Master's Thesis in International Human Rights Law

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INVOLUNTARY PLACEMENT AND TREATMENT OF PERSONS WITH MENTAL DISORDERS: A SHIFT IN THE HUMAN RIGHTS PARADIGM

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Title page illustration: Rowlands, Gwyneth (no date). *Untitled (Blue Butterfly).* [Watercolour on pebble] Adamson Collection, available at www.adamsoncollectiontrust.org

Edward Adamson (1911–1996) was a British artist and a pioneer of art therapy in the United Kingdom. Between 1946 and 1981 Adamson worked at the British long-stay mental hospital in Surrey, where he ran an art studio for patients. Gwyneth Rowlands, who resided at the asylum throughout those years, would paint on pebbles and flints she gathered from the seaside and farm fields during hospital outings. Psychiatrists at the time saw art as a diagnostic tool and tried to find symptoms of a mental illness in their patients' works. By contrast, Adamson would say, *"I want the creators to interpret their pictures to me. Because you can read all sorts of things into a picture which are not true. It's the easiest thing in the world, to tell a false story."* (David O'Flynn, "Private Intentions: The story behind the Adamson Collection" in *Ladybeard Magazine*, The Mind Issue, 2016, pp. 36-39)

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Abstract for Master's Thesis

Subject: Public International Law, Master's Degree Programme in International Human Rights Law

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Title of the Thesis: Involuntary Placement and Treatment of Persons with Mental Disorders: A Shift in the Human Rights Paradigm

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Abstract:

Mental health laws worldwide authorise involuntary hospitalisation and treatment of persons with mental disorders. The debate over the future of mental health care has spurred two competing positions: one supporting traditional resort to compulsion in psychiatry, and the other arguing that such practices are incompatible with the newly emerged human rights standards. This study explores the permissibility of involuntary interventions in mental health care under international and regional human rights law.

In pursuing the aim of the thesis, various legal sources are analysed, most valuable being binding instruments. The latter include, *inter alia*, the United Nations Convention on the Rights of Persons with Disabilities and the European Convention on Human Rights. It is demonstrated how the obligations set forth in these (and other) instruments in relation to mental health care are inherently conflicting. 'Soft law' sources, international and regional jurisprudence as well as scholarly literature shed more light on this conflict of norms.

The study is structured around three major subjects: legal capacity, involuntary placement and involuntary treatment. Since the deprivation of one's legal capacity often leads to other non-consensual interventions, the corresponding chapter is useful in understanding the subsequent ones. The chapters on involuntary placement and treatment are organised by contemporary approaches to

compulsory care, i.e. traditional, disability-neutral and revolutionary. Each of these approaches will be backed up by relevant international and regional instruments and jurisprudence.

This work pays considerable attention to the approach taken by the United Nations Disability Convention as the treaty has inspired other instruments and bodies to adopt similar perspective. This approach emphasises everyone's legal capacity and the right to consent to treatment. However, important drawbacks of such proposition are also explored, which come down to it being unrealistic to implement. Several ways to reconcile revolutionary approach to mental health care ('no forced interventions allowed') with the traditional one ('involuntary interventions as last resort') are offered.

Ultimately, the resolution of the research problem largely relies on which interpretation of the norms we adopt. For example, the CRPD Committee believes that the treaty outlaws all forms of involuntary interventions on the basis of (mental) disability. Other international and regional bodies argue that human rights law allows for exceptions to the principle of informed consent. Overall, the answer to the research question is affirmative: involuntary placement and treatment are allowed under international and regional law as long as they are not linked to the person's disability. Otherwise such interventions would be discriminatory in nature and thus in breach of human rights law.

Key words: mental health law, compulsory psychiatric care, autonomy, Convention on the Rights of Persons with Disabilities, CRPD.

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I AM! yet what I am who cares, or knows?
My friends forsake me like a memory lost.
I am the self-consumer of my woes;
They rise and vanish, an oblivious host,
Shadows of life, whose very soul is lost.
And yet I am – I live – though I am toss'd

Into the nothingness of scorn and noise,
Into the living sea of waking dream,
Where there is neither sense of life, nor joys,
But the huge shipwreck of my own esteem
And all that's dear. Even those I loved the best
Are strange – nay, they are stranger than the rest.

I long for scenes where man hath never trod
A place where woman never smiled or wept
There to abide with my Creator, God,
And sleep as I in childhood sweetly slept,
Untroubling and untroubled where I lie
The grass below – above the vaulted sky.

John Clare (1793–1864)
Written in Northampton General Lunatic Asylum
(England, United Kingdom)
during the 1840s, published in 1848

To those who could not find their peace of mind on this earth.

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However, I would never have started, let alone finished, my thesis if it were not for the kind people who helped me along the way. I would like to express my heartfelt thanks to

Catarina Krause, whose indispensable guidance and ongoing support encouraged me to continue my research regardless of the difficulties I might have encountered,

the attentive and caring mental health professionals, both in Finland and Ukraine, who guided me through a sensitive time in my life and incidentally inspired the topic of my thesis,

as well as everyone who is dear to me and who motivated me to move forward when I was about to lose heart.

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LIST OF ACRONYMS

ACHPR	African Charter on Human and Peoples' Rights
CoE	Council of Europe
CPT	European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment
CRPD	Convention on the Rights of Persons with Disabilities
CRPD Committee	Committee on the Rights of Persons with Disabilities
DSM	Diagnostic and Statistical Manual of Mental Disorders (by American Psychiatric Association)
ECHR	European Convention for the Protection of Human Rights and Fundamental Freedoms
ECtHR	European Court of Human Rights
EU	European Union
FRA	European Union Agency for Fundamental Rights
HR Committee	The United Nations Human Rights Committee
IACtHR	Inter-American Court of Human Rights
ICCPR	International Covenant on Civil and Political Rights
ICD	International Statistical Classification of Diseases and Related Health Problems (by World Health Organisation)
MI Principles	Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care
OHCHR	Office of the High Commissioner for Human Rights
UDHR	Universal Declaration of Human Rights
UK	The United Kingdom of Great Britain and Northern Ireland
UN	United Nations
UN Charter	Charter of the United Nations
USA	United States of America
WHO	World Health Organisation

CHAPTER 1: INTRODUCTION

1.1. Background

One of the core values of democratic societies founded on fundamental freedoms and human rights is respect for personal autonomy and self-determination. The legal point of departure here is that competent human beings have the right to make their own decisions in matters concerning themselves.[1] The right of autonomous decision-making applies to health care as well, albeit with certain exceptions.

Mental health care is unique among other medical fields due to its common use of compulsion, be it involuntary hospitalisation or treatment. The use of compulsion in psychiatry involves many ethical and legal challenges, but it has generally been accepted as a last resort in case other measures fail. The starting premise here is that mental health professionals know how to help their patients and that if help is rejected it is better to compel the person to receive it. National laws reflect this idea by authorising involuntary placement and treatment of a person who was found to be mentally ill, is considered likely to harm himself or others and/or believed to be in need for treatment.[2]

Compulsion in psychiatry is thus justified as being in the patients' best interests. This argument assumes that patients are irrational in rejecting psychiatric care, that psychiatric treatments such as antipsychotic medication are always beneficial, and that patients compelled to receive treatment do better in the long term. None of these propositions is fully supported by research, however.[3] Nevertheless, the practices like seclusion, restraint, psychosurgery, electroconvulsive therapy and administration of mind-altering drugs without the person's informed consent are common in many jurisdictions. The absence of a better alternative in most psychiatric institutions might explain why such practices continue to prevail.

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[1] Aasen, Henriette Sinding, Chapter 2. Dignity and human rights in the modern welfare state, in Aasen, Henriette Sinding, Halvarson, Rune and Silva, António Barbosa (eds) *Human rights, dignity and autonomy in healthcare and social services: Nordic perspectives*, Intersentia, 2009, p.64.

[2] Zhang, Simei, Mellsop Graham, Brink, Johann & Wang, Xiaoping, "Involuntary admission and treatment of patients with mental disorder", in *Neuroscience Bulletin*, Vol. 31, No. 1, 2015, p. 100.

[3] Bartlett, Peter, "'The Necessity Must be Convincingly Shown to Exist': Standards for Compulsory Treatment for Mental Disorder under the Mental Health Act 1983", in *Medical Law Review*, Vol. 19, No. 4, 2011, pp. 517-519; Bentall, Richard, "Too much coercion in mental health services", in *The Guardian*, posted on newspaper's website on 1 February 2013 at 14:00 GMT, available at: https://www.theguardian.com/commentisfree/2013/feb/01/mental-health-services-coercion (last visited 22 August 2018).

Until recently, both international and regional law has been upholding national legal systems and has recommended safeguards for the use of coercion in psychiatry, not challenging the routine itself. One of the main instruments providing guidance on the procedures for involuntary detention and treatment is the MI Principles,[4] adopted by the United Nations General Assembly in 1991. The document became a critical global step in recognising mental health issues within the human rights arena and established the most comprehensive international human rights standards for persons with mental disorders. However, the MI Principles have been criticised as offering *"in some cases a lesser degree of protection than that offered by existing human rights treaties",* for example with regard to the requirement for prior informed consent to treatment.[5] More importantly, instruments like these may be seen as obsolete with the emergence of the United Nations Convention on the Rights of Persons with Disabilities (the CRPD).[6]

The CRPD was adopted by the United Nations General Assembly on 26 December 2006 and it entered into force on 3 May 2008. The Convention is the first comprehensive human rights treaty protecting persons with disabilities, including those who have mental impairments. Its adoption was greeted with enthusiasm by persons with disabilities and future State Parties, having the highest number of signatories in the history of UN treaties on its opening day.[7] The Convention embodies a paradigm shift from a medical to a social model of disability. Now the focus is not on person's impairment, but on the interaction of the individual with an environment that does not accommodate that individual's differences.[8] The treaty also reflects a human rights approach where persons with

[4] The Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, 17 December 1991, UN doc. A/RES/46/119.
[5] Report of the UN Secretary-General, Progress of efforts to ensure the full recognition and enjoyment of the human rights of persons with disabilities, GA, 58th session, 27 July 2003, UN doc. A/58/181, para 13.
[6] Convention on the Rights of Persons with Disabilities, concluded 26 December 2006, entered into force 3 May 2008, A/RES/61/106.
[7] 83 States signed the CRPD on 30 March, 2007. To compare, the UN Convention on Enforced Disappearance was signed by 58 States on its opening day a few weeks earlier. See United Nations Treaty Collection, available at: https://treaties.un.org (last visited 22 August 2018).
[8] *The Convention on the Rights of Persons with Disabilities Training guide*, Professional Training Series No. 19, UN Office of the High Commissioner for Human Rights, 2014, p 9, available to download at http://www.ohchr.org/Documents/Publications/CRPD_TrainingGuide_PTS19_EN%20Accessible.pdf (last visited 22 August 2018).

disabilities are not merely seen as objects of charity and pity but are holders of rights. This transition from 'objects' to 'subjects' has been regarded as a *"profound message"* in the Convention.[9]

The CRPD may seriously challenge the way we treat people with mental disorders. The Convention guarantees to persons with mental impairments equal right to enjoy legal capacity (Article 12), as well as the rights to liberty (Article 14), physical and mental integrity (Article 17) independent living (Article 19), and to health care on the basis of free and informed consent (Article 25). The revolutionary implications of the abovementioned articles on mental health law have been voiced by various United Nations and regional bodies. Nevertheless, the traditional approach to compulsory interventions within the human rights field co-exists alongside these novel ideas. The extent (if any) to which involuntary measures can now be applied towards persons with mental disorders is to be assessed.

1.2. Research problem and significance of the study

Despite informed consent being at the core of modern day clinical practice, involuntary interventions remain common in mental health field. Traditionally, international and regional human rights law authorises non-consensual psychiatric hospitalisation and treatment under certain circumstances. For example, the UN MI Principles lists instances when psychiatric treatment can be given to a patient without his informed consent[10] and the European Convention on Human Rights directly allows for deprivation of liberty of 'persons of unsound mind'.[11] Relatively new UN Disability Convention, however, has cast a doubt on whether such measures can be justified same as before.

The pressing challenge is to respect the person's autonomy, on the one hand, and, on the other, respond to the needs of, and/or risks posed by, someone having a mental disorder and not consenting to the proposed intervention. Involuntary placement of persons in a mental health hospital or ward and treating them regardless of their consent have become a common means to address a crisis situation in

[9] Quinn, Gerard, Resisting the 'Temptation of Elegance': Can the Convention on the Rights of Persons with Disabilities Socialise States to Right Behaviour? in Arnardóttir Oddný, Mjöll and Quinn, Gerard (eds), *The UN Convention on the Rights of Persons With Disabilities: European and Scandinavian Perspectives*, Martinus Nijhoff Publishers, 2009, p. 216.
[10] *supra* note 4: MI Principles, 1991, Principle 11.
[11] Council of Europe, European Convention for the Protection of Human Rights and Fundamental Freedoms, as amended by Protocols Nos. 11 and 14, concluded 4 November 1950, entered into force 3 September 1953, ETS 5, Article 5(1)(e).

mental health care. The purpose of the thesis is to examine how contemporary human rights law tackles this situation.

Until recently, the topic of involuntary measures in psychiatry has not been very visible in human rights discourse. As Prof. Perlin recalls, mainstream human rights protection systems had difficulty acknowledging mental disability rights as part of their mandates. This problem was sometimes articulated in rather unfortunate ways: *"We work in human rights, not mental disability rights."*[12] The situation within the legal literature began to change with the publication of Rosenthal's and Rubenstean's ground-breaking article in 1993.[13] There international human rights principles were for the first time applied to the institutionalisation of persons with mental disorders. Since then, many scholars started to approach the field from the human rights perspective, including Quinn, Perlin, Bartlett and Szmukler (their respective ideas will be mentioned in this work). In 2017 Anna Nilsson has defended her doctoral dissertation on the permissibility of compulsory mental health interventions under the UN CRPD.[14]

Overall, today there is ample literature on involuntary psychiatric interventions from the human rights perspective. However, the vast majority of recent publications focus exclusively on the UN Disability Convention, or, at most, compare the CRPD with a specific regional instrument or national regime. There is barely anything that would take a broader look on both international and regional human rights standards regarding involuntary hospitalisation and treatment. This work aims to fill this space and take a comprehensive look at the contrasting approaches to involuntary interventions around different world regions and within the United Nations scope.

The research problem is thus the following: "The compatibility of involuntary placement and treatment of persons with mental disorders with international and regional human rights standards". The term 'mental disorder' will be defined later in this chapter, while the terms 'involuntary placement' and 'involuntary treatment' will be explained in their corresponding chapters.

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[12] Perlin, Michael, *International Human Rights and Mental Disability Law: When the Silenced are Heard,* Oxford University Press 2012, p. 10.
[13] Rosenthal, Eric & Rubenstein, Leonard S., "International human rights advocacy under the "principles for the protection of persons with mental illness" in *International Journal of Law and Psychiatry*, Vol. 16, Issues 3–4, pp. 257-300, 1993.
[14] Nilsson, Anna, *Minding Equality: Compulsory Mental Health Interventions and the CRPD,* Doctoral thesis (monograph), 2017, Lund: Lund University (Media-Tryck). 230 p.

1.3. Method and sources

In preparing the thesis legal dogmatic method shall be applied. The content of legal rules (norms) shall be studied, interpreted and systematised. While conducting research and analysis of the law, principal attention will be given to existing normative framework (*lex lata*). However, the relevant drafts of international legal instruments (*lex ferenda*) will be discussed as well.

Primary sources of the research comprise of international and regional human rights documents which legally bind states that have ratified them. Specific binding instruments to be analysed or mentioned in the thesis can be found under the 'Treaties' section of the Bibliography. The UN Disability Convention, the CoE Convention on Human Rights and the Inter-American Disability Convention,[15] however, will be subject to closer scrutiny. This is due to the special relevance of these instruments to the subject of involuntary interventions towards persons with mental disorders. Although having less legal weight, 'soft law' sources reflect international agreement on good practice and can also influence the practice of states. Thus, human rights guidelines enshrined in international and regional declarations, resolutions or recommendations will be also referred to. Other documents of the United Nations and regional bodies (e.g.: guidelines, concluding observations, special reports) are to be consulted as well. Finally, the subsidiary means for determining rules of law will be applied, namely the case law of regional judicial institutions and scholarly literature.

1.4. Limitations and structure

The focus of the thesis is involuntary placement and treatment of persons with mental disorders in the context of international human rights law. What the term *'a person with a mental disorder'* entails will be explained in the next subsection, while the meaning of *involuntary placement* and *treatment* will be covered in the following chapters. Still, some delimitations of this work can be mentioned already at this stage. These are the following:

[15] Organization of American State, Inter-American Convention on the Elimination of All Forms of Discrimination against Persons with Disabilities, concluded 7 June 1999, entered into force 14 September 2001, OAS doc. AG/RES. 1608 (XXIX-O/99).

1) The research will focus only on mental health interventions concerning adults (over 18 years old), while the challenges related to minors within the mental health system will not be dealt with;
2) Attention will be given only to mental conditions which are treatable in principle; non-treatable conditions like life-long learning disability or personality disorders (e.g. psychopathy) will not be covered;
3) The subject of forensic psychiatry, i.e. insanity defence or treatment of mentally ill offenders, will be excluded;
4) Community treatment orders (outpatient commitment) will not be the focus of this work

The above delimitations are necessary in narrowing the research problem to what seem the most essential aspects of the topic. Tackling minors or criminals with mental disorders in this work, for example, would make it unnecessarily cumbersome while distracting from the core issues. Thus, it was deemed worthwhile to give preference to depth over width when it comes to the topic of involuntary interventions in psychiatry.

Moreover, not just any interventions into the lives of persons with mental disorders will be tackled. It is true that the autonomy of a mental health patient may be infringed in everyday healthcare, including decisions related to meals, personal hygiene, physical activities and security.[16] This study, however, will not explore such instances, as well as the issues related to treatment of somatic illnesses that persons with mental disorders might have. It will focus on involuntary placement and treatment within the mental health institutions as primary and most problematic examples of coercive measures in psychiatry.

Comparing regional human rights instruments with international ones shall be part of the discussion. The development of certain approaches to involuntary interventions on the regional level will be given as much attention as the manifestation of these approaches on a global level. While the examples of individual states' mental health legislation will be used to provide some context, the comprehensive analysis of selected national law would not be conducted. This is to keep the thesis

[16] Aasen, Henriette Sinding, Chapter 5. Autonomy, human dignity and treatment of individuals with cognitive impairment, in *Aasen, Henriette Sinding, Halvarson, Rune and Silva, António Barbosa (eds) Human rights, dignity and autonomy in healthcare and social services: Nordic perspectives*, Intersentia, 2009, p. 105.

centred on international and regional human rights law relevant for involuntary mental health care and avoid lengthy diversions from the main focus of the thesis.

The thesis will comprise of three core chapters, besides the introduction and conclusion. These are the chapters on legal capacity, involuntary placement and involuntary treatment. Even though one does not need to be officially devoid of legal capacity and appointed a guardian to be placed and treated involuntary, the lack of capacity and involuntary interventions in mental health care are often related. Inclusion of the chapter on legal capacity would thus provide certain context and help to comprehend the other chapters better.

The chapters on involuntary placement and treatment will be organised by different approaches to these practices in international and regional human rights law. Specifically, 2-3 distinct approaches will be discussed as they are applied on both universal and regional levels, different regions being tackled separately. The aim of such structure is to make the discussion consistent and clear while not deeming it repetitive or overly-descriptive. The research problem will be resolved in the conclusion and some proposals of reconciling the conflicting international and regional standards will be offered.

1.5. Defining 'persons with mental disorders'

Various international and regional instruments fully dedicated or partially related to mental health use different terms to refer to their target group. These include 'persons of unsound mind'[17], 'insane and mentally abnormal' persons,[18] 'the mentally disadvantaged',[19] 'mentally retarded persons',[20] 'mentally disabled persons'[21] (also 'people with mental disabilities'[22]), 'the mentally ill'[23]

[17] ECHR, 1950.
[18] UN Standard Minimum Rules on the treatment of prisoners, adopted on 30 August 1955 by the United Nations Congress on the Prevention of Crime and the Treatment of Offenders, Geneva, approved by the Economic and Social Council in resolutions 663 C (XXIV) of 31 July 1957 and 2076 (LXII) of 13 May 1977.
[19] Declaration on Social Progress and Development, 11 December 1969, adopted by the UN General Assembly Resolution 2542 (XXIV).
[20] Declaration on the Rights of Mentally Retarded Persons, adopted by the UN General Assembly, 20 December 1971, UN doc. A/RES/2856 (XXVI).
[21] Declaration on the Rights of Disabled Persons, adopted by the UN General Assembly, 9 December 1975, UN doc. A/RES/3447 (XXX).
[22] Access to rights for people with disabilities and their full and active participation in society, Council of Europe Parliamentary Assembly Resolution 1642 (2009), 26 January 2009.

(also 'persons with mental illness'[24],), 'persons suffering from mental disorder'[25] (also 'persons who have a mental disorder'[26] or 'persons with mental disorder'[27]), '[mentally] handicapped',[28] 'persons with psychiatric disabilities' [29] and 'persons who have mental impairments'. [30] Few of the abovementioned sources define persons with mental disorder (or the equivalent term) though. Nevertheless, the 1975 UN Declaration on the Rights of Disabled Persons provides a definition that is worth comparing with the more recent UN Disability Convention in this respect.

The 1975 Declaration holds that *"[t]he term "disabled person" means any person unable to ensure by himself or herself, wholly or partly, the necessities of a normal individual and/or social life, as a result of deficiency, either congenital or not, in his or her physical or mental capabilities."*[31] From this definition follows that a person with a mental disorder is deficient in her mental capabilities, which makes it problematic for her to function normally. The emphasis here is put onto the impairment as something that hinders individual's personal and social development.

The 2006 UN CRPD, however, utilises a different perspective in its definition of persons with disabilities. Here they *"include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others."*[32] We can see that the CRPD provides an illustrative description of persons with disabilities rather than an exhaustive definition (*'include those who'*, *'may hinder'*).[33] More importantly, it does not focus exclusively on a disorder as a limiting

[23] World Programme of Action concerning Disabled Persons, adopted by the UN General Assembly Resolution 37/52, 3 December 1982.
[24] supra note 4: MI Principles, 1991.
[25] Recommendation No. R (83) 2 of the Committee of Ministers to member states concerning the legal protection of persons suffering from mental disorder placed as involuntary patients, Council of Europe, 22 February 1983.
[26] Council of Europe, Convention for the protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine, concluded 4 March 1997, entered into force 1 December 1999, ETS 164.
[27] Recommendation No. Rec(2004)10 of the Committee of Ministers to member states concerning the protection of the human rights and dignity of persons with mental disorder and its Explanatory Memorandum, adopted by the Council of Europe Committee of Ministers on 22 September 2004.
[28] Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights "Protocol of San Salvador", concluded 17 November 1988, entered into force 16 November 1999.
[29] Equalization of opportunities for persons with disabilities, the UN Economic and Social Council Resolution 1997/19, 21 July 1997.
[30] CRPD, Article 1(2).
[31] *supra* note 21, Declaration on the Rights of Disabled Persons, 1975, para 1.
[32] CRPD, Article 1(2).
[33] Thus, the CRPD Committee itself has concluded that persons with short-term impairments are also covered under the Convention, despite it referring to persons with long-term impairments only. See *Ms S.C. vs. Brazil*, Committee on the

factor in one's development. The Disability Convention acknowledges that various social barriers play an equal, if not a bigger role in hindering one's participation in a specific society.

Since the CRPD definition is more recent, can be found in a binding instrument and since it embodies more progressive ideas, we should note it in this work. However, the phrasing *'persons with mental disorders'* will usually be used here instead of the terms *'persons with mental disabilities'* or *'persons with mental impairments'*.[34] This decision was made to match the language used in the world's most common manuals for mental health: the International Classification of Diseases (ICD), maintained by the WHO (with its Chapter V dedicated to *'Mental and behavioural disorders'*),[35] and the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association.[36] In the current versions of these documents and in the most recent revised draft of ICD (ICD-11)[37] the term 'disorder' is used consistently to refer to various types of mental impairments (psychotic disorders, mood (affective) disorders, eating disorders etc.).

Thus, while the UN Disability Convention emphasises the societal barriers in its definition of disability, we will opt for a narrower medical term of 'disorder'. This may seem like a step backwards, but it will better encompass the approach still found in most international instruments as well as in national legislation. Those sources do not pay sufficient attention to the social dimension of disability, meaning that the phrase 'persons with mental disorders' would seem more adequate when discussing them. While there is no official definition of the term 'mental disorder', it is possible to describe it by its characteristics. Professor Derek Bolton discusses the following attributes of a mental disorder, relying on the abovementioned health manuals:

- a clinically recognisable set of symptoms (a behavioural or mental pattern)

Rights of Persons with Disabilities, Communication No. 10/2013, 28 October 2014, UN doc. CRPD/C/12/D/10/2013, para 6.3.

[34] An alternative term, used by the CRPD Committee, is *'persons with psychosocial disabilities/impairments'* and appears to be interchangeable with *'persons with mental disabilities/impairments'*. See e.g., UN Committee on the Rights of Persons with Disabilities, Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities – The right to liberty and security of persons with disabilities, adopted at the CRPD 14th Session (17 August – 4 September 2015), paras 1, 3, 14.

