www.cpt.coe.int/en/annual/rep-08.htm>> accessed 10 June 2009 para. 27.

316 Restraint devices include lap belts and bars, Posey vests, wrist and ankle cuffs and chairs with locking lap trays. Graber, R.D., Sloane, D.P., 'Nursing Home Survey Deficiencies for Psychical Restraint Use' *Medical Care* (1995) 1051, 1063 p. 1051.

317 Seclusion means solitary confinement under close observation and supervision. Hale, B., 'Justice and equality in mental health law: The European experience' *IJLP* (2007) 18, 28 p. 21.

318 Hale, B., 'Justice and equality in mental health law: The European experience' *IJLP* (2007) 18, 28 p. 21.

319 Saks, E.R., 'The Use of Mechanical Restraints in Psychiatric Hospitals' *The Yale Law Journal* (1986) 1836, 1856 p. 1839.

320 *Ibid.*

321 Recommendation No. R (98) 7 Concerning the ethical and organisational aspects of health care in prisons (8 April 1998) para. 56.

322 *Ibid* para. 57.

323 CPT, 16th General Report on the CPT's Activities, Strasbourg, 2006, CPT/Inf(2006) 35, <http://www.cpt.coe.int/en/annual/rep-16.htm#_Toc147633167> accessed 22 June 2009 para. 36.

they have no rightful place in psychiatric practice and should be withdrawn from use immediately.³²⁴

The CPT permits use of restraints only 'as a measure of last resort' and requires release of the person concerned immediately after the situation has elapsed.³²⁵

As to the case law of the ECtHR, it can be observed that the Court follows the CoE Recommendation and also the CPT standards in respect of capable adults and requires States to prove the absolute necessity of the use of restraints. Thus, for instance, the Court examined obstacles in a case where the applicant was placed in restraining belts in a sobering-up centre. The Court stated that 'in the instant case no explanation has been given for the necessity of placing the applicant in restraining belts for such an excessive period of time'.³²⁶ Accordingly the Court concluded that such immobilisation 'must have caused the applicant great distress and physical discomfort'³²⁷ and therefore found a violation of Article 3. The ECtHR has also considered degrading treatment of the applicant, who 'was brought in handcuffs to court and held in a cage during the hearings'.³²⁸ The Court found in this case that safety measures were not justified by the circumstances of the case.³²⁹ Similarly in *Hénaf v. France*, the Court considered that 'the use of restraints was disproportionate to the needs of security'.³³⁰ In this case the applicant was handcuffed during the transfer from prison to hospital, remained so for the whole day, while during the night a restraint was applied to the applicant, consisting of a chain attaching one of his ankles to the bedpost.³³¹

From the *Herczegfalvy v. Austria* case it follows that in cases where restraint or seclusion is used in psychiatric institutions in respect of legally incapable adults, the Court applies the principle of medical necessity which prescribes that 'a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading'.³³² In the *Herczegfalvy* case the applicant was tied up to a security bed and subjected to handcuffing for more than two weeks and the Court found no violation of Article 3. It is striking that the Court in *Herczegfalvy* did not even evaluate the necessity of use of restraints. It is to be hoped that the Court would change its position in this respect as it is hard to find arguments to justify such a different approach by the Court towards legally capable and incapable adults concerning the use of restraints.

The current approach of the ECtHR might also be viewed as ineffective, taking into account the CPT findings that in many of the establishments visited

324 Ibid para. 40.

325 Ibid paras. 43, 45.

326 *Wiktorko v Poland* (App no 14612/02) ECHR 31 March 2009 para. 55.

327 Ibid.

328 *Sarban v Moldova* (App no 3456/05) ECHR 4 January 2006 para. 88.

329 Ibid para. 89.

330 (App no 65436/01) ECHR 2003-XI para. 56.

