

## **The European Convention on Human Rights and the rights of people with mental health problems and/or intellectual disabilities**

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*“... it is the inherent nature of all human beings to yearn for freedom, equality and dignity, and they have an equal right to achieve that.”*

His Holiness The Dalai Lama, New York, April 1994

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## Introduction

These materials have been written primarily for participants of training seminars organised by the Mental Disability Advocacy Center (MDAC) and partner NGOs. In 2002 MDAC – with support from the Council of Europe - successfully held training seminars in Bulgaria, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovak Republic and Slovenia.

Information about the previous and forthcoming seminars can be found on the MDAC website [www.mdac.info](http://www.mdac.info).

Further information about the work of the Council of Europe can be found at [www.coe.int](http://www.coe.int).

These materials are intended to provide guidance to the European Convention on Human Rights and mental disability in central and eastern Europe. They are not intended to be a complete guide to the mental disability system in central and eastern Europe, nor a comprehensive guide to the European Convention on Human Rights in areas other than mental disability. Please seek the advice of a human rights lawyer in individual cases. The Mental Disability Advocacy Center is keen to provide advice and assistance to NGOs and lawyers representing people with a mental disability and would be keen to hear of cases which were taken as the result of the training or these materials.

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## MDAC

The Mental Disability Advocacy Center (MDAC) is a human rights organization that operates primarily in central and eastern Europe, central Asia, Russia and Mongolia. MDAC promotes and protects human rights of people with mental disability (mental health problems and/or intellectual disabilities). The goal of MDAC is to improve the quality of life for individuals with mental disability by advocating public policies that respect human rights and promote community integration.

MDAC's current activities include:

- training for NGOs, lawyers and other professionals on how to use international law to promote positive social change within mental disability systems
- training for NGOs on how to monitor human rights within psychiatric and social care institutions
- technical and financial assistance to lawyers pursuing mental disability law public interest cases in domestic and international courts and tribunals
- reporting on human rights abuses in the region
- providing comprehensive information to lawyers and activists on its website, including summaries of key mental disability cases decided by the European Court of Human Rights
- promoting the rights of people with mental disabilities at intergovernmental bodies within the United Nations, European Union, Council of Europe and World Health Organization

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## Definitions

In an area full of stigmatising words and phrases (in English and other languages), we offer some definitions of words which are used throughout these training materials, and which will form the vocabulary of the training seminars.

We use the umbrella term **mental disability**. By mental disability we include people with a **mental health problem** (those with a diagnosis of “mental illness” such as bipolar affective disorder, depression or schizophrenia), and people with **intellectual disabilities** (in other regions known as “learning disability”, “learning difficulties”, “developmental disability”, the old-fashioned “mental handicap” or the particularly stigmatising “mental retardation”). By intellectual disability we mean a lifelong condition that affects a person’s intellectual, social and emotional development. We also include within the term mental disability those people with a diagnosis of personality disorder.

By “**psychiatric institution**”, we include psychiatric hospitals, high security forensic hospitals and long-stay institutions for people with mental disability – commonly and euphemistically known as “social care homes” in central and eastern Europe.

When talking about people who live in psychiatric institutions we use the word “**resident**”. We also refer to “patient”, which is the term most commonly found in judgments of the European Court of Human Rights, but in doing so we do not necessarily advocate for the medical model of psychiatry.

When referring to the European Convention on Human Rights we grudgingly make reference to “**persons of unsound mind**”, as this is the term used in Article 5 of the Convention. We recognise that this term particularly stigmatising, but must remember that the Convention is now over 50 years old.

We also use the terms “**user**” or “**ex-user**” of psychiatric services.