[35] International Statistical Classification of Diseases and Related Health Problems 10th Revision, World Health Organisation, version of 2016, available at: http://apps.who.int/classifications/icd10/browse/2016/en (last visited 22 August 2018).

[36] Diagnostic and Statistical Manual of Mental Disorders (DSM), American Psychiatric Association, 2013, available at: https://www.sciencetheearth.com/uploads/2/4/6/5/24658156/dsm-v-manual_pg490.pdf (last visited 22 August 2018).

[37] International Statistical Classification of Diseases and Related Health Problems 11th Revision, WHO, released on 18 June 2018 for preparing implementation, available at: https://icd.who.int/browse11/l-m/en (last visited 22 August 2018).

- related to significant distress and interference with personal functions (associated with harm)
- not being a mere deviation from social norms (e.g. political or sexual)
- not being a culturally expectable response to a particular event (e.g. the death of a loved one).[38]

Consequently, for the purposes of this study 'a person with a mental disorder' means someone who displays the listed characteristics.

[38] Bolton, Derek, *What is Mental Disorder?: An Essay in Philosophy, Science, and Values*, Oxford University Press, 2008, p. 6.

CHAPTER 2: LEGAL CAPACITY OF PERSONS WITH MENTAL DISORDERS

2.1. Understanding human autonomy

The protection of the autonomy of the individual is a cornerstone of modern thinking on human rights, with roots back to the Age of Enlightenment and the ethical philosophies of humanism, affirming the dignity and worth of all human beings.[39] It was German philosopher Immanuel Kant who brought the concept of moral autonomy into prominence, seeing it as a unique feature of humans as reasonable beings and an expression of their dignity.[40] The idea of autonomous person as an independent agent with full responsibility for his or her life is typical in Western societies as a normative ideal for human beings.[41] At the same time, the term 'autonomy' (from Greek *autos* – oneself and *nomos* – law) remains difficult to define, and law philosopher Gerald Dworkin points out at least fourteen meanings of the word:

> *... '[A]utonomy' ... is used sometimes as an equivalent to liberty ..., sometimes as equivalent to self-rule or sovereignty, sometimes as identical with freedom of the will. It is equated with dignity, integrity, individuality, independence, responsibility, and self-knowledge. It is identified with qualities of self-assertion, with critical reflections, with freedom from obligations, with absence of external causation, with knowledge of one's own interests ... About the only features held constant from one author to another are that autonomy is a feature of persons and that it is a desirable quality to have.*[42]

While this might be a valid observation, for the purposes of the study a more definite approach to the concept of autonomy should be adopted. To bring some substance to the term, it is useful to

[39] Bernt, Jan Fridthjof, Preface. The welfare state and protection of individual autonomy, in Aasen, Henriette Sinding, Halvarson, Rune and Silva, António Barbosa (eds) *Human rights, dignity and autonomy in healthcare and social services: Nordic perspectives*, Intersentia, 2009, p. v.

[40] Silva, António Barbosa, Chapter 1. Autonomy, dignity and integrity in health care ethics, in Aasen, Henriette Sinding, Halvarson, Rune and Silva, António Barbosa (eds) *Human rights, dignity and autonomy in healthcare and social services: Nordic perspectives*, Intersentia, 2009, p.15.

[41] Aasen, Henriette Sinding, Halvarson, Rune and Silva, António Barbosa, Conclusions and challenges, in Aasen, Henriette Sinding, Halvarson, Rune and Silva, António Barbosa (eds) *Human rights, dignity and autonomy in healthcare and social services: Nordic perspectives*, Intersentia, 2009, p. 208.

[42] Dworkin, Gerald, *The Theory and Practice of Autonomy. Cambridge Studies in Philosophy*, Cambridge University Press, 1988, p. 6.

consider the post-Kantian humanism viewpoint in this relation. Post-Kantian humanists talk about autonomy in a threefold sense: the individual's freedom of the will (ability to think up alternative courses of actions and reflect upon one's preferences), freedom of choice (ability to choose one alternative action) and freedom of action (ability to realise the chosen action).[43] Autonomy is thus understood as a person's ability to exercise his or her free will, free choice and action without intervention from outside forces.[44] Actual freedom in these three senses may vary by individual, and in the same individual it may vary by situation. However, from a humanistic perspective, persons whose actual capacity of autonomous decision-making is diminished have the same inherent human dignity as every other person.[45] Even if an individual does not exhibit reason or free will in the given circumstances (e.g. due to illness or being imprisoned), he or she is still a potentially rational and autonomous human being, with inalienable dignity and worth.[46]

In a health care setting the idea of autonomy finds expression in a principle of informed consent. The main rule of 'free and informed consent' is established as a legal norm in the health care legislation of most Western civil law and common law countries, as well as laid down in international law.[47] The European Convention on Human Rights and Biomedicine (the Oviedo Convention) sets as a general rule that *"[a]n intervention in the health field may only be carried out after the person concerned has given free and informed consent to it"*.[48] The Convention on the Rights of Persons with Disabilities expects health professionals to provide care of the same quality to persons with disabilities as to others, *"including on the basis of free and informed consent".*[49] The requirement of informed consent, as put forward in several human rights instruments and national legislation, is not only an essential right of every patient, but also the main legal way of securing respect for human autonomy.[50] Besides, *"[r]espect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons"* is the first on the list of CRPD principles.[51]

[43] *supra* note 40: Silva, António Barbosa (2009), p.17.
[44] *supra* note 40: Silva, António Barbosa (2009), p.46.
[45] *supra* note 16: Aasen, Henriette Sinding (2009), p.107.
[46] *supra* note 40: Silva, António Barbosa (2009), pp. 18, 35, 46.
[47] *supra* note 1: Aasen, Henriette Sinding (2009), p.65.
[48] *supra* note 26: Convention on Human Rights and Biomedicine, 1997, Article 5.
[49] CRPD, Article 25(1)(d).
[50] *supra* note 16: Aasen, Henriette Sinding (2009), p.127.
[51] CRPD, Article 3.

Dworkin holds that *"[t]he purpose of requiring the patient's consent to treatment is to protect his physical and psychic integrity against unwanted invasions, and to permit the patient to act as an autonomous being"*.[52] However, the individualistic view of an autonomous human being does not fit situations in which the person is in a state of vulnerability and dependency (e.g. due to severe impairment, a comatose state or a serious mental illness). Hence, in Western health care ethics today autonomy is used in a changeable post-Kantian humanistic sense, meaning that the person may lose his or her full autonomy in certain circumstances.[53] An attempt to protect individual autonomy in situations where the patient is not able to understand the implications of (not) consenting to proposed treatment may lead to serious, even fatal, consequences for the patient. In such cases health care professionals may at times refrain from respecting the patient's diminished autonomy and deviate from the principle of informed consent for the sake of respecting his or her dignity, integrity and basic rights.[54]

As Dworkin points out, there are values of fundamental moral importance and of crucial significance to any person, including dignity, health, well-being, integrity and security.[55] In order to promote any of these values it may be necessary to sacrifice some autonomy. Moreover, according to the scholar, promotion of autonomy in the long run may require sacrificing autonomy in the short run.[56] An example is the violation of the personal autonomy to protect the individual's right to life or health in emergency situations, when consent to treatment cannot be obtained because the person is unconscious.

Thus, in certain situations it seems ethically and legally justifiable to give preference to the protection of dignity, life and health (as the values that most urgently need protection) at the expense of the person's autonomy. This prioritisation suggests a form of 'ranking' and balancing the values and rights involved, in situations where they cannot all be upheld simultaneously.[57] Indeed, the tension between the right to autonomy and other values constitutes a constant dilemma in the provision of many health services.[58] Characteristic in such situations is that the conflict of interests is often related

[52] *supra* note 42: Dworkin (1988), p. 102.
[53] *supra* note 40: Silva, António Barbosa (2009), p. 51.
[54] *supra* note 40: Silva, António Barbosa (2009), pp. 46, 52.
[55] *supra* note 42: Dworkin (1988), p. 114.
[56] *ibid*.
[57] *supra* note 1: Aasen, Henriette Sinding (2009), p. 63.
[58] *supra* note 16: Aasen, Henriette Sinding (2009), p. 106.

to the same person, as opposed to conflicts of interests between the person concerned and society or between the person and other persons.[59]

2.2. Legal capacity of persons with mental disorders

The international human rights law seems to be more supportive of human dignity in general rather than the autonomy of a human being. Indeed, the protection of human dignity is fundamental to the human rights framework of the United Nations.[60] It has been incorporated into the Charter of the United Nations (UN Charter)[61], the Universal Declaration of Human Rights (UDHR)[62] and many other documents of the United Nations, including all the United Nations' core treaties on human rights.[63] The preamble of the UN Charter reaffirms *"faith in ... the dignity and worth of the human person"*. The preamble to the UDHR also begins by recognising the *"inherent dignity ... of all members of the human family".* In its proclamation of human rights, the UDHR first guarantees in Article 1 that *"[a]ll human beings are born free and equal in dignity and rights"*. Thus, both documents place the protection of human dignity at the top of their actual formulation[64], while the value of autonomy earned the mention in neither of them.

The aforementioned idea of compromising the patient's autonomy for the sake of upholding other values is reflected in a long tradition of the involuntary hospitalisation and treatment of psychiatric patients. The latter constitutes a wide exception from the general rule of autonomy and informed consent.[65] This exception stems from the observation that some individuals in obvious need

[59] *supra* note 16: Aasen, Henriette Sinding, p. 105.
[60] Kämpf, Annegret, Involuntary Treatment Decisions: Using Negotiated Silence to Facilitate Change? in McSherry, Bernadette & Weller, Penelope (eds), *Rethinking Rights-Based Mental Health Laws*, Hart Publishing, 2010, p. 134.
[61] Charter of the United Nations, 24 October 1945, 1 UNTS XVI.
[62] Universal Declaration of Human Rights, 10 December 1948, adopted by the UN General Assembly Resolution 217 A (III).
[63] see e.g. International Covenant on Civil and Political Rights, concluded 16 December 1966, entered into force 23 March 1986, United Nations, Treaty Series, vol. 999, p. 171, Preamble: *"recognition of the inherent dignity ... is the foundation of freedom, justice and peace in the world"*, Article 10: *"[a]ll persons deprived of their liberty shall be treated ... with respect for the inherent dignity of the human person"*; International Covenant on Economic, Social and Cultural Rights, concluded 16 December 1966, entered into force 3 January 1976, United Nations, Treaty Series, vol. 993, p. 3, Preamble: *"recognition of the inherent dignity ... is the foundation of freedom, justice and peace in the world"*, Article 13: "*education shall be directed to the full development of the human personality and the sense of its dignity".*
[64] *supra* note 60: Kämpf, Annegret, p. 134.
[65] *supra* note 1: Aasen, Henriette Sinding, pp. 63-64.

of psychiatric care and treatment may not be able to give full and valid consent to proposed interventions. As Dr. Aasen illustrates:

> *If a person with serious dementia clearly does not understand the implications of a particular treatment or of no treatment at all, but smiles and says 'yes' or repeatedly says 'no' to everything, determining his or her wishes is very difficult. Thus, an appeal to respect for 'autonomy' and the requirement of 'informed consent' clearly will not sufficiently safeguard the person's interests or dignity. ... [In fact], when the patient has a serious mental disability, the requirement of informed consent may become almost meaningless.*[66]

Thus, respecting the patients' refusal of psychiatric treatment and care, especially when they are not able to fully protect themselves through the exercise of informed consent, is not necessarily a good solution.

Coercion towards individuals with serious mental health problems is an example of paternalistic policies that are widely recognised as ethically and legally justified. The paternalistic principle of beneficence – even when benevolent act violates the liberty of the person concerned – is based on a general trust in the ability of experts in different fields (doctors, psychologists) to make sound ethical and professional judgements about what is in the best interest of the patient or for society.[67] It follows from the Biomedicine Convention that *"any intervention in the health field ... must be carried out in accordance with relevant professional obligations and standards".*[68] Indeed, when determining individual needs in a situation where valid consent to treatment cannot be obtained, one must rely heavily on the professional standards in the field.[69]

In addition to being sensitive ethical issues among health professionals, individual's autonomy and ability to consent constitute important legal concepts. The law will not recognise consent to medical treatment, nor a refusal of medical treatment unless it is made with capacity. Only decisions

[66] *supra* note 16: Aasen, Henriette Sinding, p. 106.
[67] *supra* note 1: Aasen, Henriette Sinding, p. 56.
[68] *supra* note 26: Convention on Human Rights and Biomedicine, 1997, Article 4.
[69] *supra* note 16: Aasen, Henriette Sinding, p. 109.

made with capacity are regarded as autonomous and thus worthy of legal respect.[70] Since there is no internationally accepted definition of legal capacity, we will refer to the definition proposed by the Office of the High Commissioner for Human Rights:

> *The concept of 'legal capacity' is a wider concept [that is, wider than legal personality] that logically presupposes the capability to be a potential holder of rights and obligations (static element), but also entails the capacity to exercise these rights and to undertake these duties by way of one's own conduct, i.e. without assistance of representation by a third party (dynamic element).*[71]

The static element is sometimes referred to as 'capacity for rights' and the dynamic element as 'capacity to act'.[72] Being the law's recognition of the decisions that a person takes, legal capacity makes a person an active subject of law, and a bearer of legal rights and obligations in all areas of life.[73] However, while the 'capacity to be a person before the law' belongs to all human beings since the moment of birth and is lost only with death, legal capacity is more fluid. Traditionally, it has been recognised that exercise of legal capacity depends on the possession of additional requirements such as minimum age and the capacity to understand the meaning of one's actions and their consequences.[74]

We can distinguish three main approaches to assessing legal capacity (and attributing incapacity): the status approach, the outcome approach and the functional approach.[75] According to the status approach, once it is established that any individual is, for example, a person with disability, the law presumes a lack of capacity. This approach is applied in the UN MI Principles, according to which

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[70] Richardson, Genevra, Right-based Legalism: Some Thoughts from the Research, in McSherry, Bernadette & Weller, Penelope (eds), *Rethinking Rights-Based Mental Health Laws*, Hart Publishing, 2010, p. 187.
[71] Background Conference Document Prepared by the Office of the United Nations High Commissioner for Human Rights: Legal Capacity, 2005, para 37, available at: www2.ohchr.org/SPdocs/CRPD/DGD21102009/OHCHR_BP_Legal_Capacity.doc (last visited 22 August 2018).
[72] Minkowitz, Tina, Abolishing Mental Health Laws to Comply with CRPD, in McSherry, Bernadette & Weller, Penelope (eds), *Rethinking Rights-Based Mental Health Laws*, Hart Publishing, 2010, p. 159.
[73] *Legal capacity of persons with intellectual disabilities and persons with mental health problems*, Report by the European Union Agency for Fundamental Rights, 2013, p. 9.
[74] supra note 71: Background Conference Document, para 25.
[75] Dhanda, Amita, "Legal Capacity in the Disability Rights Convention: Stranglehold of the Past or Lodestar for the Future?" in *Syracuse Journal of International Law and Commerce*, Vol. 34, No. 2, 2007, pp. 431-433.

the decision that a person lacks legal capacity can be made *"by reason of his or her mental illness"*.[76] Under status approach, the person either has full legal capacity or lacks capacity entirely.[77]

Someone adhering to the functional approach, on the other hand, would not link the fact of disability alone to a finding of incompetence. Instead, the person with disability would be considered incapable if, by reason of the disability, he or she is unable to perform a specified function.[78] Thus, this approach involves a consideration of legal capacity on an issue-specific basis: a person might not be able to make decisions of a financial nature but might be considered to have capacity to make personal care decisions.[79]

Finally, the outcome approach is rooted in the belief that in circumstances where a person makes a bad decision or a number of bad decisions that person should lose the right to continue to make decisions.[80] For example, if a person with mental disorder decides to discontinue psychiatric treatment despite having voluntarily sought it at first, the person's competence to discontinue treatment is questioned.[81] This approach to capacity is now seen as outdated. In the Mental Healthcare Act of India (2017), for instance, it is explicitly stated that:

> *[w]here a person makes a decision regarding his mental healthcare or treatment which is perceived by others as inappropriate or wrong, that by itself, shall not mean that the person does not have the capacity to make mental healthcare or treatment decision…*[82]

All of the approaches mentioned have been criticised as being over inclusive with the burden to prove one is not incapable placed upon the person.[83] The UN CRPD, on the other hand, seems to move away from these approaches, signifying a new mindset for the topic of legal capacity.

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[76] *supra* note 4: MI Principles, Principle 1(6).
[77] O'Mahony, Charles, "Legal capacity and detention: implications of the UN disability convention for the inspection standards of human rights monitoring bodies" in *The International Journal of Human Rights*, Vol. 16, Issue 6, 2012, p. 886.
[78] *supra* note 75: Dhanda, Amita (2007), p. 431.
[79] supra note 77: O'Mahony, Charles (2012), p. 886.
[80] *ibid.*
[81] *supra* note 75: Dhanda, Amita (2007), pp. 431-432.
[82] Mental Healthcare Act No. 10 of 2017, Ministry Of Law And Justice, India, 7 April 2017, Chapter 1, Section 4(3).
[83] *supra* note 75: Dhanda, Amita (2007), p. 433.

2.3. Revolutionary approach to legal capacity

The important starting point of the UN Disability Convention is that it clearly recognises persons with disabilities as equal bearers of human rights and fundamental freedoms.[84] In addition, respect for *"individual autonomy including the freedom to make one's own choices"* is one of the general principles of the treaty.[85] These ideas underlie the presumption that persons with disabilities are full subjects of law, capable of making legally valid decisions. The latter was translated into far-reaching Article 12 on equal recognition before the law.

Article 12(1) of the CRPD reaffirms that *"persons with disabilities have the right to recognition everywhere as persons before the law".* Article 12(2) requires the contracting states to *"recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life"*. The Office of the High Commissioner for Human Rights interprets this as meaning *'[w]hether the existence of a disability is a direct or indirect ground for a declaration of legal incapacity, legislation of this kind conflicts with […] article 12, paragraph 2."*[86] The Article further deliberates that persons with disabilities shall have access to the support they might require in exercising their legal capacity and that appropriate and effective safeguards against the abuse of such support must be established. The goal of these safeguards is to ensure that the person's 'will and preferences' are respected,[87] marking a shift away from 'best interests' or protection approach.[88]

The provision on legal capacity is at the core of Article 12, which might as well be a pivotal Article of the Convention. It was regarded as triggering a significant change in how legal capacity is approached and empowering persons with disabilities to have control over their lives.[89] At the same time, CRPD admits that some persons with disabilities may require help in exercising their legal

[84] see, in particular, the Convention's Preamble (c) and Article 1.
[85] CRPD, Article 3(a).
[86] Thematic Study by the Office of the United Nations High Commissioner for Human Rights on enhancing awareness and understanding of the Convention on the Rights of Persons with Disabilities, 26 January 2009, UN doc. A/HRC/10/48, para 45.
[87] CRPD, Article 12(4).
[88] see, e.g. Convention on the Rights of the Child, adopted by UN GA Resolution 44/25 of 20 November 1989, entered into force 2 September 1990, Article 3(1).
[89] Morten Kjaerum, Foreword to *Legal capacity of persons with intellectual disabilities and persons with mental health problems*, Report by the European Union Agency for Fundamental Rights, 2013.

capacity. However, Article 12 aims to facilitate decision-making *with* the person, rather than *for* the person, and moves away from the concept of substituted decision-making in favour of supported one.[90]

The Disability Convention authoritative body, the CRPD Committee, defines legal capacity as *"the ability to hold rights and duties (legal standing) and to exercise those rights and duties (legal agency)"*.[91] Therefore, legal capacity affects all areas of life and is an essential tool for opening up all other rights. Indeed, the High Commissioner for Human Rights has highlighted *"the centrality of [Article 12] in the structure of the Convention and its instrumental value in the achievement of numerous other rights".*[92] The key role of Article 12 is reinforced by the fact that the CRPD Committee has prepared its first General Comment specifically on interpreting its provisions.

As acknowledged in the said General Comment persons with cognitive or psychosocial disabilities remain the group whose legal capacity is most commonly denied in legal systems worldwide.[93] Since such persons are often considered to have impaired decision-making skills, their legal capacity to make a particular decision is consequently removed. CRPD Committee's explains that this happens due to the concepts of legal capacity and mental capacity being (mistakenly) conflated.[94] Rather, the Convention's body emphasises that these are distinct concepts, the latter referring to varying decision-making skills of a person, which must not be used as justification for denying legal capacity (*"an inherent right accorded to all people"*).[95]

Adhering to its views, the Committee often voices concern over national legislation allowing for the deprivation of a person's legal capacity and the appointment of a guardian, on the grounds of psychosocial and/or intellectual disabilities. In one of its recent concluding observations the body urged the Republic of Moldova to *"restore the full legal capacity of all persons with disabilities and review its guardianship system with the aim of introducing supported decision-making mechanisms"*.[96] Ultimately, the goal is to abolish substitute decision-making regimes entirely, not keep them in parallel

[90] *supra* note 60: Kämpf, Annegret, p. 144.
[91] General comment No. 1, Article 12: Equal recognition before the law, Committee on the Rights of Persons with Disabilities, 19 May 2014, UN doc. CRPD/C/GC/1, para 13.
[92] *supra* note 86: Thematic Study by the OHCHR, para 43.
[93] *supra* note 91: General comment No. 1, paras 8-9.
[94] *supra* note 91: General comment No. 1, para 15.
[95] *supra* note 91: General comment No. 1, paras 13-14.
[96] UN Committee on the Rights of Persons with Disabilities, Concluding observations on the initial report of the Republic of Moldova, 18 May 2017, UN doc. CRPD/C/MDA/CO/1, para 25(b).

with the development of supported decision-making.[97] This ambition stems from a premise that all persons retain legal capacity and that with the right level of support people with disabilities (including mental ones) are able to express their will and preferences like anyone else.[98]

It is worthwhile to note one of the Committee's adoption of views regarding the communication against Australia.[99] Here the body found that *"the decision that the complainant was unfit to plead because of his intellectual and mental disability resulted in a denial of his right to exercise his legal capacity to plead not guilty and to test the evidence against him."*[100] Since he never had the opportunity to have the criminal charges against him determined and his status as an alleged sexual offender potentially cleared, the author could not exercise his rights to access to justice and a fair trial. Therefore, the CRPD Committee found a violation of the author's rights under articles 12(2) and (3) and 13(1) of the Convention (access to justice).[101]

As we can see, the extent of legal capacity to be granted to persons with mental disabilities is noticeably broad. In its reporting guidelines the CRPD Committee urges states to report on:

> *Measures taken by the State Party to ensure that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life, in particular such measures as to ensure the equal right of persons with disabilities to maintain their physical and mental integrity, full participation as citizens, own or inherit property, to control their own financial affairs and to have equal access to bank loans, mortgages and other forms of financial credit, and their right not to be arbitrarily deprived of their property.*[102]

What is worth emphasising is that Article 12 of the Convention and its interpretation by the Committee challenge virtually universal provisions in mental health and capacity law. Never before an international instrument implied that the existence of a mental impairment must never be the ground

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[97] *supra* note 91: General comment No. 1, para 28.
[98] Szmukler, George, "The UN Convention on the Rights of Persons with Disabilities: 'Rights, will and preferences' in relation to mental health disabilities" in *International Journal of Law and Psychiatry*, Vol. 54, 2017, p. 91.
[99] *Mr Noble v Australia*, Committee on the Rights of Persons with Disabilities, Communication No. 7/2012, 10 October 2016, UN doc. CRPD/C/16/D/7/2012.
[100] *ibid*, para 8.6.
[101] *ibid*.
[102] UN Committee on the Rights of Persons with Disabilities, Guidelines on treaty-specific document to be submitted by states parties under article 35, paragraph 1, of the Convention on the Rights of Persons with Disabilities, 18 November 2009, UN doc. CRPD/C/2/3, Section C, Article 12 – Equal recognition before the law.

for denying legal capacity. Indeed, Article 12 is one of the most contentious areas in the Convention, judging by the high number of declarations and reservations that has been lodged on it.[103] Unsurprisingly so, since the Article contests the public's notion of persons with disabilities as lacking decision-making skills and requires substantial reform of the paternalistic legal capacity systems that dominate the world today.[104]

Observation of a former New York judge Kristen Booth Glen is worth quoting in this regard:

> *[The CRPD] sees incapacity as socially constructed, insists on the full legal capacity of every person with [disabilities], and does away with substituted decision-making in favor of society's obligation to provide appropriate supports to permit everyone to make his or her own decisions. Like every emerging paradigm, this challenges our perceptions and our understanding of when, how, and even if the state may intervene in a person's life, and it has the potential to be deeply unsettling. And, unsurprisingly, it takes time… This new conceptualization based on international human rights may initially appear hopelessly utopian, or dangerously naive. Why? Because it is a new way of thinking, a radically different view, a reorientation rather than an incremental change.*[105]

Here the author acknowledges that the Convention's radical take on legal capacity may appear as unrealistic to many. Indeed, not everyone is enthusiastic for the revolutionary approach of the new Convention, and the opposing viewpoints deserve attention as well.