331 Ibid paras. 11-13.

332 (App no 10533/83) (1993) A/242-B, 15 EHRR 437 para. 82.

there is an excessive recourse to means of restraint. It is not always that such restraints are used due to the emergency health situation of the patients. Unfortunately the CPT has observed, that 'the application of restraints is resorted to as a means of convenience for the staff; securing difficult patients while other tasks are performed'.³³³

3.6. Concluding remarks

The right to private life and prohibition of inhuman and/or degrading treatment stands for protection of such fundamental values as human dignity, personal autonomy and the right to consent. As the analysis in the instant chapter shows, medical treatment can interfere and in certain circumstances violate both Article 8 (the right to private life protection) and/or Article 3 (prohibition of inhuman and/or degrading treatment).

The ECtHR has established that forced medical treatment interferes with a person's private life and autonomy.³³⁴ Even though the Court leaves a broad margin of appreciation to states regarding necessity of medical treatment, in certain cases the Court has established that treatment has amounted to unjustifiable intervention in a person's private life.³³⁵

In the landmark case of *Herczegfalvy v. Austria*, where the Court was for the first time examining medical treatment of incapable adult in light of the prohibition of inhuman and/or degrading treatment, the Court established the doctrine of medical necessity, which prescribes that 'a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading'.³³⁶ Even though the approach of the Court is considerably clear in this respect, the term "medical necessity" leaves many questions unanswered regarding the standards that should be used to determine medical necessity and in particular concerning the use of such treatments as ECT, "mega-dosing" or psychosurgery. Unfortunately, the principle of least restriction (as defined in "soft law" documents) is not used by the Court in this respect, which causes some doubts regarding evaluation of use of medical treatment, restraints and seclusion in the framework of "medical necessity."

The analysis of the CPT reports and case law of the ECtHR also highlights the important aspect of financial coverage for the health care system and institutions. As has been indicated, in many cases, violation of Article 8, and moreover of Article 3, in relation to medical treatment and use of restraint and seclusions arose not due to the malice, but as a consequence of lack of funding, medical personnel and appropriate education of staff-either in prisons or psychiatric institutions.

333 CPT, 16th General Report on the CPT's Activities, Strasbourg, 2006, CPT/Inf(2006) 35, <http://www.cpt.coe.int/en/annual/rep-16.htm#_Toc147633167> accessed 22 June 2009 para. 43.

334 See *Matter v Slovakia* (App no 31534/96) ECHR 5 July 1999 and *Pretty v UK* (App no 2346/02) ECHR 2002-III.

335 See, for instance, *Glass v UK* (App no 61827/00) ECHR 2004-II.

336 (App no 10533/83) (1993) A/242-B, 15 EHRR 437 para. 82.

CONCLUSION

This thesis began with the disclosure of statistical data pointing to the great number of individuals likely to face mental disabilities and thereby equally exposed to different interventions in their lives: deprivation of liberty, interference in private life, and in certain circumstances even experiencing inhuman and/or degrading treatment.

The goal of this thesis was to define and examine safeguards, which protect persons with mental disabilities from unlawful and unjustified interventions in their lives. For this purpose, the paper included analysis of both: corresponding recommendations and principles of the CoE and the UN ("soft law" documents) and such legally binding treaties as the ECHR and the ICCPR ("hard law" instruments). The reflection and compliance of the "soft law" requirements with the legally binding rules and, in particular, with the case law of the ECtHR was also highlighted.

1. The research of the paper displayed that interpretation and implementation of legal guarantees in respect of involuntary placement and medical treatment in psychiatric institutions are not straightforward processes. To a large extent this results from the close interrelation of law and medicine regarding protection of the rights of persons with mental disabilities. The need to draw a border between legal and medical appraisals has been acknowledged by the ECtHR. In doing so, the Court has outlined distinct but strictly legal assessment frameworks: it has established criteria for evaluation of involuntary placement in psychiatric institutions (the *Winterwerp* case) and developed a test for examination of involuntary medical treatment of incapable adults (the *Herczegfalvy* case). Both the criteria and test have been at the very centre of the analysis and their frameworks of reference have been used to evaluate different problematic aspects regarding involuntary placement and medical treatment.

2. Throughout the research of this paper the interconnection between involuntary placement and medical treatment has proved obvious, although it is clear that it is the origin of complex issues. While both of them fall under different articles of documents such as the ICCPR and the ECHR, they often are closely related and in respect of certain questions, the margin between applicable articles is considerably narrow (for instance, in respect of issues such as involuntary placement in a psychiatric institution and the requirement of ensuring a therapeutic environment; or, in the Court's approach, that medical treatment does not fall under the scope of Article 5).