## Article 2 ECHR – the right to life

Article 2 of the European Convention on Human Rights states:

**1) Everyone’s right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided for by law.”**

**2) Deprivation of life shall not be regarded as inflicted in contravention of this Article when it results from the use of force which is no more than absolutely necessary:**  
**in defence of any person from unlawful violence**  
**in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;**  
**in action lawfully taken for the purposes of quelling a riot or insurrection**

### The application and interpretation of Article 2

The right to life is one of the most fundamental provisions of the ECHR. Surprisingly, it was only really from the 1990 onwards that the European Court had occasion to interpret this Article. During the 1990s numerous cases involving counter-terrorism activity, particularly by the UK and Turkey, began to reach the Court. These cases led to extensive analysis of the implications of “lethal action by state agents”, and the circumstances in which it can claim to be justified under the second paragraph of Article 2.

The Court has also decided a number of cases which have involved violent action by one individual against another, and the extent of a State’s duty to protect individuals from crime. And in a few more recent cases the Court has considered the extent of a State’s duty to protect the lives of those who are receiving health care from national health services.

The Court’s jurisprudence under Article 2 has identified both substantive and procedural obligations. Substantively the State has a “**negative obligation**” to refrain from taking life, and a “**positive obligation**” to take reasonable measures to safeguard life. In addition a State has ‘**procedural obligations**’ to establish a legal regime which properly protects life. These latter obligations have sometimes been characterised as “**adjectival**” to the substantive obligations. In cases decided under Article 2 the decisions of the Court usually fall into two parts, answering two separate questions. First, the Court decides whether a death occurred in breach of the substantive duties under Article 2; secondly it decides whether the State’s investigation following the death satisfied the State’s procedural obligations under Article 2.

These procedural obligations are not set out in the terms of Article 2, but have been evolved in the Court’s case-law. They include the most basic obligation to criminalise unlawful killing, to ensure it is properly investigated and (where appropriate) duly

prosecuted. One of the most important of the “procedural obligations” is a duty on the State properly to investigate deaths. In the Court’s early decisions under Article 2 this obligation was stated to apply in cases of “lethal action by agents of the state”, these being the kinds of cases which were before the Court at the time. But it has become clear in later decisions that the obligation is not limited to killing by state agents, nor even to cases of violent deaths. It applies to all deaths.

### **Protecting patients**

Article 2 requires that a State ensures that hospitals have regulations for the protection of patients in hospitals, and a system of judicial investigation into medical accidents (Isiltan v. Turkey<sup>1</sup> and Zoggia v. Italy<sup>2</sup>). Although a State is not required to fund very expensive and exotic treatments to keep all patients alive in all circumstances, it clearly requires that the basic pre-requisites for life, like heating in winter, adequate food and treatment against normal infections should be provided.

### **The form of investigation required**

Exactly how the State must investigate deaths – the form of machinery, the extent of the obligation for the machinery to be conducted in public, and the extent to which next of kin must be involved - is still being developed by the Court. The Court recognises that certain categories of cases require higher degrees of rigour and openness than others, particular cases where agents of the state were involved, and where deaths have occurred in custodial state institutions like prisons and mental health facilities. It is therefore not yet possible to provide clear guidance to the manner in which the obligation to investigate deaths applies in all cases. But it is already clear that this aspect of the Court’s jurisprudence provides mental health reformers with a powerful tool for addressing one of the most disturbing phenomena in mental health care, namely high and avoidable mortality in psychiatric hospitals and social care homes which is not normally acknowledged or investigated by the country concerned.

In some European countries there is evidence that mortality rates in mental disability institutions are grossly elevated. For example when the CPT<sup>3</sup> visited Poiana Mare Psychiatric Hospital in Romania in 1995 they examined the registry of deaths and found that 25 out of 61 deaths in an 8 month period were explicitly attributed to “severe protein and calorific malnutrition”. The overall mortality rate was in excess of 20% per annum. In a visit to the Terter Social Care Home in Bulgaria in 1999 the CPT noted a very worrying increase in deaths at the Home. Statistics quoted in their Report showed an annual mortality rate running at 33%. Causes of death included asphyxia and hypothermia. High and avoidable mortality rates may well be a problem in a number of other eastern European countries and in Russia. In these countries, as well as many others, the system for investigating deaths does not begin to meet the standards required by the European Court under Article 2.