When talking about persons with mental disorders given unlimited freedom to make decisions, an example of somebody about to commit suicide comes to mind. Upholding someone's will in such

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[103] Can be viewed on the website of the United Nations Treaty Collection, available at: https://treaties.un.org (last visited 22 August 2018); e.g. note the reservation of Canada: *"Canada declares its understanding that Article 12 permits supported and substitute decision-making arrangements in appropriate circumstances and in accordance with the law. To the extent Article 12 may be interpreted as requiring the elimination of all substitute decision-making arrangements, Canada reserves the right to continue their use in appropriate circumstances and subject to appropriate and effective safeguards."* and Norway: *"Norway recognises that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life. Norway also recognizes its obligations to take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity. Furthermore, Norway declares its understanding that the Convention allows for the withdrawal of legal capacity or support in exercising legal capacity, and/or compulsory guardianship, in cases where such measures are necessary, as a last resort and subject to safeguards."*

[104] Arstein-Kerslake, Anna, Legal Capacity and Supported Decision-Making: Respecting Rights and Empowering People, in O'Mahony, Charles & Quinn, Gerard (eds), *Disability Law and Policy: an Analysis of the UN Convention*, Clarus Press Ltd., 2017, p. 75.

[105] Booth Glen, Kristin, "Changing Paradigms: Mental Capacity, Legal Capacity, Guardianship, and Beyond" in *Columbia Human Rights Law Review*, Vol. 44, No 1, 2012, pp. 98-99.

situation, abandons them to the (often extreme) consequences of their choices allowing such people to "*die with their rights on"*.[106] In addition, Article 12 of the Convention seems to overlook the prospect of a person being unconscious or having her mental function severely impaired, and who have given no prior indication of her views.[107] Even in such circumstances, when a person's genuine 'will and preferences' are impossible to determine, the treaty makes no exceptions to its legal capacity and supported decision-making concepts.

In the CRPD Committee's understanding to deny a person with disabilities legal capacity (or only a specific form of it) is to deny them *"a core human right — the right to equal recognition before the law"*.[108] Discussing Article 12 of the treaty, the United Nations High Commissioner for Human Rights asserts that *"[n]orms of laws disqualifying a person from office or performing a function on the basis of their disability […] need to be abolished."*[109] Both bodies refuse to recognise that person's impairment may legitimately call for a differential treatment that does not constitute discrimination. As one of the commentators puts it:

> *It is not discrimination to say that a blind person can be denied the right to drive, under the relevant legislation, when they cannot see. Nor is it discrimination to say that a person's firearms license can be suspended when acute paranoid delusions about their neighbours affect their ability to use a weapon responsibly.*[110]

In the author's view, these are the examples of relevant distinctions between the capacities of an impaired person and those of others to safely perform a particular task. Ignoring such distinctions, allegedly in the name of human rights and equality, could seriously endanger the interests of that person or others.

Overall, Article 12 drafters and official interpreters seem to have good intentions – prevent unnecessary removal of legal capacity and support autonomous decision-making – but tend to over-shoot these aims.[111] Moreover, with the treaty's emphasis on social model of disability, the objective

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[106] Treffert, Darold, "Dying with Their Rights On" in *American Journal of Psychiatry*, Volume 130, No 9, 1973, p. 1041.
[107] E.g. by preparing an advance directive or a 'living will' beforehand. See also Dawson, John, "A Realistic Approach to Assessing Mental Health Laws' Compliance with the UNCRPD" in *International Journal of Law and Psychiatry*, Vol. 40, 2015, p. 72.
[108] *supra* note 91: General comment No. 1, para 15.
[109] *supra* note 86: Thematic Study by the OHCHR, para 46.
[110] *supra* note 107: Dawson, John (2015), p. 73.
[111] *supra* note 107: Dawson, John (2015), p. 72.

reality of the impairment is often neglected. Serious mental health issues are not merely social constructs, but are real illnesses, and the differences they cause cannot in all cases *"be equalised by merely supportive social responses"*.[112] At the same time, restricting person's legal capacity too much and making unnecessary involuntary interventions remain a common problem in mental health systems worldwide.

[112] Bartlett, Peter, "The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law" in *Modern Law Review*, Vol. 75, No 5, 2012, p. 759.

CHAPTER 3: INVOLUNTARY PLACEMENT IN PSYCHIATRY

3.1. Overview of the involuntary placement practice and key concepts

Every person has the right to the enjoyment of the highest attainable standard of physical and mental health.[113] Informed consent is recognised as a core element of the right to health, both as a freedom and an integral safeguard to its enjoyment.[114] Ideally, free and informed consent should be at the basis of mental health care like it is in general medical healthcare. Usually mental health legislation indeed aims to promote and facilitate voluntary placement in a mental health facility.[115] However, if obtaining the person's consent is impossible and getting psychiatric help is deemed necessary in a particular case, non-consensual procedures are commonly implemented as an exception.[116]

According to Mental Health Atlas, prepared by the World Health Organisation in 2014, more than one in ten (11.6%) of admissions into mental health facilities around the world were on an involuntary basis.[117] This figure encompasses all facility types: mental hospitals, psychiatric wards in general hospitals and community residential facilities. For mental hospitals more specifically, the global rate of involuntary placements is higher (around 17%) and in some regions reaches more than 60% (South East Asia and Western Pacific Regions).[118] While the majority of inpatients (80%) globally are discharged within one year, in some countries (particularly in the Caribbean) over 65% of psychiatric patients remain in the facility for more than 5 years.[119]

[113] ICESCR, Article 12(1).
[114] Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 28 March 2017, UN doc. A/HRC/35/21, para 63; General Comment 14 to Article 12 of the ICESCR provides that the right to health includes non-consensual medical treatment. See CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), adopted at the Twenty-second Session of the Committee on Economic, Social and Cultural Rights, on 11 August 2000, UN doc. E/C.12/2000/4, para 8.
[115] As the MI Principles encourage, *"[w]here a person needs treatment in a mental health facility, every effort shall be made to avoid involuntary admission*." (Principle 15(1))
[116] A good example of mental health legislation in this regard is Victorian Mental Health Act of 1986 (Astralia), requiring that the Act must be interpreted so that *"any restriction upon the liberty of patients and other people with a mental disorder and any interference with their rights, privacy, dignity and self-respect are kept to the minimum necessary in the circumstances."* See Victorian Mental Health Act No. 59, Version No. 098, Astralia, 1986, Section 4(2)(b).
[117] Based on 79 responses. See Mental health atlas 2014, published by World Health Organization in 2015, p. 42.
[118] Based on 56 responses. *Ibid*.
[119] *ibid*, pp. 40-41.

Involuntary placement to mental health facilities is a controversial topic as it impinges on personal liberty and the right to choose, as well as carries the risk of abuse.[120] Prolonged retention is particularly problematic as it can lead to the loss of social skills and developing an 'institutionalised' mentality.[121] Naturally, being admitted and confined as a mental patient can be an unpleasant or even traumatic experience. One woman recalls how she was brought to a psychiatric clinic by her family, without previously discussing a possibility of clinic admission with her:

> *It was not voluntary at all! […] I felt like I was being swallowed up in a funnel. And I met the psychiatrist who said to me: give your car keys to your daughter and go up. I'm hospitalising you.*[122]

Although some people may agree their involuntary placement was necessary in retrospect, many do not form a positive attitude towards their detention in the facility.[123] Studies show that even those who view their placement as justified are still not grateful: they do not change in the way they felt about its coercive aspects.[124] Voluntary patients, on the other hand, tend to appreciate their hospital stay more:

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[120] Common elements of involuntary placement: isolation and segregation from community life; lack of control over day-to-day decisions; rigidity of routine, irrespective of personal preferences or needs; identical activities in the same place for a group of persons under a central authority; a paternalistic approach in the provision of services; supervision of living arrangements without consent; and disproportion in the number of persons with disabilities living in the same environment. As expressed by the OHCHR, *"[i]nstitutionalization is therefore not just about living in a particular setting; it is, above all, about losing control as a result of the imposition of a certain living arrangement."* See OHCHR, Thematic study on the right of persons with disabilities to live independently and be included in the community, 12 December 2014, UN doc. A/HRC/28/37, para 21; Freeman, Melvyn & Pathare, Soumitra, WHO Resource Book on Mental Health, Human Rights and Legislation, Geneva: World Health Organization, 2005, p. 46.

[121] Meaning the former patient will find it difficult to adjust to independent living after release. See Eric Rosenthal and Clarence Sundram, *The Role of International Human Rights in National Mental Health Legislation*, World Health Organization, 2004, p. 31.

[122] Woman, 65, France. Quoted in Involuntary placement and involuntary treatment of persons with mental health problems, Report by the European Union Agency for Fundamental Rights, 2012, p. 43.

[123] One American study showed that about 40% of involuntary patients who at the time of admission believed they did not need to be hospitalised changed their belief 4-8 weeks following discharge. A more recent British study concluded that only 40% of the 396 patients interviewed a year after hospitalisation thought their involuntary admission was justified (the actual number can in fact be lower since roughly half of the original sample dropped out). See Gardner, William *et al.*, "Patients' Revisions of Their Beliefs About the Need for Hospitalization", in *The American Journal of Psychiatry*, Vol. 156, Issue 9, September 1999, pp. 1385-1391, Table 4; Priebe, Stefan et al., "Patients' Views and Readmissions 1 Year after Involuntary Hospitalisation" in *The British Journal of Psychiatry*, Vol. 194, Issue 1, 2009, pp. 49-54.

[124] supra note 123: Gardner et al (1999); Gardner, William & Charles-Lidz, "Gratitude and Coercion between Physicians and Patients" in *Psychiatric Annals*, Vol. 31, Issue 2, 2001, p. 125-129.

> *I've got a wonderful clinic, I can turn up straight away in a crisis and I feel very comfortable there.*[125]

Despite the obvious shortcomings of involuntary placement, it is recognised that this practice (alongside involuntary treatment) can be an appropriate response in critical situations. According to mainstream psychiatric convention, treating someone in a hospital can prevent harm to self and others, and assist some people in attaining their right to health, which, due to their mental disorder, they may be unable to manage voluntarily.[126] In fact, the basis for involuntary placement in psychiatry is commonly the diagnosis of mental disorder paired with additional criteria such as being a 'danger to oneself and others' or 'in need of treatment'.[127]

There are many terms for the legal process through which an individual believed to be suffering from a mental disorder is admitted to an institution without his or her free consent and is not allowed to leave the premises freely. These include *compulsory/forced/coercive admission* and *detention, institutionalisation, hospitalisation, internment, incarceration, civil commitment* and *sectioning*. In addition to ordering someone into treatment in a mental health facility (*inpatient*), a separate procedure exists for ordering someone into treatment in the community (*outpatient*). Outpatient commitment means that a person continues to live in their home community under certain conditions, which often involve taking psychiatric medication as directed and attending appointments with a mental health

[125] Woman, 50, Germany. Quoted in *supra* note 122: FRA, 2012, p. 44.

[126] *supra* note 120 WHO, 2005, p. 46.
It is worth noting, however, that many of the assumptions in mental health care lack empirical support. These include the following ideas: involuntary psychiatric interventions normally benefit patients, including in the long term; persons with mental disorders lack decision-making skills to an extend that others do not; persons with mental disorders are more likely to engage in self-harm or violence against others than any other category of people. Even though they are often perceived as common knowledge, existing research is insufficient to consider these assumptions true. See Nilsson, Anna, "Objective and Reasonable? Scrutinising Compulsory Mental Health Interventions from a Non-discrimination Perspective", *Human Rights Law Review*, Vol. 14, Issue 3, September 18, 2014, pp. 459-485.

[127] An illustrative example of national legislation in this regard is Finnish Mental Health Act of 1990. Section 8 (1) of the act requires a set of conditions to be present before a person could be ordered to treatment in a psychiatric hospital against his or her will. These comprise the following:
(1) the person is diagnosed as *mentally ill*;
(2) the person *needs treatment* for a mental illness which, if not treated, would become considerably worse or severely *endanger* the person's health or safety or the health or safety of others;
(3) all other mental health services are inapplicable or inadequate.
The 'dangerousness' criterion is well elaborated in Utah, United States and is satisfied if a person is at serious risk to commit suicide, inflict serious bodily injury on himself or herself or suffer serious bodily injury because he or she is incapable of providing the basic necessities of life (food, clothing, and shelter); is at serious risk to cause or attempt to cause serious bodily injury or engage in harmful sexual conduct (Utah Code of 2003 (published by LexisNexis, 2011), subsection 62A-15-602(17) and subsection 62A-15-631(10)).

professional.[128] In this chapter only compulsory *admission* and *detention* within the premises of a mental health facility will be discussed and together referred to as *involuntary placement*.[129]

As mentioned above, inpatient (residential) care for persons with mental disorders involves staying in a *mental health facility*. The latter shall be understood as any establishment, or any unit of an establishment, providing mental health care as its primary function.[130] Normally these are mental (psychiatric) hospitals or psychiatric wards within a regular hospital. *Mental hospitals* are specialised hospital-based facilities that provide inpatient care and long-stay residential services for people with mental disorders. In many countries, they remain the main type of mental health care facility.[131] Other states promote community mental health services as a less restrictive alternative. These include the above-mentioned outpatient commitment, supported housing (e.g. halfway houses), community mental health centres and self-help groups for mental health.[132]

According to the WHO Mental health atlas, there are 6.5 mental hospital beds per 100,000 population in the world.[133] High-income countries have a far higher number of mental hospital beds (41.8 per 100,000 population) and admission rates (142.3 per 100,000 population) than low-income countries (1.6 and 7.6 respectively).[134] This is notwithstanding the transition in a number of high-income countries towards psychiatric wards in general hospitals and the provision of community-based residential care places.

Naturally, while *voluntary* placement in a mental health facility indicates that free and informed consent of the patient was obtained, *involuntary* placement means that no such consent was given.

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[128] E.g. English Mental Health Act of 2007 introduced *'community treatment orders'* allowing to return the patient to hospital for treatment, if the medication regime is not being complied with in the community (Sections 17A-17G, 20A-20B).

[129] Such an understanding of terms is common in the European human rights system. See, e.g. "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 of the Council of Europe, 3 January 2000, CoE Doc. DI R/JUR (2000)2, Appendix 1, Glossary; Explanatory Memorandum to Recommendation Rec (2004)10 of the Committee of Ministers to member states concerning the protection of the human rights and dignity of persons with mental disorder, Council of Europe, 2004. para 37.

[130] This definition is used in the MI Principles, Definition (d).

[131] *supra* note 117: WHO, 2015, p. 39.

[132] E.g. Jamaican Mental Health Act of 1999 lists some examples of community mental health services:
"(a) services at outpatient psychiatric clinics in health centres and general hospitals; (b) rehabilitative services for persons after their discharge from a psychiatric facility; (c) supervised home care and support for persons with mental disorders; and (d) services for the promotion of mental health." (Article 25(1))

[133] *supra* note 117: WHO, 2015, p. 39.

[134] *ibid.*

Informed consent can be defined as "*consent obtained freely, without threats or improper inducements, after appropriate disclosure to the patient of adequate and understandable information in a form and language understood by the patient."* [135] Usually voluntary admission brings with it the right to voluntary discharge from the facility at any time. However, this right may be overridden and the person admitted voluntarily may be later prevented from leaving the institution if the criteria for involuntary admission are met.[136] Thus, involuntary placement in this chapter will refer to instances when a person was both involuntarily *admitted* and *detained,* or detained at some point after his or her voluntary admission.

Even though technically one can be admitted to a mental health facility as either voluntary or involuntary patient, the reality is not so clear-cut. Not all persons who have been admitted as voluntary patients have actually given their free consent. In some countries, persons may be admitted regardless of their will, but with the consent of guardians or legal representatives, in which case they are considered 'voluntary' (or informal) patients.[137] In addition, some people may be unwilling to stay in a hospital, but act compliant due to the threat of compulsion or are simply too intimidated to refuse. [138] They are often 'voluntarily' admitted to the facility simply because they do not protest against the admission. This lack of protest is mistakenly construed as consent, even though consent must be voluntary and informed.

So-called *'non-protesting' patients* also include those who may not understand the fact or the purpose of the admission due to their mental health condition. Legislation in some countries contains provisions for persons who are incapable of giving consent to mental health interventions, but who do not refuse them.[139] This ensures that people who are not resisting placement and treatment are not

[135] MI Principles, Principle 11(2).
[136] E.g. Ontario Mental Health Act of 1990 (Canada) allows the attending physician to change the status of an informal or voluntary patient to that of an involuntary patient if a set of conditions for involuntary placement are met (Sections 19, 20(1.1) and 20(5)). While Norwegian Mental Health Care Act of 1999 explicitly forbids conversion from voluntary to involuntary care, exceptions can be made for those posing a serious threat to themselves or others (Section 3-4).
[137] E.g., Russian Psychiatric Assistance Act of 1992 provides that a person declared incapable can be subjected to hospitalisation in a psychiatric hospital at the request of his guardian (section 28(3) and (4)). This hospitalisation is regarded as voluntary and does not require approval by the court, as opposed to involuntary hospitalisation (sections 39 and 33 of the Act).
[138] *supra* note 120: WHO, 2005, pp. 44-45; Keys, Mary, Article 12 [Equal Recognition Before the Law] in Della Fina, Valentina et al. (eds.), *The United Nations Convention on the Rights of Persons with Disabilities. A Commentary*, Springer International Publishing, 2017, p. 273.
[139] E.g. South African Mental Health Care Act of 2002 refers to such patients as *'assisted mental health care users'* (Sections 26-31).

incorrectly made either involuntary or voluntary patients. For the purposes of this work, however, all persons who have not exercised their free choice to stay in a facility will be discussed in the context of involuntary placement. These include both patients admitted despite their active protest (involuntary patients) and 'non-protesting' patients who are unwilling to be admitted or cannot understand the implications of admission.

Involuntarily placement in a mental health facility often suggests that the patient will also be treated without his or her consent, but this is not always the case. Different procedures for determining the need for involuntary treatment will be discussed in the next chapter. Regardless of how non-consensual interventions are addressed in national law though, they must always comply with relevant human rights standards. Since persons with mental disorders are no longer seen as mere 'objects' of welfare policies and medical treatment, but rather as holders of rights,[140] they should be treated accordingly. The practice of involuntary placement in a psychiatric facility has been addressed in various human rights documents on both international and regional levels. These documents provide guidance on how to help persons with mental disorders without violating their human rights. This usually involves limiting involuntary placement to the cases when it is absolutely necessary and specifying safeguards for its application.

Unlike most human right standards, the Convention on the Rights of Persons with Disabilities appears to signal a new era in terms of limitations on, if not the abolition of, involuntary placement for persons with mental disorders.[141] At present, the exact state obligations in this regard are unclear, given different interpretation of the CRPD by international human rights mechanisms and States Parties. As a result, there is an ongoing debate in legal literature on the extent to which involuntary placement is acceptable under current human rights law.

Three major approaches to involuntary placement in mental health care can be distinguished:

1) Involuntary placement of persons with mental disorders complies with human rights law provided certain standards are met;

[140] Della Fina, Valentina, Article 1 [Purpose], in Della Fina, Valentina et al. (eds.), *The United Nations Convention on the Rights of Persons with Disabilities. A Commentary*, Springer International Publishing, 2017, p. 93.
[141] McSherry, Bernadette and Waddington, Lisa, "Treat with care: the right to informed consent for medical treatment of persons with mental impairments in Australia" in *Australian Journal of Human Rights*, Volume 23, Issue 1, 2017, p. 109.

2) Involuntary placement on the basis of mental disorder is discriminatory, but it is acceptable if neutrally defined;
3) No involuntary placement in mental health facilities should be permitted.

Each of these approaches relies on certain human rights instruments and their interpretation by the competent bodies. All three will be successively discussed in the following sections, the CRPD providing the rationale for the last two approaches. For clarity, the positions of relevant bodies on an international scale and within regional human rights regimes will be examined separately.

3.2. Traditional approach: involuntary placement is possible with certain safeguards

3.2.1. Universal level

Naturally, international human right treaties apply to all human beings, and persons with mental disorders are no exception. Like everyone else, they have the right to liberty and, like everyone else, they may be deprived of their liberty on the grounds and in accordance with procedures established by law.[142] Similarly, while everyone is free to choose their residence in principle, this freedom is subject to necessary legal restrictions.[143] Involuntary placement in a mental health facility is considered to be an example of a lawful limitation of personal liberty. In fact, the Human Rights Committee has interpreted the ICCPR to allow psychiatric detention, as long as the procedure follows the law and is subject to periodic review.[144] While it is clear the pre-CRPD international treaties do not exclude persons with mental disorders from protection, their text does not generally address this group's

[142] ICCPR, Articles 9(1). The Human Rights Committee pointed out that this article is applicable to all deprivations of liberty, including in the case of mental illness: See UN Human Rights Committee, CCPR General Comment No. 8: Article 9 (Right to Liberty and Security of Persons), 30 June 1982, para 1.
In addition, Article 10 (1) ICCPR requires that those deprived of their liberty *"are treated with humanity and with respect for the inherent dignity of the human person."*
[143] ICCPR, Article 12(1) and (3).
[144] *A v New Zealand*, Human Rights Committee, Communication No. 754/1997, views adopted on 3 August 1999, UN doc. CCPR/C/66/D/754/1997, paras 7.2-7.4. The case concerned a man with a mental disorder displaying threatening behaviour, who was detained in a mental health facility. No violation of Article 9 ICCPR (or any other invoked article) was found.

specific circumstances.[145] Therefore, it is worthwhile to look into some soft law instruments directly targeting this category of people.

The majority of international instruments dealing with involuntary placement in mental health care reflect the legal position that exists in many states. The legitimacy of involuntary placement *per se* is not challenged and only the specifics of the practice are addressed. For example, the earliest UN documents focused on persons with disabilities encourage living with one's family and participating in community life whenever possible, but recognise that institutional care may be necessary instead. [146] In the latter scenario, it is suggested that the environment and living conditions in a specialised establishment are as close as possible to those of normal life. The idea of abolishing institutionalisation and involuntary practices in mental health care was not even contemplated at the time. On the contrary, the issue of concern was failing to hospitalise *"persons who should be in the proper care of a mental institution"* and letting them live freely.[147]

While the need for involuntary placement in psychiatry was not questioned at the UN level, it was acknowledged that the practice is highly intrusive and may lead to multiple human rights violations.[148] As an attempt to prevent abuse, subsequent UN instruments on mental health care are quite intricate when it comes to justifying involuntary placement. The questions asked when drafting these documents appear to be:

> *Under what circumstances may disabled or mentally ill persons be committed to a mental health facility? If the commitment is involuntary, what procedures should be followed? Is it enough for a certified doctor to decide that commitment is medically necessary or should a judge be involved? […] Are therapeutic arguments sufficient or should it first be*

[145] Convention on the Rights of the Child is a notable exception, devoting its Article 23 to *'mentally or physically disabled'* children. The article affirms that such children *"should enjoy a full and decent life, in conditions which… promote self-reliance and facilitate the child's active participation in the community."*

[146] *supra* note 20: Declaration on the Rights of Mentally Retarded Persons, 1971, para 4. Note that more appropriate term used today is persons with intellectual, cognitive or developmental disabilities.
supra note 21: Declaration on the Rights of Disabled Persons, 1975, para 9. Note that the document covers people with *'deficient mental capabilities'* (para 1). The Declaration recognises that *"the stay of a disabled person in a specialized establishment [may be] indispensable", "required by his or her condition or by the improvement which he or she may derive therefrom."* (para 9).

[147] Principles, guidelines, and guarantees for the protection of persons detained on grounds of mental ill-health or suffering from mental disorder, Study by Erica-Irene A. Daes, a Special Rapporteur of the Sub-Commission on Prevention of Discrimination and Protection of Minorities, UN doc. E/CN.4/Sub.2/1983/17/Rev.1, para 225(d).

[148] *ibid*, para 243.

established that the person to be committed presents a danger to him/herself or to others?[149]

The most comprehensive global set of standards for protecting persons with mental disorders is the UN document commonly known as the MI Principles.[150] While Principle 15 stresses that *"every effort shall be made to avoid involuntary admission"*, Principle 16 elaborates on when such practice is acceptable. For someone to be admitted involuntarily to a mental health facility, a qualified mental health practitioner needs to determine that one has a mental illness and is very likely to cause imminent harm to oneself or to other persons. Involuntary admission is also possible when two such practitioners agree that failure to admit or retain someone with severe mental illness and impaired judgement is likely to lead to a serious deterioration in his or her condition or will prevent the giving of appropriate treatment. In both cases involuntary placement shall initially be for a short period pending approval of the review body.