The close connection between medical treatment and restriction of liberty also reflects the difference of applicability of human rights guarantees with regards persons suffering from mental disabilities and the ones who do not. Detention of the persons suffering from mental disabilities is not an end itself. It differs from the detention of prisoners with the need (and aim) of ensuring medical treatment and care.

3. The research regarding involuntary placement in psychiatric institutions has stressed the very detailed character of the substantive and procedural issues related to the deprivation of liberty of persons with mental disabilities dealt with by the ECtHR. It seems that the "hard law" is more scrupulous in this respect than the "soft law" documents. Nevertheless, the general approach and procedural

guarantees for involuntary placement in psychiatric institutions are comparatively similar in both "soft law" and "hard law" instruments.

It appears that the Court agrees with the "soft law" requirements regarding procedural guarantees in cases of involuntary placement and with the requirement to take into account the person's actual capacity in cases of placement and not to rely unconditionally on the legal incapacity of the person concerned. The differences are appearing (and becoming more obvious in the latest cases) when the Court has to deal with the issues which are falling out of the "traditional" *Winterwerp* case criteria for deprivation of liberty. Such issues are, for example, treatment in the community, lack of therapeutic environment as a violation of the right to liberty or conditional discharge. While the "soft law" instruments might not provide detailed regulation in respect of all these issues, they do prescribe and command observance of certain principles (such as the principle of best interests of persons with mental disabilities, the principle of least restriction and the principle of maximum preservation of capacity). The use of those principles by the ECtHR might be a helpful tool for resolving some further problematic aspects and might develop the ECtHR case law in a more protective direction for persons suffering from mental disabilities.

4. The analysis of the coercive medical treatment has unfortunately highlighted inconsistencies between the "soft law" and "hard law" norms. The case law of the ECtHR leaves the impression of being less protective regarding persons who are subjected to coercive medical treatment than the "soft law" framework. Thus, for instance, the Court does not clearly establish the necessity for separate authorisation of coercive medical treatment in psychiatric institutions. While there perhaps has not yet been a case where the Court could prescribe such requirement, it can be hoped the Court would take "soft law" guidance into account should such a case be heard in a near future.

It has proved evident that, so far, the ECtHR does not take into account the principle of least restrictiveness, which requires treatment of the patient using the least intrusive methods available. The ignorance of such principle is particularly striking regarding medical treatment of legally incapable adults, particularly when one considers the Court's findings in the *Herczegfalvy* case: "A measure which is therapeutically necessary from the point of view of established principles of medicine cannot in principle be regarded as inhuman and degrading." The Court's established doctrine of medical necessity has been subjected to serious criticism by various authors. It raises legitimate concerns as to possible discrimination of incapable adults in respect of coercive medical treatment and also its use in cases where restraints and seclusion are at stake.

Contrary to involuntary placement in psychiatric institutions, involuntary medical treatment does not have obvious regulation in the ECHR. Thus, the interpretation of the Convention could be seen as more challenging for the ECtHR. In such circumstances the role of "soft law" gains immediate relevance in ensuring a more protective interpretation of "hard law" standards regarding persons subjected to coercive medical treatment (and in particular of incapable adults).

5. Further research regarding involuntary placement in psychiatric institutions may be needed, particularly on such issues as involuntary medical treatment in the community and conditional discharge from psychiatric institutions. As has

been indicated in this paper, involuntary treatment in the community does not fully fall under the scope of Article 5 of the ECHR. It nevertheless causes some concern, as such treatment, to a certain extent, restricts a person's liberty. Conditional discharge has proved to be a complicated matter in cases when conditions cannot be fulfilled by the States and thus also leaves a space for further study.

Concerning involuntary medical treatment, it is relevant to investigate further the ECtHR established approach to justify any medical treatment imposed to incapable adults, which has been performed due to the proven medical necessity. As has been highlighted, certain medical treatments (such as "mega-dosing" and use of unmodified ECT), might be a challenge to the Court's current approach.

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