*The Court has held that to comply with Article 2 a State must have a system of investigation which incorporates the following safeguards:*

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<sup>1</sup> Application No. 20948/92

<sup>2</sup> Application No. 44973/98

<sup>3</sup> The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (see the section on the CPT below)

- (a) it must be carried out by an independent body in public;
- (b) it must be thorough and rigorous, and capable of imputing responsibility for a death;
- (c) if agents of the state are responsible, it must be capable of determining whether the killing was or was not justified under Paragraph 2 of Article 2;
- (d) it must enable effective involvement of the next of kin to safeguard their their legitimate interests. Although the nature and degree of the necessary scrutiny will depend on the circumstances of each case, investigations into deprivations of life must be independent, effective, and reasonably prompt.

### **The obligation to investigate deaths is not limited to action by state agents**

*“[T]he obligation is not confined to cases where it has been established that the killing was caused by an agent of the State. Nor is it decisive whether members of the deceased’s family or others have lodged a formal complaint about the killing with the relevant investigatory authority. In the case under consideration, the mere knowledge of the killing on the part of the authorities gave rise ipso facto to an obligation under Article 2 of the Convention to carry out an effective investigation into the circumstances surrounding the death”. (Ergi v. Turkey, July 28 1998)*

The obligation also arises in cases where individuals die without any violence whilst under the care and responsibility of health professionals. The case of Powell v. UK involved the death of a young man from what his parents believed to be medical negligence rather than any deliberate act. The Strasbourg Court was clear that the duty to investigate applied.

### **Investigations must be held into deaths where individuals are receiving medical treatment**

*“The Court considers that the procedural obligation as described cannot be confined to circumstances in which an individual has lost his life as a result of an act of violence. In its opinion, and with reference to the facts of the instant case, the obligation at issue extends to the need for an effective independent system for establishing the cause of death of an individual under the care and responsibility of health professionals and any liability on the part of the latter”. Powell v. UK, May 4 2000*

The Court regards cases where an individual dies whilst detained in a state institution, for example a mental health facility or a prison, as requiring a particularly high standard of openness and investigative rigour. In the recent case of Edwards v. UK,<sup>4</sup> where a prisoner killed a cellmate in prison, an inquiry was established to investigate how the killing occurred, and to make recommendations. The inquiry sat in private, but later published its findings. The Court was not satisfied with the procedure which it followed.

### **The deceased’s family’s right to attend the investigation**

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<sup>4</sup> 14 March 2002

*“1. The Inquiry sat in private, during its hearing of evidence and witnesses. Its report was made public, containing detailed findings of fact, criticisms of failures in the various agencies concerned and recommendations.*

*2. The Government argued that the publication of the report secured the requisite degree of public scrutiny. The Court has indicated that publicity of proceedings or the results may satisfy the requirements of Article 2, provided that in the circumstances of the case the degree of publicity secures the accountability in practice as well as theory of the state agents implicated in events. In the present case, where the deceased was a vulnerable individual who lost his life in a horrendous manner due to a series of failures by public bodies and servants who bore a responsibility to safeguard his welfare, the Court considers that the public interest attaching to the issues thrown up by the case was such as to call for the widest exposure possible. No reason has been put forward for holding the inquiry in private, any possible considerations of medical privacy not preventing the publication of details of the medical histories of Richard Linford and Christopher Edwards.” Edwards v. UK*

The family of a deceased person may also be able to claim a violation of their rights to privacy under Article 8 of the Convention. The Court in Edwards also found that the inquiry’s inability to compel witnesses to attend violated Article 2.