Although the MI Principles are nonbinding, they have been helpful in interpreting international conventions[151] and are regarded as the minimum UN standards for the protection of human rights of persons with mental disorders.[152] The Inter-American Commission on Human Rights has referred to them as nothing short of "*a guide to States in the design and/or reform of mental health systems"* and being *"of utmost utility in evaluating the practices of existing systems."*[153] At the same time, the UN Secretary-General has criticised the MI Principles for offering *"in some cases a lesser degree of protection than that offered by existing human rights treaties"* in the context of involuntary interventions.[154]

[149]Degener, Theresia, Disability and freedom: the International Covenant on Civil and Political Rights (ICCPR), in Quinn, Gerard and Degener, Theresia, *The current use and future potential of United Nations human rights instruments in the context of disability*, United Nations, New York and Geneva, 2002, pp. 55-56.
[150] *supra* note 4.
[151] E.g. Principle 13(3) from the MI Principles was used to interpret the ICESCR Articles 6-8 on rights relating to work in UN Committee on Economic, Social, and Cultural Rights, General Comment 5: Persons with Disabilities, 9 December 1994, UN doc. E/1995/22, paras. 7, 21.
[152] United Nations, Economic and Social Council, Commission on Human Rights, Human Rights and Scientific and Technological Developments, Report of the working group on The principles for the protection of persons with mental illness and for the Improvement of mental health care, UN doc. E/CN.4/1991/39, Annex II, p. 20.
[153] *Victor Rosario Congo v Ecuador*, Inter-American Commission on Human Rights, Report 63/99, Case 11,427, OEA/Ser.L/V/II.106, doc. 6 rev., 13 April 1999, footnote 8.
[154] *supra* note 5: Report of the UN Secretary-General (2003), UN doc. A/58/181, para 13.

Another relevant document is Ten Basic Principles for mental health care law, adopted by the WHO.[155] Principle 4 calls for provision of the least restrictive mental health care while Principle 5 requires free, informed and documented consent before any type of interference can occur, including *'mandatory commitment to hospital'*. It is then explained, however, that a surrogate decision-maker should decide on behalf and in the best interest of a person with mental disorder who is unable to consent. In a similar vein, the Madrid Declaration emphasises that *"psychiatrist-patient relationship must be based on mutual trust and respect to allow the patient to make free and informed decisions"* while acknowledging the possibility of involuntary interventions in relation to those *"[unable] to exercise proper judgment because of a mental disorder"*.[156]

As for the relevant jurisprudence, it is worth noting the case of *A v. New Zealand*, considered by the UN Human Rights Committee.[157] The ICCPR review body found no violation of the Covenant since author's detention in psychiatric institutions was justified by his aggressive behaviour and the committal order was issued according to law and periodically reviewed.[158] The Committee reiterated that *"it is for the courts of States parties concerned to review the evaluation of the facts as well as the application of the law in a particular case […] unless the Courts' decisions are manifestly arbitrary or amount to a denial of justice."*[159] In the present case, the Committee found that the Court's reviews of the author's compulsory status did not suffer from such defects.

Although international instruments and bodies have continued to authorise involuntary psychiatric interventions decade after decade, a gradual move away from a paternalistic, medical model of treating persons with mental disorders can be traced. At first, the relevant documents were premised on the idea that these people should be 'fixed' to fit society,[160] but later adopted a more respectful human right approach.[161] Yet the human rights model did not preclude involuntary

[155] Mental Health Care Law: Ten Basic Principles, World Health Organization, Geneva, 1996, WHO/MNH/MND/96.9.
[156] Madrid Declaration on Ethical Standards for Psychiatric Practice, approved by the General Assembly of the World Psychiatric Association in Madrid, Spain, 25 August 1996, paras 3-4.
[157] *supra* note 144: *A v New Zealand*.
[158] *ibid*, para 7.2.
[159] *ibid*, para 7.3.
[160] E.g. one of the means to achieving social progress was considered be the *"institution of appropriate measures for the rehabilitation of mentally or physically disabled persons, especially children and youth, so as to enable them to the fullest possible extent to be useful members of society"*. See *supra* note 19: Declaration on Social Progress and Development, 1969, Article 19(d).
[161] E.g. the purpose of one of the instruments was to ensure that persons with disabilities (including mental illness) may exercise the same rights and obligations as others; the obstacles to this goal were considered to lie within society, and not in

placement since this practice was viewed as protecting the individuals in exceptional circumstances, ultimately safeguarding their rights. Depending on how the CRPD is interpreted, such an approach may not last for a long time. Meanwhile, involuntary psychiatric placement remains largely authorised on regional and national levels of protection.

3.2.2. Regional level

Regional human rights systems have their own instruments covering persons with mental disorders and regional courts have ruled on matters related to them. The most extensive case law on involuntary placement in psychiatry has been developed by the European Court of Human Rights. Hence, mental health standards in the European region will be discussed first, with other regions to follow.

3.2.2.1. Europe

Placement in psychiatric institutions is primarily concerned with the terms of Article 5 of the European Convention on Human Rights, which covers the right to liberty.[162] This is the area that has attracted the most cases taken to the European Court concerning persons with mental disorder.[163] Article 5(1)(e) is the only one in the Convention that refers explicitly to mental health, by including the now-derogatory term *'persons of unsound mind'*. Such persons can be lawfully deprived of their liberty, but subject to conditions that the ECtHR has developed in its case law. It was emphasised that *"[t]he position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with."*[164] Nevertheless, the Court allows countries certain flexibility in defining the criteria for involuntary placement in mental health law.[165]

A landmark ECtHR case in relation to deprivation of liberty and mental disability is *Winterwerp v. Netherlands*. Here the Court acknowledged that the scope of the phrase *'persons of unsound mind'* is

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the impairment itself. See Standard Rules on the Equalization of Opportunities for Persons with Disabilities, adopted by the UN General Assembly on 20 December 1993, UN doc. A/RES/48/96, para 15.

[162] *supra* note 11.

[163] Bartlett, Peter, Lewis, Oliver and Thorold, Oliver, Chapter 2: Admission to and Discharge from Psychiatric and Related Institutions, *Mental disability and the European Convention on Human Rights*, Martinus Nijhoff Publishers, 2007, p. 31.

[164] *Herczegfalvy v. Austria*, European Court of Human Rights, Judgment of 24 September 1992, no. 10533/83. para 82.

[165] *Winterwerp v. Netherlands,* European Court of Human Rights, Judgment of 24 October 1979, no. 6301/73, para 40.

dependent on developing medical understanding of mental disorders. In the Court's own words, "*[t]his term is not one that can be given a definitive interpretation: […] 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 mental illness changes."*[166] The Court noted, however, that mere eccentricity (when one's views or behaviour deviates from the prevailing norms) is insufficient to constitute unsoundness of mind.

Winterwerp established the following criteria for involuntary psychiatric placement:

1) The individual concerned has been reliably shown to be of 'unsound mind': a true mental disorder was established by objective medical expertise;
2) The mental disorder is of a kind or degree warranting compulsory confinement;
3) The confinement continues no longer than such disorders persist.[167]

Generally, if a disorder is contained in the most recent version of ICD[168] or DSM,[169] it is likely to be recognised as a *'true mental disorder'*.[170] As was determined in *Hutchison Reid v UK,* a disorder may warrant confinement when a person concerned needs medical treatment or when he or she would be dangerous if left at large.[171] If a mental disorder does justify confinement, it should be effected in the appropriate institution with therapeutic environment.[172] So far the Court has been unwilling to

[166] *ibid,* para 37.
[167] *ibid,* para 39.
[168] *supra* note 35: International Statistical Classification of Diseases and Related Health Problems, 2016.
[169] *supra* note 36: Diagnostic and Statistical Manual of Mental Disorders, 2013.
[170] Since, e.g. homosexuality is no longer contained in either taxonomy, detention of people on this basis would almost certainly fall afoul of the requirement for a *'true mental disorder'*. See *supra* note 163: Bartlett et al (2007), p. 43.
[171] In the Court's interpretation, Article 5(1)(e) ECHR authorises the confinement of someone who needs control and supervision to prevent him, e.g., from causing harm to himself or others – even where no medical treatment for his mental disorder is envisaged (e.g. psychopathic personality disorder cannot be treated). See *Hutchison Reid v the United Kingdom*, European Court of Human Rights, Judgment of 20 February 2003, no. 50272/99, para 52.
[172] *Ashingdane v UK*, European Court of Human Rights, Judgment of 28 May 1985, no. 8225/78, para 44; *Aerts v Belgium*, European Court of Human Rights, Judgment of 30 July 1998, no. 25357/94, para 49.
This can in principle include a social care home. See *Stanev v Bulgaria*, European Court of Human Rights, Judgment of 17 January 2012, no. 36760/06, paras 121, 132.
Also note that the existence of a mental disorder warranting confinement must be established at the time of the placement (i.e. a person cannot be admitted to a facility on the basis of the medical examination conducted years earlier). See *Witek v. Poland*, 21 December 2010, no. 13453/07, paras 41-43; *Stanev v Bulgaria*, para 156; *Yaikov v Russia*, 18 June 2015, no. 39317/05, paras 63-66.

impose obligations on states to provide community services that would make institutionalisation unnecessary.[173]

According to the ECtHR jurisprudence, involuntary hospitalised persons have the rights to be informed of the reasons of their detention[174] as well as the right to a periodic hearing to challenge the detention (either in person or through a representative).[175] However, the protections under Article 5 ECHR are significantly reduced in emergency situations. If a person is presenting a danger to others, for example, no thorough medical examination prior to admission is required.[176] It is important though that any detention, emergency or otherwise, is justified under domestic law and is not arbitrary.[177]

The European Court's approach to involuntary placement has not changed following the CRPD adoption. To understand the implications of this, the Court's post-CRPD jurisprudence will be discussed in the following section, after the treaty analysis. Meanwhile, some of the European soft law instruments are worth mentioning here given their explicit authorisation for involuntary placement.

The Council of Europe has been actively involved in the protection of persons with mental disorders since 1977, when it adopted a Recommendation on the situation of the mentally ill.[178] Subsequent Recommendations, concerning involuntary mental health patients[179] and respect for human rights in psychiatry,[180] defined specific criteria for involuntary placement.[181] However, the most relevant minimum standards for mental health care can be found in a more recent document.[182] The

[173] *supra* note 163: Bartlett et al (2007), p. 46.
[174] *Van der Leer v the Netherlands*, European Court of Human Rights, Judgment of 21 February 1990, no. 11509/85, paras 25-31.
[175] Generally, there's no right to routine re-assessment of the length of a sentence, determined by the crime committed. However, it is reasonable to protect the right to periodic hearing for those detained under Article 5(1)(e) (often for an indefinite period) since a mental disorder is usually a changing condition. See *supra* note 165: *Winterwerp v. Netherlands,* paras 55, 60; *X v UK*, European Court of Human Rights, Judgment of 5 November 1981, no. 7215/75, para 52.
[176] *ibid: X v UK*, para 41.
[177] *supra* note 174: *Van der Leer v the Netherlands*, paras 22-23.
[178] Recommendation (818) on the situation of the mentally ill, Council of Europe Parliamentary Assembly, 8 October 1977.
[179] *supra* note 25: Recommendation R(83)2 of the Committee of Ministers, 1983.
[180] Recommendation 1235 (1994): Psychiatry and human rights, Council of Europe Parliamentary Assembly, 12 April 1994.
[181] According to these two instruments, the practice may be resorted to when there is a serious danger to the patient or to other persons or if the absence of placement would lead to a deterioration of his disorder or prevent the patient from receiving appropriate treatment. See *supra* note 25: Recommendation R(83)2, Article 3 and *supra* note 25: Recommendation 1235 (1994), Section 7.1.a, 7.1.b, 7.1.c.
[182] *supra* note 27: Recommendation Rec(2004)10 of the Committee of Ministers.

Recommendation of 2004 lists five conditions required for involuntary placement (all of them must be met):

1) The person has mental disorder;
2) The person poses a significant risk of serious harm to herself or others;
3) The placement has a therapeutic purpose;
4) No less restrictive care is available;
5) The opinion of the person concerned has been taken into consideration.[183]

The Recommendation further elaborates that placement decision should be taken by a court or another competent body and state the maximum period beyond which it must be reviewed (without prejudice to the patient's own rights to reviews and appeals).[184] Involuntary placement should be terminated if any of the criteria for the measure are no longer met.[185]

The standards set out in the Recommendation of 2004 might be reiterated in the future Additional Protocol to the European Biomedicine Convention.[186] The Committee on Bioethics has presented the working draft of this legally binding instrument in 2015,[187] raising serious concerns about its compatibility with the UN Disability Convention. Since some grasp of the CRPD requirements is needed to understand these concerns, the draft Additional Protocol will be discussed in the subsequent section.

3.2.2.2. The Americas

Core human rights instruments under the auspices of the Organization of American States reaffirm everyone's rights to humane treatment, personal liberty, freedom of movement and residence, and the right to health.[188] The Inter-American Convention on the Elimination of All Forms of

[183] A different procedure exists for an emergency situation: if one's behaviour is strongly suggestive of a mental disorder and represents a significant risk of harm, such a person may be detained for the minimum period necessary to determine the actual presence of a mental disorder. See *supra* note 27: Rec(2004)10, Articles 17, 21.
[184] *supra* note 27: Rec.(2004)10, Articles 20, 25.
[185] *supra* note 27: Rec.(2004)10, Article 24.
[186] *supra* note 26: Convention on Human Rights and Biomedicine, 1997.
[187] Council of Europe Committee on Bioethics, Working document concerning the protection of human rights and dignity of persons with mental disorder with regard to involuntary placement and involuntary treatment, 22 June 2015, DH-BIO/INF (2015) 7.
[188] Organization of American States, American Convention on Human Rights, "Pact of San Jose", Costa Rica, concluded 22 November 1969, entered into force 18 July 1978, Articles 5, 7, 22; *supra* note 28: Protocol Of San Salvador, Article 10.

Discrimination against Persons with Disabilities (covering persons with permanent or temporary mental impairments) encourages facilitation of *"independence, self-sufficiency, and total integration into society of persons with disabilities, under conditions of equality."*[189] The non-binding Principles and Best Practices on the Protection of Persons Deprived of Liberty in the Americas, adopted by the Inter-American Commission on Human Rights, provide more specific guidelines.[190] According to the document the deprivation of liberty of a person in a psychiatric hospital or similar institution *"shall be applied as a measure of last resort, and solely when there is serious likelihood of immediate or imminent harm to that person or to others."*[191] Gradual deinstitutionalisation is encouraged to *"avoid unnecessary deprivation of liberty in hospitals or other institutions"* while developing community-based psychiatric care. [192]

Ximenes-Lopes v Brazil was the first case where the Inter-American Court of Human Rights (IACtHR) addressed the human rights violations of a person with mental disorder.[193] In its ruling the Court asserted the States' duty to guarantee the provision of effective health care services to all persons with mental disorder, in the least restrictive way possible.[194] The vulnerability of anyone admitted to mental health institutions was acknowledged, given an intrinsic imbalance in power between such patients and the persons having authority over them.[195] The practice of involuntary interventions was not questioned though since *"the patients' needs… may sometimes require the adoption of measures without their consent".*[196] Of course, hospital conditions should be decent and

[189] *supra* note 15: Inter-American Convention on the Elimination of All Forms of Discrimination against Persons with Disabilities, Article IV(2)(b).
[190] Principles and Best Practices on the Protection of Persons Deprived of Liberty in the Americas, Resolution 01/08 of the Inter-American Commission on Human Rights, 31 March 2008, OEA/Ser/L/V/II.131 doc. 26.
[191] *ibid,* Principle III(3).
[192] *ibid.*
[193] It was also the case where the Inter-American Disability Convention and the UN MI Principles were used as sources of interpreting the ACHR See *Ximenes-Lopes v Brazil,* Inter-American Court of Human Rights, Series C No 149, Judgment of July 4, 2006, paras 110-111, 123.
[194] *supra* note 193: *Ximenes-Lopes v Brazil,* paras 128, 138-140.
[195] *supra* note 193: *Ximenes-Lopes v Brazil,* paras 101, 106-107, 129. Judge Sergio García-Ramírez elaborated in his reasoned opinion that *"the most intense form of limitation on personal self-governance becomes visible in persons with mental illness […], who are subject to the almost absolute authority of physicians and custodians while confined in an institution with rigorous rules and regulations."* (Reasoned opinion of Judge Sergio García-Ramírez to the Judgment of the Inter-American Court of Human Rights in the case of *Ximenes-Lopes v. Brazil,* para 14)
[196] *supra* note 193: *Ximenes-Lopes v Brazil,* para 130.

the patient's dignity must be respected at all times.[197] Since this was not the case with Mr. Ximenes-Lopes, a violation of his right to humane treatment was found.[198]

The infringement of the right to personal liberty was not invoked or considered in this case, and the issue in focus was the abuse of involuntary interventions, not their application in the first place. One of the judges, however, commented that the requirements for confinement of persons with mental disorders are not as detailed as the conditions for the detention of criminals. To him this seems to imply that the right to personal freedom of the former category is less worthy of protection, which should not be the case.[199]

It is worth noting that the judgement on the *Ximenes-Lopes v Brazil* case was passed before the CRPD adoption. Since then the IACtHR has repeatedly referenced the UN Convention in its judgements[200], but none of them dealt with involuntary psychiatric placement. The Inter-American Commission, however, has recently urged States to protect those detained in psychiatric institutions and encouraged *"establishing community-based services in accordance with international standards."*[201] This indicates a gradual move towards deinstitutionalisation in the region (perhaps under the CRPD influence), but involuntary placement is still considered acceptable.

3.2.2.3. Africa

Similarly to European and American systems, Article 6 of the African Charter on Human and Peoples' Rights (ACHPR) guarantees everyone's right to liberty and condemns unlawful and arbitrary deprivation of liberty.[202] However, as the African Commission concluded in the case of *Purohit and*

[197] *supra* note 193: *Ximenes-Lopes v Brazil,* para 131. The Court makes it clear that *[t]he States have the duty to supervise and guarantee that in all psychiatric institutions, either public or private, the patients´right to receive a worthy, human, and professional treatment be preserved and that said patients be protected against exploitation, abuse, and degradation* (para 108).
[198] *supra* note 193: *Ximenes-Lopes v Brazil,* para 150.
[199] Reasoned opinion of Judge Sergio García-Ramírez*,* paras 23-24.
[200] see e.g. *Gonzales Lluy et al. v. Ecuador,* Inter-American Court on Human Rights, Judgment of September 1, 2015, Series C No. 298. Par. 169 and *Furlan and Family v. Argentina*, Inter-American Court on Human Rights, Judgment of 31 August 2012, no. 12.539.
[201] IACHR Urges States to Protect the Rights of Persons with Disabilities at Mental Health Facilities, Press Release No. 179/16, December 2, 2016, available at: http://www.oas.org/en/iachr/media_center/PReleases/2016/179.asp (last visited 22 August 2018).
[202] Organization of African Unity, African Charter on Human and Peoples' Rights ("Banjul Charter"), concluded 27 June 1981, entered into force 21 October 1986, OAU doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982).

Moore v Gambia, this protection does not extend to psychiatric placement.[203] While acknowledging that Gambian mental health legislation fell far short of international standards,[204] the African Commission held there was no violation of Article 6 of the ACHPR. It explained that this provision *"was not intended to cater for situations where persons in need of medical assistance or help are institutionalised"*.[205] Such a narrow interpretation of the right to liberty is out of step with other human rights regimes and perpetuates unlawful institutionalisation of persons with mental disorders in Africa.[206]

Currently mental health legislation of African states tends to be antiquated (dating back to the colonial era), reflects the paternalistic approach to persons with mental disorders, heavily relies on involuntary placement and lacks the necessary safeguards.[207] The regional protection in the mental health field may improve if a protocol to the African Charter on the rights of persons with disabilities is adopted.[208] The document's latest draft is heavily influenced by the CRPD and provides a level of protection that is absent from Article 6 of the ACHPR. However, since it appears to outlaw involuntary placement, it will be discussed under a different section.

3.2.2.4. Other regions

There are no regional human rights organisations or conventions in Asia or Oceania. Yet the Asia-Pacific region has its own non-binding human rights instrument, the ASEAN Human Rights Declaration.[209] The document declares the right to personal liberty and recognises that when it comes to rights and freedoms there should be no distinction based on disability.[210] The binding Arab Charter on Human Rights, ratified by most Arab League member States, is also worth mentioning.[211] The

[203] *Purohit and Moore v Gambia*, African Commission of Human and Peoples' Rights, Communication No. 241/2001, Sixteenth Activity Report 2002–2003.
[204] This showed even in the name: The Lunatics Detention Act.
[205] *supra* note 203: *Purohit and Moore v Gambia*, para 68.
[206] Enonchong, Laura-Stella, "Mental disability and the right to personal liberty in Africa", *The International Journal of Human Rights*, 2017, p. 8-9.
[207] *ibid*, p. 9.
[208] Draft Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa, adopted at the 19th Extra-Ordinary Session of the African Commission on Human and Peoples' Rights, 25 February 2016.
[209] Association of Southeast Asian Nations, ASEAN Human Rights Declaration, adopted 18 November 2012 in Phnom Penh, Cambodia, published by the ASEAN Secretariat, July 2013.
[210] *ibid*, Articles 4, 12.
[211] League of Arab States, Arab Charter on Human Rights, adopted 22 May 2004, reprinted in 12 *International Human Rights Report* 893 (2005). Information on ratification status is available at the League of Arab States website at http://www.lasportal.org/ar/humanrights/Committee/Pages/MemberCountries.aspx (Arabic) and translated into English at

instrument guarantees everyone's right to liberty (subject to lawful limitations) and contains a separate article on persons with disabilities, urging states to *"enhance their self-reliance and facilitate their active participation in society."*[212] Unfortunately, since the documents of the Arab Human Rights Committee (the Charter's monitoring body) are not translated into English, it is difficult to analyse the body's interpretation of the treaty in relation to persons with mental disorders.

3.3. Disability-neutral approach: no involuntary placement based on a mental disorder permitted

3.3.1. Universal level

International human right instruments discussed earlier in this chapter are quite clear in their authorisation of involuntary psychiatric placement. From their perspective mental health law is an area warranting separate standards than those in general health care. The message in the UN Disability Convention, on the other hand, is essentially about equality and non-discrimination. Amongst other things, the CRPD text grants people with disabilities the right to liberty as well as a right to respect for their physical and mental integrity *"on an equal basis with others"*.[213] Health care should also be provided *"of the same quality to persons with disabilities as to others"*, including on the basis of free and informed consent.[214]

What deserves special attention is the second half of Article 14(1)(b), which holds that *"the existence of a disability shall in no case justify a deprivation of liberty"*.[215] The Convention's

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the International Center for Not-for-Profit Law website at http://www.icnl.org/research/monitor/las.html (last visited 22 August 2018). The Arab League is a regional organization of Arab states in and around North Africa, the Horn of Africa and Arabia.

[212] *ibid*, Articles 14, 40(1). Persons with mental disabilities are explicitly mentioned in Article 40.

[213] CRPD, Articles 14(1)(a), 17.

[214] CRPD, Article 25(d). This provision will be discussed in more detail in chapter 4.

[215] The exact wording of this provision was hotly debated during the treaty negotiations. While the drafters acknowledged that forced institutionalisation is often linked to the most intrusive and appalling abuse of human rights, many governments wished to keep their ability to detain and treat persons in exceptional circumstances. Views were firmly polarised between those in favour of and against keeping text on safeguards for involuntary placement. Eventually, the text containing only a short one-sentence principle was adopted, given the lack of time to agree on anything more complex. Behind-the-scene view on the negotiations and evolution of the treaty text can be found in Begg, Andrew and Degener, Theresia, From Invisible Citizens to Agents of Change, in Fina, Della et al. (eds.), *The United Nations Convention on the Rights of Persons with Disabilities. A Commentary*, Springer International Publishing, 2017, pp. 1-39.

monitoring body, the CRPD Committee, has reiterated this proscription numerous times: from its general Reporting guidelines[216] to specific Guidelines on Article 14[217] and from its earliest concluding observations on the states' reports to the most recent ones.[218] More specifically, it has been stated that Article 14(1)(b) *"prohibits the deprivation of liberty on the basis of actual or perceived impairment even if additional factors or criteria are also used to justify the deprivation of liberty."*[219] Such an interpretation is supported by the treaty's *travaux preparatoires*: the proposals to limit the prohibition of detention to cases '*solely'* or *'exclusively'* determined by disability were ultimately rejected.[220] Thus, the Convention's final text requires states to *"repeal provisions which allow for involuntary commitment of persons with disabilities in mental health institutions"* based on their health diagnosis or *"other reasons tied to [it]."*[221]

The CRPD's Committee's interpretation of Article 14 has been echoed throughout the UN system.[222] Thematic study on the Disability Convention, conducted by the Office of the United

[216] In relation to Article 14 CRPD the Committee encouraged States Parties to report on measures taken *"to ensure that all persons with all forms of disabilities enjoy the right to liberty and security of person and that no person is deprived of her/his liberty on the basis of her/his disability"*. See *supra* note 102: Guidelines on Article 12, p. 10.

[217] *supra* note 34: Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities, 2015. The Committee has repeatedly urged State parties to follow these guidelines; see e.g. Concluding observations on the initial report of the European Union, 2 October 2015, UN doc. CRPD/C/EU/CO/1, para 40; Concluding observations on the initial report of Portugal, 20 May 2016, UN doc. CRPD/C/PRT/1, para 33; Concluding observations on the initial report of the Russian Federation, 9 April 2018, UN doc. CRPD/C/RUS/CO/1, para 33.

[218] E.g. in 2011 the CRPD Committee recommended that Spain *"review its laws that allow for the deprivation of liberty on the basis of disability, including mental… disabilit[y]"* and *"repeal provisions that authorize involuntary internment linked to an apparent or diagnosed disability."* When considering the EU report a few years later it expressed concern about *"the involuntary detention of persons with disabilities in psychiatric hospitals or other institutions on the basis of actual or perceived impairment."* In its recent Concluding Observations on the Russian Federation, body noted with concern that *"persons with disabilities, particularly with psychosocial disabilities, may still be deprived of their liberty in psychiatric hospitals or other institutions based on their impairment"* and urged the state to *"fully harmonize"* its legislation with Article 14 CRPD. See Concluding observations on the initial report of Spain, 19 October 2011, UN doc. CRPD/C/ESP/CO/11, para 36; Concluding observations on the initial report of the European Union, 2 October 2015, UN doc. CRPD/C/EU/CO/1, para 40; Concluding observations on the initial report of the Russian Federation, 9 April 2018, UN doc. CRPD/C/RUS/CO/1, paras 32-33.

[219] *supra* note 34: Guidelines on Article 14, para 7.

[220] Current wording implies that disability cannot be a ground for the deprivation of liberty either alone or when accompanied by other reasons. Even if involuntary placement is only partly justified by the person's disability, it is discriminatory and violates Article 14 CRPD. See Ad Hoc Committee on a Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities, Fifth Session, Daily summary of discussions, January 26, 2005; supra note 86: Thematic Study by the OHCHR, 2009, para 48.

[221] The CRPD Committee gives examples of *'other reasons'* that can be linked to one's impairment: perceived dangerousness, severity of impairment, alleged need of care, treatment, observation or prevention. See *supra* note 34: Guidelines on Article 14, paras 10, 13 and footnote 16.

[222] Even before the CRPD Committee started operating, there was certain consensus on the UN level about Article 14 implications. It was acknowledged that disability should not be a basis for deprivation of liberty and that related laws should be equally applied to all. See Expert seminar on freedom from torture and ill treatment and persons with disabilities,

Nations High Commissioner for Human Rights, acknowledges a dramatic shift brought by the treaty's adoption:

> *Prior to the entrance into force of the Convention, the existence of a mental disability represented a lawful ground for deprivation of liberty and detention under international human rights law. The Convention radically departs from this approach by forbidding deprivation of liberty based on the existence of any disability, including mental or intellectual, as discriminatory.*[223]

A later OHCHR study on Article 19 CRPD (living independently and being included in the community)[224] has likewise concluded that this article, in conjunction with Articles 12 and 14, *"prohibits forced institutionalization and deprivation of liberty on the basis of the existence of an impairment."* [225] Recently, the High Commissioner himself reiterated that Article 14 CRPD *"establishes an absolute ban on deprivation of liberty on the basis of impairments", "whether or not it is connected with other factors."*[226] Two former UN Special Rapporteurs on torture, Manfred Nowak and Juan Méndez, pointed out that involuntary commitment on grounds of disability not only contradicts Article 14 CRPD, but might also inflict severe pain or suffering on the individual, thus falling under the scope of the UN Convention against Torture.[227]

Geneva, 11 December 2007, Report prepared by the Office of the High Commissioner for Human Rights, in collaboration with the Special Rapporteur on Torture (Manfred Nowak), and the Committee against Torture, p. 8.

[223] *supra* note 86: Thematic Study by the OHCHR, para 48.

[224] The article holds, *inter alia*, that *"States Parties to this Convention recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community, including by ensuring that: (a) Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement."*

[225] *supra* note 120: Thematic study by the OHCHR, para 20.

[226] Mental health and human rights, Report of the United Nations High Commissioner for Human Rights, 31 January 2017, UN doc. A/HRC/34/32, para 29.

[227] In making such an assessment, factors like fear and anxiety produced by indefinite detention, the infliction of forced medication or electroshock, the use of restraints and seclusion and the segregation from family and community should be taken into account. See: Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, 28 July 2008, UN doc. A/63/175, paras 64-65; Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, 1 February 2013, UN doc. A/HRC/22/53, paras 68-69; Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, concluded 4 February 1984, entered into force 26 June 1987, United Nations, Treaty Series, vol. 1465, p. 85.

The discussed approach is incorporated into the UN Basic Principles and Guidelines pertaining to the right of anyone deprived of their liberty to bring proceedings before court.[228] According to Principle 20, dealing with specific measures for persons with disabilities, courts are urged to comply with:

> *... the State's obligation to prohibit involuntary committal or internment on the grounds of the existence of an impairment or perceived impairment, particularly on the basis of psychosocial or intellectual disability or perceived psychosocial or intellectual disability, as well as with their obligation to design and implement de-institutionalization strategies based on the human rights model of disability.*[229]

The prohibition of the involuntary committal or internment on the grounds of the (perceived) impairment (including psychosocial disability) is elucidated in the corresponding Guideline 20.

What is important to note is that under this approach persons with mental disorders, apparently, can still be lawfully subject to detention for care and treatment or to preventive detention. However, *"the legal grounds upon which restriction of liberty is determined must be de-linked from the disability and neutrally defined so as to apply to all persons on an equal basis".*[230] In other words, mental disability *per se* should play no role in laws that deprive persons of liberty and involuntary placement rules must be drafted so as to apply to everyone.[231] Prof. Peter Bartlett warns, however, that 'neutrally defined' provisions are likely to be applied disproportionately to people with mental disorders anyway, so direct discrimination can merely turn into indirect one.[232] At the same time, a 'neutral' law providing for detention of persons perceived as, e.g., dangerous (irrespective of whether they have a mental disorder) invites political abuse.[233] Thus, while satisfying the problems of Article 14

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[228] The United Nations Working Group on Arbitrary Detention, Basic Principles and Guidelines on Remedies and Procedures on the Right of Anyone Deprived of His or Her Liberty by Arrest or Detention to Bring Proceedings Before Court, 6 July 2015, UN doc. A/HRC/30/37.
The document was developed at the request of the Human Rights Council: Resolution of 17 July 2012, UN doc. A/HRC/RES/20/16, para 10.
[229] *ibid*, para 38.
[230] *supra* note 86: Thematic Study by the OHCHR, 2009, para 49.
[231] Slobogin, Christopher, "Eliminating mental disability as a legal criterion in deprivation of liberty cases: The impact of the Convention on the Rights of Persons with Disabilities on the insanity defence, civil commitment, and competency law", in *International Journal of Law and Psychiatry*, Vol. 40, 2016, p. 37.
[232] Bartlett, Peter, "A mental disorder of a kind or degree warranting confinement: examining justifications for psychiatric detention" , in *The International Journal of Human Rights*, Vol. 16, No. 6, 2012, p. 835.
[233] *supra* note 112: Bartlett (2012), p. 773.

interpretation, this approach may prove to be unproductive or create more serious problems when applied.

Another issue comes with the UN Human Rights Committee's interpretation of Article 9 ICCPR and Article 14(1)(b) CRPD. In one of its General Comments the body stated that *"[t]he existence of a disability shall not in itself justify a deprivation of liberty'* but must be combined with *'the purpose of protecting the individual in question from serious harm or preventing injury to others."*[234] This interpretation causes tension with the CRPD Committee's view, as it implies that involuntary placement may be based on the person's disability if other criteria are met. Given that the Human Rights Committee has historically been a highly respected UN treaty body, its position may be favoured over that of the CRPD Committee.[235]

3.3.2. Regional level

The provisions holding that disability cannot justify involuntary placement are difficult to find in regional human rights systems. However, one of the non-binding documents in the Americas partially follows this approach, providing a good case in point.[236] In addition, the controversy surrounding the possible Additional Protocol to the Biomedicine Convention indicates that several European bodies consider the deprivation of liberty on the basis of a mental disorder as violating the CRPD. However, the same cannot be said about the ECtHR as its case law on involuntary placement takes little account of the CRPD requirements. The problematic issues within the European region will be addressed after a brief look at the American document.

[234] It was also made clear that involuntary interventions must be applied only as a measure of last resort and for the shortest appropriate period of time. Adequate community-based services should be available to provide less restrictive alternatives. See Human Rights Committee, General comment No. 35 – Article 9 (Liberty and security of person), 16 December 2014, UN doc. CCPR/C/GC/35, para 19.
More recently, the Human Rights Committee applied this approach in CO Moldova, 18 November 2016, UN doc. CCPR/C/MDA/CO/3, para 24(a).
[235] Fennell, Philip, "Conflicting or complementary obligations? The UN Disability Rights Convention, the European Convention on Human Rights and English law", in *European Human Rights Law Review*, Issue 6, 2011, p. 672.
[236] The author acknowledges that there might be other examples among regional human rights instruments of which she is not aware.

3.3.1.1. The Americas

The relevant regional instrument mentioned above is the Principles and Best Practices on the Protection of Persons Deprived of Liberty in the Americas.[237] It was adopted by the Inter-American Commission on Human Rights when the CRPD had not come into force yet (the treaty is nonetheless mentioned in its Preamble). The Principles' scope extends to the *"persons who are under the custody and supervision of certain institutions, such as: psychiatric hospitals and other establishments for persons with… mental… disabilities."*[238] While the whole document is generally applicable to them, Principle III(3) is specifically dedicated to persons with mental disabilities.

The instrument establishes that *"[t]he mere existence of a disability shall in no case justify a deprivation of liberty."* This statement would exactly mirror the one in Article 14(1)(b) CRPD if the word *'mere'* was not added here. The Principles' wording implies that involuntary placement cannot take place on the basis of a disability alone, but requires additional conditions to be present as well. The CRPD, on the other hand, seems to outlaw any deprivation of liberty which is wholly or partly based on one's disability.

The Principles add that involuntary placement must be applied as a measure of last resort, and solely when there is serious likelihood of immediate or imminent harm to the person concerned or to others. Gradual de-institutionalisation is strongly encouraged in favour of a community-based psychiatric care to *"avoid unnecessary deprivation of liberty in hospitals or other institutions."* Adding the word *'unnecessary'* may indicate that involuntary placement can sometimes be *necessary.* Thus, the Principles do not necessarily recommend that all mental health institutions shall be eventually shut down.

3.3.1.2. Europe

As was mentioned earlier, the CoE Committee on Bioethics is working on drawing up an Additional Protocol to the Biomedicine Convention, concerning involuntary placement and treatment of persons with mental disorder. In 2016 the Parliamentary Assembly has addressed the Committee of

[237] *supra* note 190: Principles and Best Practices on the Protection of Persons Deprived of Liberty in the Americas.
[238] *ibid*, General Provision.

Ministers in an attempt to prevent the Additional Protocol from being adopted.[239] It doubted the added value of this instrument and expressed concerns about its incompatibility with the CRPD. Based on the CRPD Committee interpretation of Article 14 CRPD, the Parliamentary Assembly concluded that any legal instrument that maintains a link between involuntary measures and disability is discriminatory and violates the CRPD. Since the draft Additional Protocol maintains such a link,[240] the instrument may create an explicit conflict between international norms at the global and European levels.[241]

Similar criticism of the Additional Protocol was articulated by other bodies within and outside of Europe, including the CoE Commissioner for Human Rights, the EU Agency for Fundamental Rights, the UN CRPD Committee, the UN Special Rapporteur on the rights of persons with disabilities and the Office of the High Commissioner for Human Rights - Regional Office for Europe.[242] This is quite significant as it shows that several European and international human rights bodies share a similar understanding of Article 14 CRPD. Nonetheless, the work on the Additional Protocol continues despite the evident opposition.[243]

The difference in approaches to what can be the basis of involuntary placement is especially noticeable when the CRPD and the ECHR are compared. As was shown in the previous section, the

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[239] "The case against a Council of Europe legal instrument on involuntary measures in psychiatry", Council of Europe Parliamentary Assembly Recommendation 2091, 22 April 2016.

[240] According to the draft Article 10 having a mental disorder constitutes the basis of the involuntary placement, together with other criteria. Interestingly, the draft Additional Protocol acknowledges the CRPD in its Preamble and states that *"the existence of a mental disorder in itself shall in no case justify an involuntary measure"* (lines 11-13 and 28-29). As was discussed earlier in this section, Article 14 CRPD was drafted in a way as to exclude any link between the disability and the deprivation of liberty, even if the additional criteria are present. By adding the words '*in itself*', the Additional Protocol drafters left room for the possibility of involuntary placement on the basis of a mental disorder paired with other grounds. See *supra* note 187, Working document concerning the protection of human rights and dignity of persons with mental disorder with regard to involuntary placement and involuntary treatment, 2015.

[241] *supra* note 239: Recommendation 2091, paras 3, 6-9.
For a substantial explanatory memorandum elaborating on these arguments see The report of the Committee on Social Affairs, Health and Sustainable Development, Council of Europe Parliamentary Assembly, The case against a Council of Europe legal instrument on involuntary measures in psychiatry, 29 March 2016, CoE doc. 14007.

[242] Compilation of comments received during the public consultation of Additional Protocol on the protection of the human rights and dignity of persons with mental disorders with regard to involuntary placement and involuntary treatment, 9 December 2015, DH-BIO/INF (2015) 20, pp. 6-14, 16-17, 18-19, 26-33, 35-36.

[243] In response to the Parliamentary Assembly's concerns, the Committee of Ministers expressed its confidence in a legal instrument on involuntary measures since it will *"contribute to prevention of abuses and encourage the progressive transition to a more uniform application of voluntary measures in psychiatry by the member States, in accordance with the spirit of the United Nations Convention on the Rights of Persons with Disabilities."* See Reply of the Committee of Ministers to "The case against a Council of Europe legal instrument on involuntary measures in psychiatry", Parliamentary Assembly Recommendation 2091 (2016), CM/AS(2016)Rec2091-final, 9 November 2016.

European Court's jurisprudence on Article 5 ECHR endorses the deprivation of liberty based on the *'unsoundness of mind'*. Since this criteria is interpreted as a *'true mental disorder'* that *'warrants compulsory confinement'*, the European Convention essentially provides for involuntary placement on the basis of a certain disability.[244] Such a position is diametrically opposite to what Article 14(1)(b) CRPD requires according to its Committee's interpretation. In Dr. Oliver Lewis' words, *"[o]ne frustration is that CRPD provisions do not map neatly onto the ECHR, but the main frustration is that the Court is not even engaging with what the CRPD has to say."*[245] Indeed, the UN Convention has not affected the ECtHR's rulings on involuntary placement, which continue to rely on the 1979 *Winterwerp* criteria.[246]

The situation creates conflicting obligation for those state parties to the CRPD who are also parties to the European Convention. The ECHR stipulates in this respect that nothing in it shall be seen as limiting any rights and freedoms ensured under other international agreements, to which a certain state is a party.[247] This might seem like a compelling argument in support of the CRPD text outweighing the European Convention. However, while the provision in question allows for the protection of rights to a level higher than that required by the ECHR, its application is problematic when key aspects of two treaties are based on different premises and are difficult to reconcile.[248]

In any case, while the States Parties are obviously bound by the UN Disability Convention, the legal status of the CRPD Committee's views and concluding observations is different. The documents adopted by the UN human rights treaty bodies are non-legally binding, and the Committees' function in relation to communications is quasi-judicial at best.[249]Judgments of the European Court, in contrast,

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[244] Moreover, the wording used by the ECtHR implies that some mental disorders not simply *justify* involuntary placement, but *necessitate* it.

[245] Lewis, Oliver, "Stanev v. Bulgaria: On the Pathway to Freedom" in *Human Rights Brief,* Vol. 19, Issue 2, 2012, p. 6.

[246] E.g. in *M v Ukraine,* 19 April 2012, the Court cited *Winterwerp* and concluded that *"it has not been reliably shown that the applicant's retention in the hospital was justified by the mental illness throughout… her… hospitalisations. Accordingly, there has been a violation of Article 5 § 1 of the Convention in this regard."* (paras 55, 67)
Also, in *Bergmann v Germany*, 7 January 2016, the Court considered *Winterwerp* a part of its *"well-established case-law"* on what justifies detention of '*a person of unsound mind'* (paras 96, 98, 106).
Even in the case of *M.S. v. Croatia*, 19 February 2015, where the Court explicitly cited the CRPD as well as some of the CRPD Committee's concluding observations under the *'Relevant international material'*, the *Winterwerp* criteria was still part of its reasoning (paras 46-47, 143).

[247] CRPD, Article 53.

[248] *supra* note 235: Fennell (2011), p. 671.

[249] The CRPD Committee can only make *"suggestions and recommendations"* after examining a state report or an individual/group communication. See CRPD, Article 36(1); Optional Protocol to the Convention on the Rights of Persons with Disabilities, 13 December 2006, UN doc. A/RES/61/106, Annex II, Article 5.

are binding on the states concerned,[250] and the latter usually comply with the Court's rulings.[251] Thus, the Committee's stance on the CRPD should not, in principle, have higher priority than the ECtHR jurisprudence.

Prof. Philipp Fennell envisages, however, that aspects of the CRPD will influence the way in which the European Court approaches certain matters.[252] The impact of the UN Convention will be gradual in promoting change, and the disagreement over the CoE legal instrument on involuntary measures in psychiatry is a good example. It demonstrates that while many entities adhere to the traditional model of mental health law, others have re-evaluated their position in light of the CRPD.

3.4. Revolutionary approach: involuntary placement must be outlawed

3.4.1. Universal level

As discussed in the previous section, the CRPD prohibits the deprivation of liberty on the basis of disability. According to the CRPD Committee's interpretation, one's disability cannot be used as a factor in authorising the practice, even when additional criteria are present. Apparently, this should not preclude persons with mental disabilities from ever being institutionalised, but the basis of such a measure must be something other than their disability.

That having been said, there is a different, much more radical position on involuntary placement, namely that the practice should be abolished altogether. Like the disability-neutral approach, this position takes the CRPD text as its basis, but now it is interpreted as to prohibit not just institutionalisation *on the ground of* disability, but institutionalisation *of* persons with disabilities – or of anyone else, for that matter. While the gradual move towards community-based mental health care has been welcomed for decades,[253] no human rights instrument has insisted on *prohibiting* involuntary

[250] ECHR, Article 45(1).
[251] To illustrate this: about 4000 new cases decided by the ECtHR were transmitted to the Committee of Ministers for supervision in 2013-2015; during the same period more than 4400 cases were successfully executed and closed by a final resolution. See Evolution of the number of cases from 1996 to 2015, Department for the Execution of Judgments of the ECHtHR, last updated 3 June 2016, available at: https://www.coe.int/en/web/execution/statistics (last visited 22 August 2017).
[252] *supra* note 235: Fennell (2011), p. 672-673.
[253] Already in 1982 the UN World Programme of Action Concerning Disabled Persons (covering persons with mental impairments) discouraged rehabilitation services being provided in large institutions. See *supra* note 23: UN General Assembly Resolution 37/52, 1982, para 18.

placement in psychiatric facilities. Even when deinstitutionalisation is strongly encouraged, the wording is chosen with an understanding that this process takes time.[254] However, much more demanding calls started appearing within the UN system recently, allegedly for the sake of meeting the Disability Convention requirements.

Interestingly, the very same bodies that have elaborated on how the CRPD outlaws the deprivation of liberty *on the basis of* disability have also advocated for the *total* end of institutionalisation. Sometimes both of these approaches are applied alongside, in the same document. For example, in its Reporting guidelines the CRPD Committee instructed states to report on:

1) *"Measures taken by the State Party to ensure that… no person is deprived of her/his liberty on the basis of her/his disability"*
2) *"Actions being taken to abolish any legislation that permits the institutionalization or the deprivation of liberty of all persons with all forms of disabilities."*[255]

Obviously, the second guideline has far greater implications than the first one as the idea of outlawing all institutional care for persons with disabilities is much more difficult to accept and put into practice.

A more radical approach is also adopted in the Committee's General Comment No. 1 on equal recognition before the law. Here the body explicitly refers to Article 14 CRPD as the one guaranteeing *"the right to be free from involuntary detention in a mental health facility and not to be forced to undergo mental health treatment".*[256]. The denial of the legal capacity and detention of persons with disabilities in institutions against their will has been recognised is an *"ongoing problem"* that

[254] E.g. in one of its concluding observations the UN Human Rights Committee encouraged a state to *"consider providing less restrictive alternatives to forcible confinement and treatment of persons with mental disabilities"*; recently, the body chooses more convincing language, calling for the adoption of *"all measures necessary to implement a policy of deinstitutionalization of persons with disabilities accompanied by appropriate community-based support"*, but the involuntary placement nevertheless is not instantly outlawed. See Concluding Observations on the sixth periodic report of Russian Federation, 24 November 2009, UN doc. CCPR/C/RUS/CO/6, para 19(b); Concluding Observations on the fifth periodic report of Romania, 11 December 2017, UN doc. CCPR/C/ROU/CO/5, para 30(c).
Likewise, the UN Human Rights Council called upon States parties to the CRPD to *"take effective and appropriate measures to facilitate the full enjoyment by persons with disabilities of the right to live independently and be included in the community on an equal basis with others"*, and urged them to *"take further measures towards their deinstitutionalization".* See The right of persons with disabilities to live independently and be included in the community on an equal basis with others, Resolution adopted by the Human Rights Council, 8 April 2015, UN doc. A/HRC/RES/28/4, para 5(b).

[255] *supra* note 102: Guidelines on Article 12, p. 10.

[256] *supra* note 91: General comment No. 1, para 31.

"constitutes arbitrary deprivation of liberty and violates articles 12 and 14 of the Convention."[257] Drastic measures in this vein are sometimes called for in the Committee's concluding observations. On one occasion, the monitoring body expressed its usual concern about the state's domestic law *"allow[ing] a person to be deprived of liberty on the basis of actual or perceived disability"* (contrary to Article 14 CRPD).[258] Oddly enough, the state was then urged *"to take all necessary legislative, administrative and judicial measures to ensure that no one is detained against their will in any kind of mental health facility."*[259] Similar language can be found in the most recent concluding observations as well.[260]

Quite relevant here is the CRPD Committee's Adoption of Views concerning Australia in 2016.[261] The author of the communication is an Aboriginal national of Australia, who has a mental and intellectual disability and who was charged with performing indecent acts to a child. The author complained about the local law allowing for his indefinite detention as a person with impairment without any finding of guilt. It was found that the differential treatment provided under local law is indeed unreasonable and results in discriminatory treatment of persons with disabilities. The CRPD Committee observed that the author's detention was decided on the basis of his intellectual disability, in the absence of any criminal convictions. Therefore, the author's disability became the core cause of his detention, in direct violation of Article 14(1)(b) CRPD.[262]

The UN High Commissioner for Human Rights[263] and the Special Rapporteur on the rights of persons with disabilities[264] have also made some contentious statements about involuntary placement

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[257] The Committee urged states to refrain from such practices and *"establish a mechanism to review cases whereby persons with disabilities have been placed in a residential setting without their specific consent.* See *supra* note 91: General comment No. 1, para 40.

[258] UN Committee on the Rights of Persons with Disabilities, Concluding observations on the initial report of Austria, 30 September 2013, UN doc. CRPD/C/AUT/CO/1, para 29.

[259] *ibid*, para 30.

[260] E.g. Panama was recently recommended to *"protect and safeguard persons with disabilities from institutionalization and explicitly prohibit their institutionalization"*, and Latvia was encouraged to *"[r]epeal all relevant legislation in order to prevent the institutionalization of persons with… psychosocial disabilities"* and *"[r]epeal the provisions that allow persons with disabilities to be involuntarily committed to mental health institution*". See UN Committee on the Rights of Persons with Disabilities, Concluding observations on the initial report of Panama, 29 September 2017, UN doc. CRPD/C/PAN/CO/1, para 35; UN Committee on the Rights of Persons with Disabilities, Concluding observations on the initial report of Latvia, 10 October 2017, UN doc. CRPD/C/LVA/CO/1, subparas 25(a) and (b).

[261] *supra* note 99: *Mr Noble v Australia*.

[262] *ibid*, para 8.7.

[263] UN High Commissioner asserts that *"[f]orced institutionalization violates the right to personal liberty and security"*, requiring states to *"repeal legislation and policies that allow or perpetuate involuntary commitment"* and *"provide effective remedies and redress for victims."* He suggested that resources are no longer allocated to building new institutions

and institutional mental health care as a whole. The Special Rapporteur on the right to health asserts that overreliance of mental health services on coercive approaches and in-patient treatment *"is inconsistent with the principle of doing no harm, as well as with human rights"*.[265] He believes that we must *"radically reduce medical coercion and facilitate the move towards an end to all forced psychiatric treatment and confinement."*[266] In the recent report, the Special Rapporteur reiterates his call to radically reduce the use of institutionalisation in mental health-care settings, with a view to eliminating such measures and institutions.[267]

Lastly, the OHCHR study on independent living, cited in the context of a disability-neutral approach, discards its earlier conclusions. The study goes on to assert that, as the CRPD Committee *"has made clear"*, *"institutionalization is incompatible with article 19, and it is an obligation of States parties to make alternatives available."*[268] Regarding this particular argument it should be noted that Article 19 provisions are not that categorical (especially, when compared to some alternative proposals during the drafting process).[269] In fact, the chapeau of Article 19 carefully requires to *"take… measures to facilitate full enjoyment by persons with disabilities"* of the right to live in the community.

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or refurbishing existing facilities, but used to create community-based support systems for persons with psychosocial disabilities. See *supra* note 226: Report of the United Nations High Commissioner for Human Rights, 2017, paras 31, 61(e).

[264] The Special Rapporteur considers institutionalisation as a *"harmful practice"*, *"prompting the ultimate objectification of persons with disabilities"*. He believes that these persons should not *"be obliged to live in a particular living arrangement such as psychiatric hospitals"*, and advocates for *"an immediate moratorium on new admissions to institutions."* See Report of the Special Rapporteur on the rights of persons with disabilities, 12 December 2017, UN doc. A/HRC/37/56, para 82; Report of the Special Rapporteur on the rights of persons with disabilities, 20 December 2016, UN doc. A/HRC/34/58, paras 84, 86.