### **The inquiry to have a power to compel witnesses**

*“3. The Inquiry had no power to compel witnesses and as a result two prison officers declined to attend. One of the prison officers had walked past the cell shortly before the death was discovered and the Inquiry considered that his evidence would have had potential significance. The Government have drawn attention to the fact that this witness had, in any event, submitted two statements and that there is no indication that he had anything different or additional to add. However, the Court notes that he was not available for questions to be put to him which might have required further detail or clarification or for any inconsistency or omissions in that account to be tested. The applicants had argued in their observations on admissibility that the evidence of the witnesses on the scene at the prison had been of particular importance since it potentially concerned the timing and duration of the attack (see the decision of admissibility in this case of 7 June 2001) and therefore might disclose matters relevant to their claims for damages.*

*4. The Court finds that the lack of compulsion of witnesses who are either eye-witnesses or have material evidence related to the circumstances of a death must be regarded as diminishing the effectiveness of the Inquiry as an investigative mechanism. In this case, as in the Northern Irish cases referred to above, it detracted from its capacity to establish the facts relevant to the death, and thereby to achieve one of the purposes required by Article 2 of the Convention.”*

### **Burden and standard of proof**

Where it is alleged that premeditated killing has occurred, the Court has stated that convincing evidence is needed for the allegation to be upheld. In Yasa v. Turkey<sup>5</sup> the Court applied the standard of “beyond a reasonable doubt”. However where an

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<sup>5</sup> 1999 28 EHRR 408

individual has died in custody, the state is under an obligation to provide a satisfactory explanation, and in the absence of a satisfactory explanation the Court will conclude that the death occurred as a result of acts or omissions of the state authorities (Salman v. Turkey)<sup>6</sup>. Except in cases where a person dies in custody, where the burden of proof falls on the state, the burden of proof is not borne by either party. The Court assesses the issues in the light of all the material before it.

Many countries do not have judicial systems which require public investigative hearings into deaths. In the UK, the USA and certain other ex-colonial jurisdictions, Coroners perform this role. In cases involving the UK, where Coroners have held inquests, the ECHR has usually found the *form of investigation* to be in conformity with Article 2 procedural requirements, even if they have found the death to have occurred in violation of the *substantive requirements* under Article 2 (see e.g. McCann v. UK 1996 21 EHRR 97). The Court's developing case-law may require countries to introduce a new form of judicial function to meet the requirements of Article 2.

### **Who can apply to the Court under Article 2?**

An applicant can only apply to the European Court of Human Rights if he/she can claim to be a "victim" of a violation within the meaning of Article 34 of the Convention. This normally means that the applicant must have been directly affected by the violation in issue. Where a person has died, and it is intended to allege a violation of Article 2, the application cannot be brought in the name of the deceased person. Instead a next-of-kin or other relative, or an heir to an estate can apply. Even though a person's Article 2 rights have been violated, if there is no family member or guardian willing to bring a case to Strasbourg, it is difficult to see how the deceased person's rights to have a proper investigation are respected.

It is arguable that where a State is failing to carry out proper investigations into cause of death, for example where high mortality is occurring in a social care home without official investigation, a fellow resident may be able to claim that a violation of his or her Article 2 is occurring. A patient who fears premature death in such circumstances will also be able to claim a violation of Article 3.

### **Asylum and expulsion**

In a number of cases the Court has considered the rights of those threatened with deportation, who would face an absence of life-preserving health care if they were returned to their home country. In D. v. UK<sup>7</sup> the Court found that Article 3 was breached when a patient suffering from AIDS was threatened with deportation to St Kitts, where no proper medical treatment was available. This principle could provide protection to people with a mental disability who, if deported, might be exposed to a life-threatening institutional regime in their home country.

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<sup>6</sup> Application No 21986/93

<sup>7</sup> 1997 24 EHRR 423

## Consent to medical treatment

Individuals have the right to decide whether a proposed medical treatment will be performed on them. That right to decide is not contingent on the convenience or economic efficacy to the state of the person being treated, nor whether a decision to refuse treatment by the patient is not the correct thing to do. It is simply a right that we enjoy. A legal authority for that general right can be found either in the right to privacy contained in Article 8 ECHR, or the right to be free of inhuman treatment contained in Article 3.

The same right has not necessarily been extended to people with mental disabilities. The tradition in many European states in the past has been to connect the enforced treatment of people with mental disabilities to their legal confinement. If the individual has been detained in a psychiatric facility, that person has historically been treated against their will. Because they have been detained, there has been a particular focus in litigation strategies on whether detention has been lawful, using Article 5 of the Convention (which is covered elsewhere in these materials).

### Link between detention and treatment?

Such an automatic relationship between compulsory detention and compulsory treatment does not necessarily follow. There is nothing theoretically inconsistent with confining someone in a psychiatric facility, but still leaving them with the authority to decide treatment decisions. **It might be an arguable point if the justification for confinement of individuals was medical beneficence, to ensure that an individual was treated, but that is not the way human rights law in general and the ECHR in particular have viewed confinement.** The Strasbourg Court has never suggested that the existence of an effective treatment is required as part of the justification for confinement. Instead, insofar as the Court has addressed the substantive justification for confinement, it has been concerned with how severe a disorder must be. As discussed in the section of these materials relating to Article 5, the Court has never provided an adequate articulation of how that severity is to be understood. It is clear that an individual whose mental disorder causes danger to the patient or to others is sufficiently severely affected to justify confinement, whether or not there is a treatment available: see the Winterwerp decision, for example. The Court has never stated categorically that a dangerousness standard is required, but nonetheless, it is clear that their concern to date has been with severity rather than treatability. In that context, it is difficult to see why the fact that the admission satisfies the Article 5 criteria would affect the patient's right to make treatment decisions following admission.

The movement in the European, North American and Australian human rights communities more broadly has been to question the relationship between enforced hospitalisation and the loss of the right to consent to treatment. Increasingly the view is that patients who are able to understand the relevant information ought to be allowed to make treatment decisions, even if they are in psychiatric facilities or social care homes. The Committee for the Prevention of Torture (CPT) has adopted this view specifically:

Patients should, as a matter of principle, be placed in a position to give their free and informed consent to treatment. The admission of a person to a psychiatric

establishment on an involuntary basis should not be construed as authorising treatment without his consent. It follows that every competent patient, whether voluntary or involuntary, should be given the opportunity to refuse treatment or any other medical intervention. Any derogation from this fundamental principle should be based upon law and only relate to clearly and strictly defined exceptional circumstances. [CPT Standards, 2002, CPT/inf/E (2002) 1, para 41]

In some Canadian jurisdictions, it has for almost twenty years been the case that patients with mental disabilities who have the mental capacity to make treatment decisions have a right to make those decisions, whether or not they are in hospital, and whether or not they are subject to legal confinement. While that was thought to be a radical step in the mid-1980s when it was introduced, and while it was viewed with a concern little short of horror by medical professionals prior to its introduction, it in fact caused few practical problems in implementation, and it would seem now that the medical professionals are broadly content with it. Indeed, it may well have caused medical practitioners to discuss treatment options more closely with their patients, thus re-enforcing good medical practice. And the reality is that while a some patients do discuss treatment choices with their doctors with considerable interest and care, virtually none choose no effective treatment at all.

Article 14 may also be relevant in support. While the Court has not yet formally stated that disability constitutes a ground upon which Article 14 prohibits discrimination, there is little doubt in the legal community that it will do so when the occasion presents itself. That raises the question: why should the right to make a treatment decision of a person with mental capacity to make that decision depend on whether that individual has a psychiatric diagnosis? Is this not a particularly clear example of the sort of differential treatment that article 14 was intended to preclude?

### **Effects of psychiatric medication**

Psychiatric medication can often be effective treatments of mental disabilities with some desirable effects. Sadly, they also have some highly invasive adverse effects, including nerve damage, sexual dysfunction, drooling, nausea, sleep disorder, depression, and others, depending on the medication. There may be coherent reasons why a patient will wish to refuse medication. There is also a question of the way in which patients understand themselves. The advertisements for psychiatric medications frequently rely on themes of restored personality: when the person takes the drug, they return to become the person their family knew. This will be the experience of many, who are likely to voluntarily take the drugs. It is not the experience of all users of psychiatric services, however. Some experience the drugs as removing the person they think of themselves as having been, and enforcing a new - and usually duller - personality onto them. Some comment that they feel they are no longer free, that the drug is controlling them. The enforcement of medication onto such individuals raises profound philosophical questions which go to the root of individual freedom in democratic societies.