[265] *supra* note 114: Report of the Special Rapporteur on the right to health, 2017, para 58.

[266] *ibid*, para 65.

[267] Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 10 April 2018, UN doc. A/HRC/38/36, para 51.

[268] *supra* note 120: Thematic study by the OHCHR, 2014, UN doc. A/HRC/28/37, para 23.

[269] The earliest draft of this article included *"the right not to reside in an institutional facility"* (later worded as *"[p]ersons with disabilities are not obliged to live in an institution"*) and *s*ome NGOs insisted on the text clearly saying that *"compulsory institutionalization is prohibited"*. These approaches were perceived as too demanding since it was thought that States Parties *"would find it impossible to guarantee this obligation without exception."* Eventually, the current wording of Article 19, representing in a positive form the alternative to institutionalisation, was adopted. See Chair of the Ad Hoc Committee, Draft Elements for a Comprehensive and Integral International Convention to Promote and Protect the Rights and Dignity of Persons with Disabilities, December 2003, Article 17; Working Group of the Ad Hoc Committee, Draft comprehensive and integral international convention on the protection and promotion of the rights and dignity of persons with disabilities, 27 January 2004, UN doc. A/AC.265/2004/WG.1, Article 15; The Disability Caucus, Daily summary of discussion at the fourth session of the Ad Hoc Committee on the UN Convention on the Human Rights of People with Disabilities, 27 August 2004, Volume 5, #5: Report of the Working Group of the Ad Hoc Committee on a Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities, p. 20, footnote 52.

As Prof. Giuseppe Palmisano explains, this provision does not impose on states the obligation to actually and completely achieve a specific result, but rather adopt measures aimed at, and actually capable of, facilitating its achievement.[270] Meanwhile, from the above examples it appears that some UN bodies may read into the CRPD text what is not necessarily there.

3.4.2. Regional level

Although no other instrument in effect prohibits deprivation of liberty on the basis of disability like the UN Convention, there are provisions in regional systems that resemble the CRPD right to live independently and be included in the community (Article 19). Some non-binding documents encouraging deinstitutionalisation also exist in the regions, but the most daring initiative so far is the draft African Disability Protocol.

3.4.2.1. Europe

The European Social Charter (Revised) establishes the *"right of persons with disabilities to independence, social integration and participation in the life of the community"*[271] According to the Charter Explanatory report,[272] the aim of the revised provision is to develop a coherent policy for people with disabilities in line with 1992 Recommendation of the CoE Committee of Ministers. One of the relevant parts of this Recommendation reads:

"To enable the integration of people with disabilities into working life and society, services should as far as possible be provided at home or in out-patient clinics, and facilities should be set up accordingly. Where institutional care is unavoidable, arrangements should be made for the patient to return home at regular intervals."[273]

The aim is therefore to reduce the reliance on institutional care (for people with physical, mental or sensory deficiencies), but obviously not to eliminate the practice. Much greater commitment was

[270] Palmisano, Giuseppe, Article 19 [Living Independently and Being Included in the Community], in Fina, Della et al. (eds.), *The United Nations Convention on the Rights of Persons with Disabilities. A Commentary,* Springer International Publishing, 2017, p. 362.
[271] Council of Europe, European Social Charter (Revised), concluded 3 May 1996, entered into force 1 July 1999, ETS 163, Article 15.
[272] Explanatory Report to the European Social Charter (Revised), 3.V.1996, European Treaty Series No. 163, para 64.
[273] Recommendation No. R (92) 6 of the Committee of Ministers to Member States on a coherent policy for people with disabilities, Council of Europe, 9 April 1992, Part IV, Section 2.9.

shown by the Ministers of Health of the Member States in the WHO European Region who adopted the Mental Health Declaration for Europe.[274] The document acknowledged that mental health services in the European region are being provided in a wide range of community-based settings and no longer exclusively in isolated and large institutions. Since this was believed to be *"the right and necessary direction"*, the next goal was set to *"develop community-based services to replace care in large institutions for those with severe mental health problems."*[275]

A similar message is found in the 2009 CoE Resolution, where the Parliamentary Assembly invited states to *"commit themselves to the process of deinstitutionalisation by reorganising services and reallocating resources from specialised institutions to community-based services"*[276] The wording in both documents suggests that community-based psychiatric care was not simply accepted as an alternative, but recognised as a standard.[277]

3.4.2.2. The Americas

The Inter-American Convention on the Elimination of All Forms of Discrimination against Persons with Disabilities contains a similar provision to the one found in the ESC. The States Parties to the Convention have undertaken to collaborate effectively in *"[t]he development of means and resources designed to facilitate or promote the independence, self-sufficiency, and total integration into society of persons with disabilities, under conditions of equality."*[278] While the drafters of this provision probably had similar aims in mind as the drafters of Article 15 ESC, the aspirations of those who drew up the non-binding Caracas Declaration were higher. The document, adopted at a conference convened by the Pan American Health Organization (Regional Office of the WHO), strongly encourages *"the restructuring of psychiatric care"* in favour of *"alternative service models*

[274] Mental Health Declaration for Europe: Facing the Challenges, Building Solutions, adopted at the WHO European Ministerial Conference on Mental Health in Helsinki, Finland, 14 January 2005, EUR/04/5047810/6.
[275] *ibid*, Sections 6, 10.xi.
[276] *supra* note 22: CoE Parliamentary Assembly Resolution 1642 (2009), para 8.1.
[277] There have also been calls for more drastic measures within the European region. The former CoE Commissioner for Human Rights has urged CoE member states to *"adopt a no-admissions policy to prevent new placements of persons with disabilities in institutional settings"* and *"set deinstitutionalisation as a goal and develop a transition plan for phasing out institutional options and replacing them with community based services"*. See The right of people with disabilities to live independently and be included in the community. Issue Paper commissioned and published by Thomas Hammarberg, Council of Europe Commissioner for Human Rights, 12 March 2012, CoE doc. CommDH/IssuePaper(2012)3.
[278] *supra* note 15: Inter-American Convention on the Elimination of All Forms of Discrimination against Persons with Disabilities, 1999, Article IV, para 2(b).

that are community-based and integrated into the social networks."[279] The Declaration has initiated a revision of mental health legislation in the region, but this involved the improvement of involuntary admission procedures, not abandoning the practice *per se*.[280]

3.4.1.1. Africa

As was discussed earlier, current human rights regime in Africa provides little protection against involuntary placement in psychiatry. The situation may change considerably if the Disability Protocol to the African Charter is adopted (based on its final draft of 2016).[281] The draft document covers those who have mental impairments (regardless of their duration) and contains extensive provisions on the right to liberty and community living. Like the CRPD, the Draft Protocol prohibits deprivation of liberty on the basis of disability and holds that persons with disabilities should be able to choose their place of residence and where and with whom they live.[282] Additionally, the draft document puts an obligation upon states to try to ensure that persons with disabilities are not *"forcibly confined or otherwise concealed by any person or institution"*[283]and are not subject to non-consensual medical intervention.[284] Finally, the draft Article 5(3) encourages States to *"prevent deprivation of liberty to persons with disabilities, to prosecute perpetrators of such abuse and to provide remedies for the victims."*

The current wording implies that the Draft Protocol supports neither deprivation of liberty *on the basis of* disability nor deprivation of liberty *of* persons with disabilities. On the other hand, it does recognise that such persons may be *lawfully* deprived of their liberty.[285] Perhaps the future Article 5

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[279] The reform was considered necessary because mental hospitals isolate patients from their natural environment and create unfavourable conditions that impel their human rights. See Caracas Declaration, adopted at the Conference on the Restructuring of Psychiatric Care in Latin America on 14 November 1990, Caracas, Venezuela.

[280] Bolis, Mónica, *The Impact of the Caracas Declaration on the Modernization of Mental Health Legislation in Latin America and the English-speaking Caribbean*, Pan American Health Organization / World Health Organization, July 2002, p. 16.

[281] *supra* note 208: Draft Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa.

[282] *ibid,* Articles 5(5), 10(2)(a).

[283] *ibid,* Article 5(2)(b).
'Concealment' apparently refers to the cultural practice of hiding persons with disabilities either for their protection or to avoid embarrassment to their families. See *supra* note 206: Enonchong (2017), pp. 5, 14.

[284] *supra* note 208: Draft Protocol, Article 5(2)(d).
Article 13(2)(d) of the Draft Protocol also urges States to ensure *"that all health services are provided on the basis of free, prior and informed consent."*

[285] *ibid,* Article 5(2)(a) and (4).

would outlaw psychiatric institutionalisation, but allow criminal detention of persons with mental disorders.[286] Such requirements are not easy to implement in developed countries, and would pose a major challenge to African governments. A further refinement and clarification of the draft's provision might be necessary to make the Protocol more coherent and practical.

[286] Dr Laura-Stella Enonchong in her analysis of the Draft Protocol concludes that effective application of its Article 5 would require the closure of psychiatric institutions. Criminal detention was beyond the scope of her analysis though. See *supra* note 206: Enonchong (2017), p. 16.

CHAPTER 4: INVOLUNTARY TREATMENT IN PSYCHIATRY

4.1. Overview of the involuntary treatment practice and key concepts

Involuntary placement and involuntary treatment are often interlinked in mental health care. As was mentioned in the previous chapter, the 'need for treatment' is a common criterion used in justifying involuntary placement. Patients admitted on this ground can normally be treated without their consent. Their hospitalisation thus serves as a means to ensure they receive the necessary medication and care: securing treatment is a central, if not the only, purpose of admission in this case.[287] When involuntary placement automatically means the patient may also be treated involuntary, we are speaking of a *'combined'* approach in mental health legislation.[288] Here the person is assessed for both interventions at the same time, and no separate procedure for sanctioning medical treatment is undertaken. That being said, more intrusive and risky interference (conducting clinical experiments, performing psychosurgery) requires patient's consent even when 'standard' involuntary treatment is authorised.[289]

It is worth noting that implementation of the 'combined' procedure of involuntary placement and treatment has been increasingly discouraged.[290] This approach assumes that a person with a mental disorder warranting hospitalisation is never capable of giving or withholding consent to medical treatment. Multiple studies, however, disproved this assumption. In a notable treatment competence study of 1995 (USA), almost 170 persons newly admitted to hospital with diagnoses of schizophrenia or depression were compared to about 80 physically ill and 250 healthy people.[291] Their abilities to

[287] This function of involuntary hospitalisation is explicitly recognised in some mental health laws. E.g., Portuguese Mental Health Law of 1998 states that *"compulsory detention may only be determined in cases where it is deemed to be the only way of guaranteeing that the detained patient is submitted to treatment*" (Article 8(1)); Mental Health Ordinance for Pakistan of 2001 covers only *"admission for assessment"* and *"admission for treatment"* (Sections 10, 11).
[288] Note that even when involuntary treatment is automatically permitted due to involuntary placement, it should never be given unless medically necessary. See *supra* note 120: WHO, Resource book, pp. 47-48.
[289] E.g., Portuguese Mental Health Law allows for compulsory therapeutic interventions in relation to involuntary patients or in case of emergency. However, the document demands patients' written consent before they can participate in clinical experiments, or before they are submitted to electroconvulsive therapy or psychosurgical interventions (Article 5(1)(c)-5(1)(e) and 5(2)).
[290] *supra* note 120: WHO, Resource book, p. 48. The relevant provisions will be cited later in this chapter.
[291] Note that the mentally ill group in this study was comprised of persons admitted voluntary, involuntary, and due to an emergency. See Grisso, Thomas and Appelbaum, Paul, "The MacArthur Treatment Competence Study. III Abilities of patients to consent to psychiatric and medical treatments", in *Law and Human Behavior*, Vol. 19, Issue 2, 1995, pp. 149–174.

communicate a choice, understand relevant information, appreciate the nature of the situation and its likely consequences, and rationally manipulate information were assessed.

The study results did show that decision-making abilities were compromised in many individuals with a mental disorder (especially those with schizophrenia). Despite that, most mental health patients still performed as well as patients with a physical illness and non-patients on any given measure of decisional abilities. Moreover, about 75% of the depression group and 50% of the schizophrenia group manifested adequate performance in all sets of abilities at once (this number was around 90% for the other groups). The study thus refuted the claim that mental health patients uniformly lack decision-making capacity.[292] It was concluded that this assumption cannot justify a blanket denial of the right to consent to or refuse treatment for mental health patients.

As an alternative to the compromised 'combined' solution, the states may utilise a *'separate'* approach to psychiatric interventions. According to it, the involuntary admission and treatment procedures are independent from each other and the person is assessed for each of them individually.[293] Authorisation of involuntary placement relies on existing mental disorder (among other conditions) while approval of involuntary treatment is based on one's lack of faculty. Thus, a stage is added when the person's incapacity to consent to treatment could be determined before imposing the treatment itself.[294]

A 'separate' approach recognises that someone committed to a psychiatric facility due to a mental disorder may regain the capacity to make treatment decisions. This method also emphasises that one may require involuntary placement when involuntary treatment is not necessary. Such patients may benefit from their stay in a facility by engaging in psychotherapy, support groups or occupational therapy. Many others, at the same time, might need compulsory treatment without having to be placed

[292] This finding has been supported by other researchers. E.g., a smaller British study found that 33 of the 41 mental hospital patients (80%) had the capacity to give or withhold consent to their treatment (including several patients admitted involuntarily). It was observed that all eight participants who lacked capacity had a psychotic illness (six of the nine participants with schizophrenia performed satisfactorily though), and all twelve participants with depression were able to consent to their treatment. See Bellhouse, John et al., "Capacity-based mental health legislation and its impact on clinical practice: 2) treatment in hospital", *in Journal of Mental Health Law*, No. 9, 2003, pp. 24-37.

[293] *supra* note 120: WHO, Resource book, p. 48.

E.g., according to Irish Mental Health Act of 2001 a person may be involuntarily admitted to and detained in an approved facility if he is suffering from a mental disorder (no other criteria are specified). Involuntary treatment may be imposed on him if it is necessary to safeguard the life of the patient, to restore his health, to alleviate his condition, or to relieve his suffering, and the patient concerned is incapable of giving consent to treatment (Sections 8(1) and 57(1)).

[294] This may not apply to emergencies though.

outside their homes or communities. They can be ordered into treatment in the community (outpatient commitment) instead.[295]

Recognising that some people can make treatment decisions even when they're confined as mental health patients seems to be the most progressive solution currently in use. The author was unable to find examples of national regimes that would entirely prohibit involuntary treatment in mental healthcare. The practice persists even in the states devoted to the process of deinstitutionalisation.[296] Thus, the laws that reflect highest respect for the autonomy of persons with mental disorders define clear conditions and safeguards for involuntary treatment, at best.

As explained earlier, involuntary placement and treatment are inseparably linked under a 'combined' approach, meaning no special criteria and procedure for authorising non-consensual treatment are specified. These matters will therefore be discussed in the context of a 'separate' approach. As for the application of involuntary treatment as such (administering certain therapeutic methods), the specific procedure followed to authorise treatment becomes less relevant. Discussion of the latter topic will thus apply to both legal approaches in mental healthcare.

Before proceeding to analyse relevant international standards, it is worth getting a basic idea about what psychiatric treatment means in practice. Treatment for mental disorders can be provided by following methods:

1) Pharmacotherapy (medical treatment in a narrow sense): treating with psychoactive drugs (e.g. antidepressants, antipsychotics, mood stabilisers).
2) Psychotherapy: using psychological methods to overcome problems, which normally involves regular interaction with a therapist (e.g. cognitive behavioural therapy, psychoanalysis).

[295] Note that the concept of outpatient treatment varies among national regimes. It can denote an independent alternative to involuntary placement, but it can also refer to discharge from inpatient treatment 'on probation' or a short-term interruption of an involuntary placement (e.g. for vacation). See European Commission - Health & Consumer Protection Directorate-General, Research Project on Compulsory Admission and Involuntary Treatment of Mentally Ill Patients – Legislation and Practice in EU-Member States, Final Report, Mannheim, Germany, May 15, 2002, p. 16.

[296] E.g. Italian mental health law (now consisting of four articles of Law 833/1978) sanctioned the abolishment of mental hospitals and established that mental health services should normally be community based. Nevertheless, the national law provides for involuntary treatment for mental disorders alongside other illnesses.

3) Electroconvulsive therapy (ECT): electrically inducing seizures to provide relief from mental disorders (often used for depression).[297]
4) Psychosurgery (neurosurgery): destroying parts of brain tissue or stimulating certain brain areas (e.g. bilateral cingulotomy, deep brain stimulation).[298]

Normally, involuntary treatment entails administration of psychotropic medication to the patient. National laws that follow the 'separate' approach to assessing the need of admission and treatment, may provide for involuntary medical treatment in cases of emergency or if the patients lacks the mental capacity to consent.[299] Electroconvulsive therapy can also be performed without the person's informed consent, but the involuntary psychosurgical procedures are more restricted (to the point of being outlawed).[300]

Some coercive measures that are not primarily psychiatric treatments can also be applied in a mental health facility. These include restrictive interventions such as physical or pharmaceutical restraint and seclusion.[301] Patients may be restrained by being strapped to a bed or heavily sedated with drugs, and secluded in an isolated room, away from other patients. Additionally, persons with mental disorders may be given medicine for reducing sexual desire[302] or forced to undergo abortion or

[297] This is the only accepted form of shock therapy today; other options used to be insulin coma therapy or deep sleep therapy (both rendering patients unconscious for days or weeks on end). New South Wales Mental Health Act of 2007 (Australia), for example, explicitly lists those among prohibited treatments. See Section 83(1).
[298] Modern psychosurgical procedures are much more delicate than, say, the infamous lobotomy, popular in XX century. Deep brain stimulation, for example, is a reversible, non-destructive form of psychosurgery, which involves implanting electrodes to stimulate certain areas of the brain.
[299] E.g., according to Indian Mental Healthcare Act of 2017 the patient can be treated without his consent if he *"requires nearly hundred per cent. support… in making a decision in respect of his treatment"* (Section 89(7)) or when the treatment is *"immediately necessary"* to prevent death, serious harm to health or serious damage to property (emergency treatment, Section 94).
[300] The laws on psychosurgery vary greatly. E.g. Finnish Mental Health Act of 1990 allows to provide non-consensual psychosurgical treatment if it is necessary to avert a danger to the patient's life (Section 22 b (2)); Irish Mental Health Act of 2001 only authorises psychosurgery with the patient's written consent (Section 58(1)); and New South Wales Mental Health Act of 2007 prohibits psychosurgery for the purpose of altering the thoughts, emotions or behaviour of the person altogether (Section 83). None of these documents outlaw involuntary ECT though.
[301] E.g., Maltese Mental Health Act of 2012 permits restrictive care if there is no other way to prevent imminent harm and danger to the patient and others. The act stresses that seclusion and restraint shall not be unnecessarily prolonged or used as a punishment or for the convenience of staff (Articles 2, 34).
[302] E.g., Scottish Mental Health (Care and Treatment) Act of 2003 (UK) provides for involuntary administration of medicine that reduces sex drive *"in the patient's best interests"* if he does not consent to this or is incapable of consenting (Sections 240(2) and (3), 241).

sterilisation.[303] Although the focus of this chapter is psychiatric treatment in a narrow sense, some of the nontherapeutic interventions will also be discussed.

As is the case with involuntary placement, many persons with mental disorders perceive their involuntary treatment as a frightening and humiliating experience.[304] Respondents in the FRA study specifically mention being forcefully wrestled down for an injection or tied to a bed (despite not being aggressive), as well as having to endure distressing side effects from the medicine they were given while unable to discuss the alternatives with a doctor.[305] Often no one informs the patients about their diagnosis or the treatment they are prescribed and its side effects. As one man recalls: *"They probably injected me in the hand, but I don't remember now, and I fell immediately asleep; my eyes closed. Right after they did electric shocks without me knowing about it. I found out later. They ruined my life."*[306] While the views about involuntary treatment are largely negative among service users, many acknowledge that medication in itself can be helpful. They admit that they would had willingly taken it if the treatment options were discussed with them and treatment plan tailored to their needs.[307] It is resorting to force where simple explanation or persuasion would suffice that seems to cause the biggest discontent about involuntary treatment.

Indeed, patients' satisfaction with their hospital treatment is inversely related to the level of coercion they experienced.[308] Those who perceive less coercion at admission and during hospital treatment are more satisfied overall. Note that their opinion relies on subjective perceptions of coercion, rather than the documented extent of coercive measures. Patients can thus feel their involuntary treatment is much more uncomfortable and intrusive than their professional carers may acknowledge. On the whole, and similarly to the situation with involuntary placement, it cannot be assumed that patients are subsequently grateful for the treatment being imposed on them.

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[303] Relevant provisions can be found in Victorian Guardianship and Administration Act of 1986 (Australia), which applies to persons with mental disorder. The Act stipulates that involuntary sterilisation or termination of pregnancy can be carried out *"in the patient's best interests"* if she is incapable of giving consent (Sections 3(1), 36, 42E).
[304] *supra* note 122: FRA, p. 44.
[305] *supra* note 122: FRA, pp. 44-48. E.g., in one woman's experience: *"They decide on a treatment. You say to them that it does not suit you because it makes you fat, it makes you drool and it makes you restless. [They say] ah well, let's talk about other things."* p. 46.
[306] Man, 55, Greece, *supra* note 122: FRA, p. 44.
[307] *supra* note 122: FRA, p. 45.
[308] Based on the study covering 778 involuntary inpatients in 22 English hospitals; their satisfaction with treatment was assessed a week after admission and at the one-month, three-month, and one-year follow-ups. See Katsakou, Christina et al., "Coercion and treatment satisfaction among involuntary patients" in *Psychiatric Services*, Vol. 61, Issue 3, 2010, pp. 286-92.

Statistics offer a glimpse at the degree of non-compliance in mental healthcare: about *three-quarters* of patients prescribed psychotropic medication prematurely discontinue it within one year of treatment, often without informing their doctor. Partial non-adherence (missing doses) is even more common.[309] It is important to stress that manifestations of mental disorder are by far not the only reason patients resist treatment. The adverse effects of medication prescribed is often the decisive factor: studies show that a lot of people cease their medication due to weight gain or sexual dysfunction associated with antipsychotic drugs.[310] Relations between patient and health professional are also important: disagreement with or low trust in one's prescribing physician correlate with worse medication adherence.[311]

As Prof. Peter Bartlett emphasises, treatment refusals are a complex phenomenon and psychiatric medication itself is much more problematic than commonly perceived.[312] He points out that despite having beneficial effects in many (but not all) cases, psychoactive drugs often cause serious and irreversible harm.[313] Remarkably, more people die from the adverse effects of anti-psychotic medication than are killed by people as a result of their mental disorder.[314] In Bartlett's words, *"[t]hese are serious treatments, with serious human rights implications"*, which *"cannot be ignored in states that purport to take human rights seriously."*[315] A more balanced reflection of the benefits and risks of therapeutic methods in mental healthcare is important when discussing involuntary treatment.

[309] Relevant studies cited in Mitchell, Alex & Selmes, Thomas, "Why don't patients take their medicine? Reasons and solutions in psychiatry" in *Advances in Psychiatric Treatment*, Vol. 13, Issue 5, 2007, pp. 336-346.
[310] In one study obese individuals were about 2.5 times more likely to stop their antipsychotic medication than non-obese people, the primary reason being distress over drug-related weight gain. Another study shows that about 40% of men and 15% of women stopped their medications based on a belief that they were experiencing sexual side effects. See Weiden, Peter et al., "Obesity as a risk factor for antipsychotic noncompliance" in *Schizophrenia Research*, Vol. 66, Issue 1, 2004, pp. 51-57; Rosenberg, Kenneth et al., "A Survey of Sexual Side Effects Among Severely Mentally Ill Patients Taking Psychotropic Medications: Impact on Compliance" in *Journal of Sex & Marital Therapy*, Vol. 29, Issue 4, 2003, pp. 289-296.
[311] See discussion in Mitchell, Alex & Selmes, Thomas (2007) "Why don't patients attend their appointments? Maintaining engagement with psychiatric services", in *Advances in Psychiatric Treatment*, Vol. 13, Issue 6, 2007, pp. 423-434; and Bultman, Dara & Svarstad, Bonnie, "Effects of physician communication style on client medication beliefs and adherence with antidepressant treatment", in *Patient Education and Counseling*, Vol. 40, Issue 2, 2000, pp. 173–185.
[312] *supra* note 3: Bartlett (2011), pp. 517-519.
[313] Diseases and syndromes caused by psychiatric medication include obesity, diabetes, heart problems, parkinsonian symptoms, akathisia (restlessness), dystonia and tardive dyskinesia (both manifesting in abnormal involuntary movements). These effects can be permanent.
[314] There were 749 deaths from anti-psychotic medication in the UK in the period of 1997-2008. The number of homicides in the same period by people with mental illness at the time of the homicide is 658. See Written response by Jil Matheson, National Statistician, to Parliamentary Question 302898, House of Commons Debate, 2 December 2009, column 825W; National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, Annual Report (University of Manchester, 2011).
[315] *supra* note 3: Bartlett (2011), p. 518.

This would allow for a fairer assessment of two positions on consent to treatment, currently present in international and regional human rights law.