### **Capacity to make treatment decisions**

MDAC would advocate that the right to make treatment decisions depends on capacity, rather than diagnosis or hospitalisation. How we are to understand capacity? There is considerable and divergent academic and jurisprudential debate in Europe and

elsewhere on this subject, but a few pointers and tensions can be identified. The person alleging incapacity must prove that the patient does not have capacity to make treatment choices. Certainly, the individual must have the intellectual capability of understanding basic information about the diagnosis and the proposed treatment provided by the doctor, although the doctor has a corresponding duty to phrase this information in terms the patient can understand.

Must the patient believe this information? Here, some care is required, for the decision regarding capacity must be determined on the basis of the patient's abilities, and not collapse into the question of whether the patient agrees with the doctor. We do not require that a patient believe a doctor's view that they have cancer in order to make treatment decisions regarding cancer. Indeed, there may be good reasons for the patient to question the diagnosis, as it may alter over the course of their troubles, sometimes depending on the doctor treating them. Scepticism by the patient in such circumstances does not mean that the person does not have capacity to make treatment decisions. Alternatively, a lack of belief in the information may be the result of the disorder itself. That would mitigate toward a finding of incapacity. Even here, care is required, however: the fact that a patient has psychotic delusions does not preclude the patient having capacity, unless the delusions are relevant to the information provided or the content of the decision to be made.

### **In practice**

What does all this mean in practical terms? Essentially, people have the right to make treatment decisions. Principle 19 of the UN's "Principles for the Protection of Persons with Mental Illness" (which are reproduced as Appendix 2 below) mandates that:

*Informed consent is 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 on:*

*(a) The diagnostic assessment;*

*(b) The purpose, method, likely duration and expected benefit of the proposed treatment;*

*(c) Alternative modes of treatment, including those less intrusive;*

*(d) Possible pain or discomfort, risks and side-effects of the proposed treatment.*

Paragraph 41 of the standards of the European Committee for the Prevention of Torture state that "consent to treatment can only be qualified as free and informed if it is based on full, accurate and comprehensible information about the patient's condition and the treatment proposed; to describe ECT as "sleep therapy" is an example of less than full and accurate information about the treatment concerned. Consequently, all patients should be provided systematically with relevant information about their condition and the treatment which it is proposed to prescribe for them. Relevant information (results, etc.) should also be provided following treatment."

Article 6(1) of the ECHR is engaged when patients may be forcibly treated upon admission to a psychiatric institution, as the right to make treatment decisions is presumably a right to carry out legal transactions indirectly effected by that confinement.

### **Judicial hearing for treatment decisions**

It is less obvious what that hearing would involve. In MDAC's view, it ought to have due process safeguards similar to the hearings provided under article 5, including rights to information and rights to counsel. As most legal systems include the presumption of capacity, no treatment ought to be provided until a determination of incapacity has been made, except in grave emergency situations where cogent grounds exist to support an application for a finding of incapacity. The hearing must be by an independent arbiter, and be judicial in character, and presumably as in Article 5(4) hearings, there must be a right of the patient to return for re-consideration of the situation at regular intervals.

Article 6 would in MDAC's view require a hearing to determine incapacity, but it is less obvious that the judge would be required to approve a treatment plan, in the event that the individual were found to lack capacity. In the view of MDAC, some effective means of reviewing treatment plans for persons lacking capacity is nonetheless important. Site visits by MDAC show that institutionalised people, and particularly those with limited mental abilities, are particularly subject to over-medication. Such overmedication can take the form of sedation, or may have adverse effects. Either way, the medication may adversely affect the individual's quality of life.