4.3. Traditional approach: there are exceptions to the principle of informed consent

4.3.1. Universal level

Within the modern mental health field there is a perception of informed consent to treatment as a general rule to be followed, unless exceptional conditions are present. Already the 1983 Hawaii Declaration, approved by the World Psychiatric Association, proclaimed that no treatment shall generally be given against or independent of a patient's own will. Exceptions can be made if, *"because of mental illness, the patient cannot form a judgement as to what is in his or her own best interest and without which treatment serious impairment is likely to occur to the patient or others."*[316] A similar approach to involuntary psychiatric treatment has been carried throughout many international documents adopted in the coming years.

The 1991 UN MI Principles provide for the most detailed international standards when it comes to mental health treatment. It is stated that patients shall not be given unjustified medication, but that it must always have a therapeutic or diagnostic purpose.[317] According to the document, patients must be treated *"in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others*."[318] Moreover, treatment itself shall be directed towards preserving and enhancing personal autonomy. [319]

Principle 11, the largest one within the document, is dedicated to consent to treatment. Informed consent to one's psychiatric treatment is set as a necessary requirement by default.[320] The term is defined as *"consent obtained freely, without threats or improper inducements, after appropriate*

[316] Declaration of Hawaii, approved by the General Assembly of the World Psychiatric Association, 10 July 1983, para 5. The document openly acknowledged *"conflicting loyalties and expectations of both physicians and patients"* and *"the delicate nature of the therapist-patient relationship"*. Its aim was thus to set *"minimal requirements for the ethical standards of the psychiatric profession"* to *"prevent misuse of psychiatric concepts, knowledge and technology"*. (Preamble)
[317] Principles 8(2), 10(1)
[318] Principle 9(1)
[319] Principle 9(4).
[320] Principle 11(1).

disclosure to the patient of adequate and understandable information in a form and language understood by the patient."[321] The information disclosed must involve the person's diagnosis; method, likely duration and expected benefit of treatment; alternative, less intrusive modes of treatment, as well as risks and side effects involved. The patient's right to refuse or stop treatment cannot be waived.[322]

As expected, the MI Principles recognise the instances when a proposed plan of treatment may be given to someone without their informed consent. This is the case with involuntary patients who, at the same time, lack the capacity to give or withhold consent, or who withhold it *"unreasonably"*, as far as their own safety or the safety of others are concerned.[323] One can also be treated involuntarily if this is *"urgently necessary"* for prevention of immediate or imminent harm; such treatment shall not be prolonged after it ceases to serve this purpose.[324] Additionally, the document acknowledges the possibility of a patient's legal representative consenting on her behalf.[325]

Physical restraint and seclusion shall be employed only when it is the only available means to prevent immediate or imminent harm to the patient or others. They must not be prolonged beyond the period which is strictly necessary for this purpose, and the person in question must be kept under humane conditions and be under the care and regular supervision during that time.[326] According to the document, clinical trials and experimental treatment do not require consent either, but only if the patient is unable to give one, and an independent body approves the practice.[327]

The MI Principles also accept a major medical or surgical procedure being carried out without the patient's consent, except when it comes to psychosurgery and other intrusive and irreversible treatments for mental illness. The latter shall never be carried out on involuntary placed patients, and must require the voluntary patient's consent and approval of an independent body.[328] Lastly, the document proclaims that sterilisation must never be carried out as a treatment for mental illness.[329]

[321] Principle 11(2).
[322] Principle 11(5).
[323] Principle 11(6).
[324] Principle 11(8).
[325] Principle 11(7).
[326] Principle 11(11).
[327] Principle 11(15).
[328] Principle 11(13)-(14).
[329] Principle 11(12).

The MI Principles have set a benchmark for mental health care worldwide, remaining relevant long after their adoption. For instance, the Committee on Economic, Social and Cultural Rights refers to the MI Principles in its general comment on the right to health: they are mentioned in the context of *"applicable international standards"* regulating coercive medical treatment.[330] The Committee recognised the right to be free from non-consensual medical treatment as part of the right to health at the beginning of this general comment.[331] Later on, the body proceeded to clarify this statement: *"obligations to respect [the right to health] include a State's obligation to refrain from… applying coercive medical treatments, unless on an exceptional basis for the treatment of mental illness or the prevention and control of communicable diseases."*[332] Such exceptional cases should be subject to specific and restrictive conditions, respecting best practices and applicable international standards.

The WHO also relies on the MI Principles in its Mental Health Policy and Service Guidance Package.[333] The document consists of different modules intended to help states improve their mental health services, law and policy. The Module on Mental Health Legislation and Human Rights proposes several principles to be enshrined in mental health law, including 'the least restrictive alternative' and 'free and informed consent to treatment'.[334] Promoting community-based treatments and voluntary placement and treatment in institutional settings are strongly encouraged. Involuntary treatment shall be allowed only under exceptional, clearly outlined circumstances, and must not be applied to patients admitted voluntarily. Involuntary patients should also be treated with their consent except in certain rare situations: e.g. lacking the capacity to give consent or if the treatment is necessary to prevent a significant deterioration in mental health and/or harm to the patients or other people.[335] Therefore, the document firmly supports separate approach to involuntary placement and treatment.

Most human rights bodies within the UN system acknowledge the vulnerable situation of mental health patients and the possibility of abuse when it comes to their involuntary treatment. However, the mere existence of the practice is rarely criticised. For example, the Human Rights Committee found psychiatric experiments (in a form of forced injection of tranquillisers) to constitute inhuman treatment

[330] supra note 114: CESCR, General Comment No. 14, 2000, para 34.
[331] *ibid*, para 8.
[332] *ibid,* para 34.
[333] see, e.g. World Health Organisation, Mental Health Policy and Service Guidance Package: Mental Health Legislation and Human Rights, 2003, p. 21.
[334] *ibid*, pp. 4, 21-23.
[335] *ibid.*

already in the early 1980s.[336] However, the body is much more accepting when it comes to *lawful* interventions in mental health care: while it may encourage the state to *"consider providing less restrictive alternatives to forcible confinement and treatment of persons with mental disabilities"*, the Committee does not condemn either practice in itself.[337] As long as living conditions and treatment in psychiatric institutions meet a certain standard, and any restrictions are legal, necessary and proportionate to the individual circumstances, the HR Committee is satisfied.[338]

The Special Rapporteur on Torture Manfred Nowak called for greater attention to abuse of psychiatry and forcing it upon persons with mental disabilities, noting that *"forced and non-consensual administration of psychiatric drugs, and in particular of neuroleptics, for the treatment of a mental condition needs to be closely scrutinized."*[339] He noted that administration of *"neuroleptics that cause trembling, shivering and contractions and make the subject apathetic and dull his or her intelligence"* has been recognized as a form of torture by the first UN Special Rapporteur on Torture in 1980s.[340] While Mr. Nowak himself acknowledged that non-consensual administration of psychiatric drugs may amount to torture or ill-treatment, the wording chosen implies that this is not always the case. [341]

In a similar vein, the UN Committee against Torture expressed concern about *"the excessive use of medication and chemical restraints; the enforced administration of non-consensual and intrusive and irreversible psychiatric treatment and therapies such as neuroleptic drugs"* in one of its recent concluding observations.[342] Nevertheless, the suggested solution was not to abolish the practice of non-consensual treatment entirely, but to *"ensure that the use of medication strictly complies with medical needs and that there is no excessive use of medication"*.[343] Interestingly, the Committee encouraged the state to rely upon the UN MI Principles in this endeavour – almost three decades after their adoption and without acknowledging the UN Disability Convention demands.

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[336] *Viana Acosta v. Uruguay*, Human Rights Committee, 31 March 1983, UN doc. Supp. No. 40 (A/39/40) at 169 (1984).
[337] *supra* note 254: CO of Russian Federation, 2009, para 19.
[338] *supra* note 254: CO of Romania, 2017, para 30(a) and (d).
[339] *supra* note 227: Report of the Special Rapporteur on torture (2008), paras 62-63.
[340] Report by the Special Rapporteur, Sr. Peter Kooijmans, 19 February 1986, UN doc. E/CN.4/1986/15, para 119 (p. 29).
[341] Whether certain psychiatric intervention amounts to ill-treatment depends on *"the circumstances of the case, the suffering inflicted and the effects upon the individual's health". Ibid*, Report of the Special Rapporteur on torture (2008), para 63.
[342] UN Committee against Torture, Concluding observations on the sixth periodic report of Bulgaria, 15 December 2017, UN doc. CAT/C/BGR/CO/6, para 15(d).
[343] *Ibid*, para 16(g).

4.3.2. Regional level

Most regional instruments and bodies adhere to the traditional approach in mental health care, with involuntary treatment being a common exception to the principle of informed consent. The most extensive sources on the matter can be found within the European system, which will be analysed first. Inter-American and African regions, with less instruments or cases of relevance, will be addressed afterwards.

4.3.2.1. Europe

The most important European document in the realm of bioethics, the CoE Oviedo Convention,[344] dedicates its Article 7 to persons with mental disorders. According to this provision, such people may be subjected to an involuntary intervention aimed at treating their disorder when not doing so is likely to result in serious harm to their heath. This constitutes an exception to the principle of free and informed consent, established in Article 5. The Convention also mentions persons unable to consent in general (for reasons not limited to a mental disorder), stipulating that a representative or an authority must authorise all interventions to be performed on them, for their direct benefit.[345] However, any medically necessary intervention can be carried out immediately during an emergency, when the appropriate consent cannot be obtained.[346]

A stronger position on involuntary treatment, with a bigger emphasis on its exceptional character and relevant safeguards, is taken by the European Committee for the Prevention of Torture (CPT).[347] Already in its 1998 report on involuntary placement in psychiatric establishments, the CPT stressed the importance of preserving the decision-making rights of mental health patients over their treatment. In the Committee's words:

[344] *supra* note 26: Convention on Human Rights and Biomedicine, 1997.
[345] *ibid,* Article 6(1) and (3).
[346] *ibid,* Article 8.
[347] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment is a specialised monitoring body of the CoE, established by the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (1987).

> *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.* [348]

We can see that the 'combined' approach in authorising involuntary placement and treatment is firmly discouraged here. However, the CPT refers only to 'competent' patients in its statement and does not condemn the practice of involuntary treatment altogether. The body acknowledges that there can be *"derogation from this fundamental principle"*, but the latter must pertain to *"clearly and strictly defined exceptional circumstances"* in accordance with law.[349] Moreover, certain methods of treatment are never accepted, like administration of ECT in its unmodified form (i.e. without anaesthetic and muscle relaxants).[350] As for the restraint of agitated and/or violent patients, the CPT recommends that it is, as far as possible, non-physical (e.g. verbal instruction) with manual control used only when strictly necessary. Resort to instruments of physical restraint (straps, strait-jackets, etc.) or seclusion shall very rarely be justified and under no circumstances applied as a punishment.[351]

The criteria for involuntary treatment set in the CoE Recommendation of 2004 are practically the same as those for involuntary placement. [352] The document identifies separate principles for involuntary treatment though: it must address specific clinical symptoms, be proportionate to the person's state of health and form part of a written treatment plan, prepared in consultation with the patient whenever possible.[353] The decision to subject a person to involuntary treatment should be taken by a court or another competent body. However, if the patient is involuntary detained or if there is an emergency, doctor's opinion is enough.[354]

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[348] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, Involuntary placement in psychiatric establishments, Extract from the 8th General Report of the CPT, published in 1998, CoE doc. CPT/Inf(98)12-part, para 41.
[349] *Ibid*.
[350] Unmodified electroconvulsive therapy can cause fractures, dislocations and dental injury. *Ibid,* para 39.
[351] *Ibid,* paras 47-49.
[352] For involuntary treatment to be authorised, no '*less intrusive'* means of providing care should be available, while for involuntary placement there should be no *'less restrictive'* means. Additionally, there is no *'therapeutic purpose'* requirement for involuntary treatment since it is already included in the definition of treatment. Other criteria reiterate verbatim those mentioned in chapter 3 of this work (having mental disorder, posing significant risk, having one's opinion considered). See *supra* note 27: Recommendation Rec 2004(10), Articles 2(3), 17-18.
[353] *ibid*, Article 19.
[354] *ibid,* Article 20-21.

Unlike in the case of involuntary placement of 'persons with unsound mind', the European Convention on Human Rights does not contain a clear-cut provision in relation to their involuntary treatment. Compulsory subjection to treatment has been considered in the broader context of private life under Article 8.[355] As the former European Commission of Human Rights pointed out: *"A compulsory medical intervention, even if it is of minor importance, must be considered as an interference with [the right to respect for private life]."*[356] This aspect of Article 8 includes the right not to be treated medically without consent. The latter, however, appears to relate only to adults deemed capable of giving consent to treatment.

In a prominent *Pretty v UK* case, the European Court established:

> *In the sphere of medical treatment, the refusal to accept a particular treatment might, inevitably, lead to a fatal outcome, yet the imposition of medical treatment, without the consent of a mentally competent adult patient, would interfere with a person's physical integrity in a manner capable of engaging the rights protected under Article 8 § 1 of the Convention.*[357]

While this case does not concern a person with mental disorder, the Court' summarised position on involuntary treatment in general is relevant to the discussion. As appears from the excerpt above, non-consensual medical treatment may violate one's right to respect for private life if the person in question is mentally capable to give and withdraw her consent. It thus seems to follow that compulsory psychiatric treatment, in principle, should not constitute a breach of Article 8 in relation to those considered unable to consent. Other case law may shed more light on the issue.

The classic Strasbourg case on psychiatric treatment is *Herczegfalvy v Austria,*[358] raising issues under Article 3 (freedom from torture and inhuman or degrading treatment) and Article 8 ECHR. The applicant, a former patient at the Vienna psychiatric hospital, complained about being strapped to a security bed for more than two weeks, force-fed for a significant period and given sedatives to allow

[355] The provisions of Article 8 ECHR are analysed in Chapter 12. Right to respect for Privacy (Article 8), revised by Heringa, Aalt and Zwaak, Leo in Pieter van Dijk et al., *Theory and Practice of the European Convention on Human Rights*, Fourth edition, Intersentia, 2006, p. 663-750.
[356] *X v Austria,* European Commission of Human Rights, Decision of 13 December 1980, no. 8278/78, Decisions and Reports, Vol. 18, p. 156, para 3..
[357] *Pretty v UK*, European Court of Human Rights, Judgement of 29 April 2002, no. 2346/02, para 63.
[358] *supra* note 164: *Herczegfalvy v Austria*, 1992.

treatment with perfusion (neuroleptic medication included). These measures were deemed necessary by the health professionals due to his violent behaviour and prolonged hunger strikes. It was also claimed that the applicant lacked capacity to make treatment decisions at the time.

European Commission, which considered the case prior to the Court, unanimously found the applicant's treatment incompatible with Articles 3 of the Convention.[359] The ECtHR, however, was of the opposite opinion. It was acknowledged that the cases concerning mental health patients (typically in the position of inferiority and powerlessness) call for increased vigilance in reviewing Convention compliance. Nevertheless, the Court observed that

> *...it is for the medical authorities to decide, on the basis of the recognised rules of medical science, on the therapeutic methods to be used, if necessary by force, to preserve the physical and mental health of patients who are entirely incapable of deciding for themselves and for whom they are therefore responsible.* [360]

It was also determined that *"a measure which is a therapeutic necessity"* according to the *"established principles of medicine"* cannot generally be regarded as inhuman or degrading. For this to be true though, it is important that *"the medical necessity has been convincingly shown to exist"*.[361] Pertaining to the present case, the ECtHR admitted that prolonged use of restrains on the applicant appeared *"worrying"*. Nevertheless, it did not find sufficient evidence to disprove the Government's argument that, *"according to the psychiatric principles generally accepted at the time, medical necessity justified the treatment in issue."* [362] Additionally, the Court could not disprove the Government's opinion that the hospital authorities were entitled to regard the applicant's mental disorder as *"rendering him entirely incapable of taking decisions for himself."* No violation of Articles 3 and 8 has thus been found.

The Court's reasoning in *Herczegfalvy* was regarded as perfunctory and problematic.[363] The scope of *"therapeutic necessity"* is unclear, as well as the criteria needed to prove it has been *"convincingly shown to exist"*. Prof. Bartlett points out that clinicians often rely on trial and error to

[359] According to the Commission, it was unnecessary to consider compulsory treatment under Article 8 as well. See *Herczegfalvy v Austria*, Report of the Commission, 1 March 1991, no. 10533/83, paras 254-255, 259-260.
[360] *supra* note 164: *Herczegfalvy v Austria*, 1992, para 82.
[361] *ibid.*
[362] *ibid*, para 83.
[363] *supra* note 3: Bartlett (2011), pp. 525-527 (specific issues of concern discussed throughout the article).

find a treatment that works for a specific patient and has more benefits than adverse effects. It is thus difficult to ascertain that it is 'therapeutically necessary' to force a chosen treatment upon a patient, considering that it may not lead to a desirable outcome. Besides, involuntary treatment is mainly discussed under Article 3 in *Herczegfalvy* case: when it comes to Article 8 allegations, the ECtHR simply refers to the points made before. This seems to indicate that therapeutic necessity test can be used for both Article 3 and Article 8 assessments, with no regard to the different content and structure of the two. The 'necessary in a democratic society' requirement from Article 8(2) is simply ignored in the Court's judgment.[364]

A quarter century later, the ECtHR still relies on *Herczegfalvy* case when dealing with psychiatric treatment: the key points made in it are reiterated word for word in 2015 case of *M.S. v Croatia*.[365] However, the Court seems to be more careful when assessing the medical necessity of involuntary interventions and the suffering induced by them. In Croatian case the applicant complained about being tied to a bed for fifteen hours without a proper justification and despite her having back-pain problems. The ECtHR noted that physical restraint is usually perceived as traumatic, unforgettable and humiliating experience, and that it must have caused the applicant *"great distress and physical suffering"*.[366] It was acknowledged that medical standards in psychiatry allow for such measures to calm down an agitated patient and prevent him from harming anyone. However, the contemporary legal standards require physical restrained to be employed as a matter of last resort when no other means can avert immediate or imminent harm.[367] This measure cannot be prolonged beyond the period which is strictly necessary for this purpose.

After examining the evidence presented, the Court found no indication that the applicant was aggressive or that any alternative means of responding to her restlessness were attempted. It did appear that she was speaking incoherently, had ideas of persecution, refused hospitalisation and resisted

[364] The relevant provision provides that the right to respect for private life can be lawfully interfered with if this is "*necessary in a democratic society", inter alia, "in the interests of public safety", "for the prevention of disorder or crime",* or *"for the protection of health or morals".*
[365] *M.S. v Croatia*, European Court of Human Rights, Judgement of 19 February 2015, no. 75450/12, para 98.
Another relevant case, cited throughout *M.S. v Croatia*, is *Bureš v the Czech Republic*. Here the Court held that the use of restraints must be necessary to prevent imminent harm to the patient or the surroundings and proportionate to this aim (mere restlessness does not justify applying restraints). See *Bureš v the Czech Republic*, European Court of Human Rights, Judgement of 18 October 2012, no. 37679/08, para 96.
[366] *ibid, M.S. v Croatia*, para 102.
[367] *ibid*, paras 104-105.

coercive measures, but all this clearly could not justify the use of physical restraint against her.[368] The Court concluded that restraining measures were not necessary and proportionate in the circumstances, leading to a violation of Article 3 ECHR (inhuman and degrading treatment).[369]

As can be seen, various European instruments and entities accept the practice of involuntary treatment in exceptional circumstances. The ECHR judicial bodies have approached the issue from the perspective of Articles 3 and 8 infringement. Still, the European Court tends to find intrusive practices in psychiatry to be justified as medically necessary. It can be argued that the Court relies too extensively on the broad principle of medical necessity when dealing with particular mental health cases. However, the ECtHR finds itself in no position to disprove the recognised rules of medical science and the accepted psychiatric principles, which is understandable as well.

4.3.2.2. The Americas

Binding human rights instruments of the Organization of American States do not contain any specific references to involuntary psychiatric treatment, but provide generalised guidance. The American Convention on Human Rights reaffirms everyone's right to have their physical, mental, and moral integrity respected.[370] Protocol of San Salvador (on economic, social and cultural rights) guarantees one's right to health, explaining the latter as enjoyment of the highest level of physical, mental and social well-being.[371] States parties to the Inter-American Disability Convention undertake to collaborate in preventing disabilities and treating persons with disabilities as well as in promoting their independence and self-sufficiency.[372]

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[368] *ibid*, paras 106-109.
In the Court's words, *"using restraints can hardly be justified by the fact that a person resists their application"*.
[369] *ibid*, paras 110, 112. Article 8 infringement was not alleged or considered in this case.
[370] supra note 188: The American Convention on Human Rights, Article 5(1).
[371] *supra* note 28: Protocol Of San Salvador, Article 10(1).
Note that Article 18 of the Protocol is dedicated to the *'handicapped'*, which include those *"affected by a diminution of [their] mental capacities"*. However, aside of the aim to *"help [them] achieve the greatest possible development of [their] personality"* no mention of these persons' treatment can be found.
[372] supra note 15: Inter-American Convention on the Elimination of All Forms of Discrimination against Persons with Disabilities, Article IV(2).

More detailed are the non-binding Principles and Best Practices on the Protection of Persons Deprived of Liberty in the Americas.[373] However, this document adopts a rather radical approach to involuntary treatment and it will thus be discussed in the next section.

Once again, it is worth mentioning the *Ximenes-Lopes v Brazil* case of the Inter-American Court of Human Rights, which was addressed in the previous chapter. The Court acknowledged that the states have to guarantee the provision of effective health care services to persons with a mental illness in the least restrictive way possible.[374] The IACtHR further asserted that

> *…any health treatment administered to persons with mental illness should aim at achieving the patient´s welfare and the respect for his or her dignity as a human person, which is translated into the duty to adopt the respect for the intimacy and autonomy of persons as guiding principles for administering psychiatric treatment.*[375]

However, the foregoing principle is not absolute in the Court's view, since the patient's needs may sometimes require the adoption of measures without their consent.[376] At the same time, *"the assumption that persons with mental illness are capable of expressing their will, which should be respected by both the medical staff and the authorities, should prevail."*[377] The Court has therefore linked the involuntary administration of treatment with the patients' inability to give their consent. The UN MI Principles are referenced in relation to the standards of such treatment.[378]

The Inter-American Court considered the use of restraints as *"one of the most aggressive measures to which a patient under psychiatric treatment can be subjected"*.[379] Relying on Article 5 of the American Convention, the Court concluded that restraint should be used as a last resort and with the only purpose of protecting the patient, the medical staff or third persons.[380] The least restrictive possible restraint techniques should be applied and only for such period of time as it is absolutely necessary and under conditions which respect the patient´s dignity and minimize the risks of impairing

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[373] *supra* note 190: Principles and Best Practices on the Protection of Persons Deprived of Liberty in the Americas.
[374] *supra* note 193: *Ximenes-Lopes v Brazil,* paras 128, 138-140.
[375] *ibid,* para 130.
[376] *ibid.*
[377] *ibid.*
[378] *ibid,* para 131.
[379] *ibid,* para 134.
[380] *ibid.*

his or her health.[381] In the present case, the IACtHR found that the physical restraint to which Mr Ximenes-Lopes was subjected was not consistent with the need to provide him with a decent treatment, nor did it protect his psychological, physical or moral integrity.[382]

As can be observed, the Inter-American Court does not condemn the practice of involuntary treatment, but rather sets a certain therapeutic threshold for it. If the recognised standards within mental health field are not met (those include the MI Principles), we can talk about the infringement of one's right to humane treatment. As long as the current psychiatric standards are followed, however, involuntary treatment is justified. It remains to be seen whether the UN Disability Convention would influence the Court's opinion in its future judgements.

4.3.2.3. Africa

Article 4 of the African Charter on Human and Peoples' Rights entitles every human being to respect for the integrity of his person. Additionally, Article 5 guarantees everyone's right to the respect of the dignity inherent in a human being and to the recognition of his legal status. The Charter provides that *"[a]ll forms of exploitation and degradation of man, particularly […] torture, cruel, inhuman or degrading punishment and treatment shall be prohibited."* Finally, Article 16 proclaims the right to enjoy the best attainable state of physical and mental health and Article 18(4) guarantees the right of the disabled to special measures of protection in keeping with their physical or moral needs.

Purohit and Moore v Gambia is the most relevant case within African system when it comes to involuntary treatment (analysed in the preceding chapter in relation to involuntary placement). In its decision the African Commission 'draws inspiration' from the UN MI Principles, similarly to the Inter-American Court in *Ximenes-Lopes v Brazil*.[383] In the Commission's words,

"…as a result of their condition and by virtue of their disabilities, mental health patients should be accorded special treatment which would enable them not only attain but also sustain their optimum

[381] *ibid,* para 135.
[382] *ibid,* para 136.
[383] *supra* note 203: *Purohit and Moore v Gambia*, para 60.

level of independence and performance in keeping with Article 18(4) of the African Charter and the standards applicable to the treatment of mentally ill persons as defined in the [UN MI Principles]."[384]

The Commission, however, is not concerned about the voluntary vs. involuntary nature of psychiatric treatment in the present case. The matters of importance here are Gambian mental health law being seriously outdated as well as scarcity of amenities and resources needed to guarantee everyone's right to health.[385] Therefore, in its decision the African Commission urges the state to provide adequate medical and material care for persons suffering from mental health problems. As we can see, in African context the challenges regarding mental health treatment are lack of access to any intervention or treatment, rather than their forced nature.[386]

4.4. Revolutionary approach: informed consent to treatment is always required

4.4.1. Universal level

The emergence of a new human rights approach to mental health treatment can be attributed to the UN Disability Convention. The CRPD adopts a viewpoint that maximises legal capacity, promotes respect for one's physical and mental integrity and ensures freedom from ill-treatment.[387] More importantly, the treaty makes a clear statement on a free and informed consent in health care. The relevant part of its Article 25 reads:

> *States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. […] In particular, States Parties shall: […] (d) Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent…*

[384] *ibid,* para 81.
[385] *ibid,* paras 83-84.
[386] *supra* note 222: Expert seminar on freedom from torture and ill treatment and persons with disabilities, Session two, p. 8.
[387] The relevant provisions are found in Articles 12, 15 and 17 CRPD.

The final wording of the provision on consent to treatment was extensively debated during the treaty negotiations.[388] One of the earliest drafts was aimed to *"[e]nsure that health and rehabilitation services… occur only after the person concerned has given their free and informed consent"*, as well as to *"[p]revent unwanted medical and related interventions and corrective surgeries from being imposed on persons with disabilities"*.[389] It was noted, however, that some members of the Working Group considered forced medical intervention acceptable if appropriate legal procedures are followed and safeguards are in place.[390] An alternative draft thus retained involuntary treatment, its use being minimised, limited to exceptional circumstances and allowed in the least restrictive setting possible.[391]

Efforts were made to find a compromise,[392] but the adopted text of Article 25 and some other treaty provisions did not satisfy all the parties. Several states made declarations upon ratification of the CRPD explaining that they interpret the Convention's text as allowing involuntary treatment.[393] For example, Norway declared its understanding of Articles 14 (liberty) and 25 CRPD as permitting *"compulsory care or treatment of persons, including measures to treat mental illnesses, when circumstances render treatment of this kind necessary as a last resort, and the treatment is subject to legal safeguards"*.[394] Given the general reluctance of States Parties to eliminate the practice of involuntary treatment,[395] it can be argued that other states choose to interpret the CRPD in the same vein as Norway did in its declaration.

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[388] See, e.g., Report of the Ad Hoc Committee, UN doc. A/AC.265/2005/2, Annex II, Draft Article 12bis, paras 58-67.
[389] *supra* note 269: Report of the Working Group to the Ad Hoc Committee, UN doc. A/AC.265/2004/WG.1, Annex I, Draft Article 21(j) and (k).
The draft article on freedom from torture also contained prohibition of forced interventions *"aimed at correcting, improving or alleviating one's impairment"* (Article 11(2)). Footnote 38 mentioned though that some drafters considered the practice acceptable under certain circumstances.
[390] *ibid.,* footnote 83.
[391] *supra* note 388: Report of the Ad Hoc Committee, Draft Article 12 bis (4)(a)-(c).
[392] A behind-the-scene view on the negotiations and evolution of the treaty text is offered in *supra* note 216: Begg & Degener (2017), pp. 1-37.
[393] Namely Australia, Ireland, Norway and the Netherlands. See United Nations Treaty Collection, available at: https://treaties.un.org (last visited 22 April 2018).
[394] *ibid.*
[395] This is apparent from the states' dialogue with the CRPD Committee. For example, the former Yugoslav Republic of Macedonia praises its Law on Mental Health in how it is *"based on the principles of the UN Convention for the rights of persons with disabilities and its particular use correlates with the right to public health, defined in Article 25 of the Convention."* However, this law regulates involuntary treatment, not prohibits the practice (as the CRPD text seems to require). See Initial report of the former Yugoslav Republic of Macedonia, 3 December 2015, UN doc. CRPD/C/MKD/1; Novotni, Antoni *et al*, "Mental health law in the Former Yugoslav Republic of Macedonia" in *The British Journal of Psychiatry International*, Vol. 15, Issue 3, August 2018, pp. 63-65.

To grasp why the States Parties' understanding of Article 25 falls short of the authoritative CRPD interpretation, a brief analysis of the CRPD Committee sources would be useful. The body has repeatedly mentioned 'the right to consent to medical treatment' throughout its General Comment No. 1.[396] In particular, the Committee asserts that *"[s]tates parties have an obligation to require all health and medical professionals (including psychiatric professionals) to obtain the free and informed consent of persons with disabilities prior to any treatment".*[397] Substitute decision-makers must not be permitted to provide consent on behalf of such persons, and assistants or support persons should not have undue influence over their decisions.[398]

In the Committee's view, forced treatment by psychiatric and other health professionals denies the legal capacity of a person to choose medical treatment and violates numerous other rights.[399] States parties must, instead, *"respect the legal capacity of persons with disabilities to make decisions at all times, including in crisis situations".* Forced treatment is recognised as a particular problem for persons with psychosocial disabilities and the states are urged to:

> *...abolish policies and legislative provisions that allow or perpetrate forced treatment, as it is an ongoing violation found in mental health laws across the globe, despite empirical evidence indicating its lack of effectiveness and the views of people using mental health systems who have experienced deep pain and trauma as a result of forced treatment*.[400]

The bottom line here is that even persons with severely impaired mental capacity are not considered a reasonable exception to the principle of informed consent. Therefore, the Convention's authoritative interpretation of Article 25 seems to leave no room for exceptions.

The Committee has also expressed a strong opposition to involuntary psychiatric treatment in the Concluding Observations on the State's reports. Practices like seclusion and various methods of restraint (physical, chemical and mechanic restrains), were strongly condemned by the monitoring body in its dialogue with Australia. The Committee has found these practices inconsistent with the prohibition of torture and other ill-treatment (Article 15 CRPD), urging the state to eliminate them

[396] *supra* note 91, paras 8, 29(f), 31.
[397] *ibid*, para 41.
[398] *ibid*.
[399] *ibid*, para 42.
[400] *ibid*.

from mental health facilities.[401] Even the *"use of continuous forcible medication, including neuroleptics"* was mentioned in the context of freedom from torture while considering the initial report of Peru.[402]

The views expressed by the CRPD Committee mirror the findings of the first UN Special Rapporteur on Torture back in the 1980s. His list of methods of physical torture included *"[a]dministration of drugs, in detention or psychiatric institutions, [including] neuroleptics, that cause trembling, shivering and contractions, but mainly make the subject apathetic and dull his intelligence".*[403] In subsequent reports of the Special Rapporteur it was confirmed that involuntary treatment and other psychiatric interventions in health-care facilities, to the extent that they inflict severe pain and suffering, are forms of torture and ill-treatment.[404] At the same time, the mere exposure of persons with disabilities to *"interventions aiming to correct or alleviate a disability"* (that is, to treat it), has also been criticised.[405] Language of the 2013 report is especially strong where the Special Rapporteur urges states to:

> *...impose an absolute ban on all forced and non-consensual medical interventions against persons with disabilities, including the non-consensual administration of psychosurgery, electroshock and mind-altering drugs such as neuroleptics, the use of restraint and solitary confinement, for both long- and short-term application*.[406]

This obligation was said to be of immediate application, with scarce financial resources not fit to justify postponement of its implementation.

The Special Rapporteur on the right to health does not support involuntary treatment in a mental health setting either. Noting that justification for using coercion is generally based on 'medical necessity' and 'dangerousness', he asserts that these subjective principles are not supported by

[401] UN Committee on the Rights of Persons with Disabilities, Concluding observations on the initial report of Australia, 21 October 2013, UN doc. CRPD/C/AUS/CO/1, paras 35-36.
[402] UN Committee on the Rights of Persons with Disabilities, Concluding observations on the initial report of Peru, 16 May 2012, UN doc. CRPD/C/PER/CO/1, para 30.
[403] supra note 340: Report of the Special Rapporteur on torture (1986), para. 119.
[404] *supra* note 227: Report of the Special Rapporteur on torture (2008), para 63 and Report of the Special Rapporteur on torture (2013), para 64.
[405] *supra* note 227: Report of the Special Rapporteur on torture (2008), para 40.
[406] *supra* note 227: Report of the Special Rapporteur on torture (2013), para 89(b).

research and open to broad interpretation.[407] The Special Rapporteur adds that there exist compelling arguments that forced treatment, including with psychotropic medications, is not effective, despite its widespread use. Finally, acknowledging that the right to health is now understood within the framework of the CRPD, the Special Rapporteur calls for immediate action *"to radically reduce medical coercion and facilitate the move towards an end to all forced psychiatric treatment and confinement"*.[408] In a manner similar to that of the CRPD Committee, he advocates for support in decision-making to be provided to persons with disabilities, including in emergency and crisis situation.

Since many people with disabilities suffer from appalling living conditions while being institutionalised Special Rapporteur Manfred Nowak has also highlighted the fact that poor conditions in institutions are often coupled with severe form of restraint and seclusion.[409] Patients may be tied to their beds, cribs or chairs, locked in "cage" or "net beds" and be overmedicated as a form of chemical restraint. He concludes that *"there can be no therapeutic justification for the prolonged use of restraints, which may amount to torture or ill-treatment."*[410] Special Rapporteur against Torture Juan Méndez notes that seclusion of persons with mental disorders often results in severe exacerbation of a previously existing mental condition. Thus, he believes that imposition of solitary confinement of any duration on persons with mental disabilities always constitutes cruel, inhuman or degrading treatment.[411]

Once again, some states foresaw that the CRPD could be interpreted as prohibiting involuntary treatment completely and made relevant formal declarations. However, while Australia has made such a declaration, it has not prevented the CRPD Committee from urging the country to:

> *...repeal all legislation that authorizes medical intervention without the free and informed consent of the persons with disabilities concerned, committal of individuals to detention in*

[407] *supra* note 114: Report of the Special Rapporteur on the right to health (2017), para 64.
[408] *ibid*, para 65.
[409] *supra* note 227: Report of the Special Rapporteur on torture (2008), para 55.
[410] *ibid.*
[411] Interim report of the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment, 5 August 2011, UN doc. A/66/268, paras 68, 78.

mental health facilities, or imposition of compulsory treatment, either in institutions or in the community.[412]

Overall, the dialogue with states, and especially the review process, demonstrates an ongoing tension between the Committee's calls for a radical reform and countervailing views of the states. The latter remain focused on the need for harm-prevention, and perceive traditional involuntary treatment as a key means of achieving it.[413]

4.4.2. Regional level

As can be derived from the previous subsection, regional human rights instruments mostly echo the position of the states on involuntary treatment. That is the practice is sometimes necessary by way of exception. Nevertheless, a few sources seem to be more in line with the CRPD Committee's stance. Thus, they will be briefly looked into in this subsection.

4.4.2.1. Europe

One of the core European regional treaties, the European Social Charter, urges states to ensure to persons with disabilities, *"irrespective of... the nature and origin of their disabilities, the effective exercise of the right to independence"*.[414] While the latter is explained to be *"the right to an independent life"*,[415] its exact content is unclear.

Along the same line goes the Mental Health Declaration for Europe, adopted by the Ministers of Health of the Member States in the WHO European Region.[416] The document requires action in *"offer[ing] people with severe mental health problems effective and comprehensive care and treatment in a range of settings and in a manner which respects their personal preferences and protects them from neglect and abuse."*[417] Although it is not clearly claimed that involuntary treatment shall be

[412] *supra* note 401: Concluding observations on Australia (2013), para 34.
[413] Callaghan, Sascha Mira & Ryan, Christopher, "Is There a Future for Involuntary Treatment in Rights-based Mental Health Law?" in *Psychiatry, Psychology and Law*, Vol. 21, No. 5, 2014, p. 748.
[414] *supra* note 271: The European Social Charter, Article 15.
[415] *supra* note 272: Explanatory Report to the European Social Charter (Revised), para 63.
[416] supra note 274: Mental Health Declaration for Europe, 2005.
[417] *ibid,* para 8 vii.

abolished, the Declaration puts emphasis on how personal preferences of persons with severe mental health problems should be respected. This brings the document closer to the CRPD requirements.

A bit more eloquent is the CoE Parliamentary Assembly in its 1642 (2009) Resolution.[418] Firstly, the Assembly invited member states to *"guarantee that people with disabilities retain and exercise legal capacity on an equal basis with other members of society"*, are not deprived of their fundamental rights and, if needed, *"afforded appropriate support, without their wishes or intentions being superseded"*.[419] This goes much in line to how the CRPD Committee interprets the UN Disability Convention. The Assembly also calls on states to *"ensure equal access to health care for people with disabilities and to encourage the consultation of people with disabilities or their representatives in the taking of decisions relating to their health plan."*[420] Care should be taken to ensure that all the relevant information is supplied in a comprehensible format and the aim of rehabilitation services should be to enable persons with disabilities to achieve maximum independence.[421] Once more, the document is not straightforward in prohibiting involuntary treatment, but at least it seems to vaguely point in that direction.

The Commissioner for Human Rights shows more persuasion in his Issue Paper on legal capacity.[422] The Commissioner calls on Council of Europe member states to identify and remedy possible flaws and gaps in their legislation *"depriving persons with disabilities of their human rights in relation to […] compulsory psychiatric care and treatment."*[423] It is recommended that supported decision-making alternatives are developed and provided on a voluntary basis.[424] Thus, those who want assistance in making decisions or communicating them to others could still be heard, in the spirit of UN Disability Convention.

[418] *supra* note 22: Council of Europe Parliamentary Assembly Resolution 1642 (2009), para 8.1.
[419] *ibid*, paras 7, 7.2.
[420] *ibid*, para 15.
[421] *ibid*, paras 15.1 and 15.6.
[422] *Who gets to decide? Right to legal capacity for persons with intellectual and psychosocial disabilities*, Issue Paper by the Council of Europe Commissioner for Human Rights, 2012.
[423] *ibid*, Recommendation 2, p. 5.
[424] *ibid*, Recommendation 7, p. 5.

4.4.2.2. The Americas

The Inter-American Disability Convention offers general provisions about facilitating independence and self-sufficiency of persons with disabilities.[425] Similarly, the Caracas Declaration declares that the resources, care, and treatment provided must invariably safeguard personal dignity and human and civil rights.[426] None of these instruments, however, displays their position on involuntary treatment in a more straightforward manner. An exception could be the Principles and Best Practices on the Protection of Persons Deprived of Liberty in the Americas, adopted by the Inter-American Commission on Human Rights.[427]

The aforementioned Principles offer protection for, *inter alia*, *"persons who are under the custody and supervision of certain institutions, such as: psychiatric hospitals and other establishments for persons with physical, mental, or sensory disabilities."*[428] The document asserts that these persons, among others, *"shall be protected from… forced intervention or coercive treatment"*.[429] Instead, the provision of health services shall, in all circumstances, respect the principles of patient autonomy and informed consent to medical treatment in the physician-patient relationship.[430] Given the document's direct reference to persons with mental disabilities as a target group for these provisions, we can see an example of a radical approach to the involuntary treatment problem.

4.4.2.3. Africa

Current human rights instruments within the African region provide little regulation of involuntary mental health treatment. However, this situation is likely to change with the adoption of the Draft protocol to the African Charter on the rights of persons with disabilities.[431] The draft protocol is clearly inspired by the UN Disability Convention as it draws extensively from its provisions. Just like the CRPD, the Draft protocol urges states to ensure that *"all health services are provided on the*

[425] *supra* note 15: Inter-American Convention on the Elimination of All Forms of Discrimination against Persons with Disabilities, 1999, Articles III 2(b) and IV 2(b).
[426] *supra* note 279: Caracas Declaration, 1990.
[427] *supra* note 190: Principles and Best Practices on the Protection of Persons Deprived of Liberty in the Americas.
[428] *ibid*, General Provision
[429] *ibid*, Principle I(3).
[430] *ibid*, Principle X(2).
[431] *supra* note 208: Draft Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa.

basis of free, prior and informed consent",[432] which concerns persons with mental impairments among the others.[433] The document reiterates elsewhere that persons with disabilities must not be *"subjected without their free, prior and informed consent to medical… intervention."*[434] Time will show whether the radical draft protocol will be adopted and how challenging it will be to follow the instrument's provision within the region.

[432] *ibid*, Article 13(2)(d).
[433] *ibid*, Article 1(g).
[434] *ibid*, Article 5(2)(d).

CHAPTER 5: CONCLUSIONS

Hospitalising adults for psychiatric treatment against their expressed wishes remains a controversial topic: it challenges the very basis of modern day clinical practice – that of informed consent. Traditionally, involuntary measures were deemed necessary in strictly defined circumstances and subject to appropriate procedural safeguards. The occasional necessity of using compulsion in mental health context was taken as a presumption that did not require re-examination. As long as good standards are implemented, involuntary placement and treatment were considered an acceptable, if not indispensable, part of mental healthcare.

Clinicians and law-makers on the national level have good intentions while implementing the traditional approach to psychiatric treatment. Their aim is to facilitate treatment of persons with certain diagnoses and prevent self-harm or violence against others. Nevertheless, according to a new approach, which has emerged with the adoption of UN Disability Convention, this state of affairs is no longer acceptable. Here, respect for liberty and integrity of the person seems to outweigh the principles of health protection and risk-prevention.

The new approach, embraced by different institutions within and outside the United Nations,[435] puts emphasis on the person's capacity and a right to medical treatment based on consent. According to it, persons with disabilities, including those with mental disorders, maintain full legal capacity and if needed, avail themselves of available support. Persons with mental disorders are thus recognised as active participants in their own lives and meaningful social actors. Such person's physical and mental integrity is preserved and communication with them has priority over the use of compulsion.

However, these aspirational ideas are rather opaque and present real challenges in executing them in practice. To name just a few:

[435] In addition to the sources discussed throughout this work, the WHO Mental health action plan 2013-2020 is worth mentioning here. The document encourages compliance of the mental health strategies, actions and interventions with the CRPD and urges states to provide community-based mental health care rather than institutional care. See paras 23, 66. Additionally, the United Nations Special Rapporteurs on the rights of persons with disabilities, Catalina Devandas-Aguilar, and on the right to health, Dainius Pûras, called on States to eradicate all forms of non-consensual psychiatric treatment. See "Dignity must prevail" – An appeal to do away with non-consensual psychiatric treatment, World Mental Health Day, Saturday 10 October 2015, available at: http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=16583#sthash.pR424c7I.dpuf (last visited 22 August 2018).

1) Complete abolition of involuntary placement and treatment is unlikely in the short-to-medium term at least, given the deeply-rooted nature of these practices worldwide;
2) The contradictions between the traditional and revolutionary approaches creates conflict of norms, which is especially evident on the regional level: e.g. the ECHR creates an exception to the right to liberty (for the 'unsound of mind') on the very ground that the CRPD aims to prohibit (no deprivation of liberty on the basis of disability);
3) Deinstitutionalisation does not equal mere administrative discharging of patients – it is a complex process involving the implementation of a network of alternatives outside psychiatric institutions;[436] this creates problems for developing countries where such alternatives may be non-existent; in addition, for some people who would otherwise be incarcerated, community services will have to be relatively intense to be a real alternative, meaning such services may be difficult to manage.[437]

It may be argued that the bodies that adopt the revolutionary approach to involuntary interventions (i.e. the latter are not allowed) may read into the CRPD text what is not necessarily there. These entities, of course, deserve credit for endeavouring to promote the rights of a historically marginalised and underrepresented social group. However, the tasks they set may be overly ambitious and unrealistic, considering that the mental health care systems worldwide are unlikely to make a complete U-turn in a short time. Having a more nuanced, flexible plan and moving towards the goal small steps at a time might be a better way to go.

There may be several ways to tackle the problems that come with the new approach to involuntary interventions in psychiatry. Their main idea is to interpret the UN Disability Convention in a way that would be reconcilable with the traditional mental health laws. First, it can be observed that Article 14 CRPD does not preclude the deprivation of liberty if it is *"in conformity with the law"*.[438]

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[436] World Health Organisation, Mental Health Policy and Service Guidance Package: The Mental Health Context, 2003, p. 3.
See the example of Italy: its so-called Basaglia Law initiated a very gradual dismantling of psychiatric hospitals around the country, which eventually led to their complete replacement with community-based services (including settings for acute in-patient care).
[437] *supra* note 163: Bartlett, Peter, *et al* (2007), p. 45.
[438] Article 14 CRPD requires states to ensure *"that any deprivation of liberty is in conformity with the law"*. See Seatzu, Francesco, 'Article 14 [Liberty and Security of Person]' in Della Fina, Valentina et al (eds.) *The United Nations Convention on the Rights of Persons with Disabilities. A Commentary*, 2017, Springer International Publishing, pp. 298-299.

Considering that involuntarily placement is lawful in many jurisdictions, this phrase may justify the deprivation of liberty for most persons held under mental health laws.

Secondly, the UN Disability Convention is interpreted as outlawing only involuntary interventions that were made on the basis of disability, and not in relation to persons with disabilities in general. This disability-neutral approach justifies involuntary placement and treatment unless they are mechanically anchored to disability, in which case this would be clearly against the CRPD.[439] Prof. Seatzu suggests linking involuntary placement to the defence of public order or the loss of a person's decision-making capability. The latter example, however, is applicable only if 'decision-making capability' is viewed as distinct from 'disability', even though they may be present at the same time.[440] Another suggestion would be to introduce a disability-neural framework for state interventions in the lives of all adults, based on risk of imminent and serious harm to the individual's life, health or safety.[441]

Prof. Nilsson also believes that determining the lawfulness of involuntary practice in mental healthcare should not rely on whether it is based on disability. Instead, she proposes to look at whether the practice constitutes equal treatment from a non-discrimination perspective.[442] That is, whether it pursues a legitimate aim and is based on objective and reasonable criteria.[443] Prof. Nilsson argues that from this perspective compulsory interventions must be relevant, necessary and proportionate to be considered lawful.[444]

Regardless of the particular approach adopted, the common message appears to be the reconciliation of the CRPD norms and other international, regional or national provisions. This leads us to the research problem of the thesis: "The compatibility of involuntary placement and treatment of

[439] *ibid,* p. 299.
[440] *ibid,* pp. 299-300.
[441] Flynn, Eilionoir and Arstein-Kerslake, Anna, "State intervention in the lives of people with disabilities: the case for a disability-neutral framework" in *International Journal of Law in Context*, 2017, pp. 39-57.
[442] *supra* note 126: Nilsson (2014), pp. 459-485.
[443] *ibid*, pp. 463-464.
[444] *ibid*, pp. 459, 470-484.
For other approaches that would be less radical than that of the CRPD Committee and some other bodies see, e.g. suggested threshold criteria in Fistein *et al*, A comparison of mental health legislation from diverse Commonwealth jurisdictions in *International Journal of Law and Psychiatry*, 2009, Vol. 32, Issue 3, pp. 147-155; or a fusion proposal in Rees, Neal, The Fusion Proposal: a Next Step? in McSherry, Bernadette & Weller, Penelope (eds), *Rethinking Rights-Based Mental Health Laws*, Hart Publishing, 2010 and Szmukler, George *et al*, Mental health law and the UN Convention on the rights of persons with disabilities in *International Journal of Law and Psychiatry*, 2014, Vol. 37, Issue 3, pp. 245-252.

persons with mental disorders with international and regional human rights standards". As could be seen from the discussion throughout this work, the core binding instrument concerning persons with mental disorders, the UN Disability Convention, can be interpreted in various ways. The authoritative body for the treaty, the CRPD Committee, holds onto its position that the Convention outlaws any involuntary measures in relation to persons with disabilities on the basis of their disability.

However, there are various 'alternative' interpretations of the Convention, both by trusted international and regional bodies and among renowned legal scholars, that claim the CRPD permits involuntary measures in psychiatry. This creates two opposing viewpoints: "involuntary placement and treatment are incompatible with current international norms" and "involuntary placement and treatment are compatible with both international and regional human right norms". This situation makes resolving the research problem rather problematic, if not impossible.

Nevertheless, if we interpret the CRPD Committee's view in a way that the treaty outlaws involuntary interventions only on the basis of disability, there would be still room left for such interventions on other grounds. If this would be the case, involuntary placement and treatment in psychiatry would be compatible with international and regional human rights standards as long as they are not linked to the disorder/disability of the person concerned. Having adopted this viewpoint, the answer to the question contained in the research problem becomes affirmative: yes, involuntary interventions towards persons with mental disorders are compatible with human rights law. Naturally, they should use disability-neutral criteria, be applied as a last resort and be subject to scrutiny to be considered acceptable and lawful.

In the words of the Special Rapporteur on the right to health, Prof. Pūras, *"We need little short of a revolution in mental health care to end decades of neglect, abuse and violence."*[445] However, it is not politically realistic to expect that states completely abandon involuntary care of persons with mental disorders, at least not in the short term. On the other hand, appropriate community housing and support will provide an option that may be preferred by many mental healthcare users. As Prof. Bartlett puts it, *"if services are provided that people want, it will not be necessary to force them to use*

[445] World needs "revolution" in mental health care – UN rights expert, 6 June 2017, available at: https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=21689 (last visited 22 August 2018).

them".[446] Involuntary psychiatric placement and treatment would then be applied as a final measure after all the options for appropriate community treatment and support have been explored. In this way, the UN Disability Convention would underpin – and not undermine – the existing human right framework, both on international and regional levels, insofar as it relates to persons with mental disorders.

[446] *supra* note 232: Bartlett (2012), p. 834.

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