It is not obvious that Article 6 would require a hearing prior to the treatment of all persons lacking capacity, or whether it merely requires that a hearing be available upon the application of those thought to lack capacity. By definition, a person who lacks capacity is someone who may have limited abilities to look after their own interests. For this reason, MDAC views it as best practice for those providing treatment to these individuals to have systems in place to ensure that overmedication is minimised, the views of the patient is considered, and their quality of life is maximised. Routine hearings prior to any treatment provided to anyone thought lack capacity, with the power of the arbiter to scrutinise the treatment plan, would be one way to meet this objective.

## **Article 3 ECHR – freedom from torture, inhuman or degrading treatment or punishment**

Article 3, the shortest in the European Convention on Human Rights, states:

**“No one shall be subjected to torture or to inhuman or degrading treatment or punishment.”**

The prohibition of torture and inhuman or degrading treatment or punishment is absolute. The Court has emphasised that such a fundamental right deserves no exceptions or limitations, nor any derogations under Article 15.<sup>8</sup>

Article 3 imposes a negative obligation on the state not to inflict torture, inhuman or degrading treatment or punishment on individuals. The article also creates a positive obligation, which can be inferred from Article 1 of the Convention, that a State must take measures to protect its citizens from ill-treatment – whether carried out by state officials or private individuals or groups.

There have been many applications to the Strasbourg Court alleging violations of Article 3, but few have concerned mental disabilities issues. The following are definitions taken from the case-law of the Court:

***Torture***

**Deliberate inhuman treatment causing very serious and cruel suffering.**

***Inhuman treatment or punishment***

**Intense physical or mental suffering**

***Degrading treatment or punishment***

**Treatment which arouses in the victim feelings of fear, anguish and inferiority capable of humiliation and debasement and possibly breaking physical or moral resistance.**

### **What constitutes a breach of Article 3?**

The court exercises control after the event by looking back at the alleged ill-treatment, and examining whether the abuse complained of has attained the minimum level of severity to fall within the scope of Article 3. In other words, not all ill-treatment will be a violation of Article 3. The assessment of this standard is relative; it depends on all the circumstances of the case, such as the duration of the treatment, its physical or mental effects and, in some cases, the sex, age and state of health of the victim.<sup>9</sup> One of the key cases is Ireland v. The United Kingdom, in which the Court said that “it was the intention that the Convention, with its distinction between “torture” and “inhuman or

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<sup>8</sup> Art 15(2) states: “No derogation from Article 2, except in respect of deaths resulting from lawful acts of war, or from Articles 3, 4 (paragraph 1) and 7 shall be made under this provision.”

<sup>9</sup> Tekin v. Turkey Application 22496/93, judgment 9 Jun 1998 (paragraph 108)

degrading treatment", should by the first of these terms attach a special stigma to deliberate inhuman treatment causing very serious and cruel suffering"<sup>10</sup>

In Kudla v. Poland<sup>11</sup> the Court said that inhuman or degrading treatment must "go beyond that inevitable element of suffering or humiliation connected with a given form of legitimate treatment or punishment" to be classed as a violation of Article 3. (One could ask the question: what is a "legitimate" form of treatment or punishment?)

There have been few Article 3 cases brought by people with mental disabilities about conditions or treatment within institutions. Perhaps the most well-known is Herczegfalvy v. Austria,<sup>12</sup> a case in which Mr Herczegfalvy was forcibly administered food and neuroleptic medication, isolated and attached with handcuffs to a security bed for some weeks. He complained about his treatment was violent and excessively prolonged, and taken together had amounted to inhuman and degrading treatment, and even contributed to the worsening of his condition. The Austrian government responded by arguing that his treatment was essentially the consequence of the Mr Herczegfalvy's behaviour, as he had refused medical treatment which was urgent in view of the deterioration in his physical and mental health. The government explained that his "resistance to all treatment, his extreme aggressiveness and the threats and acts of violence on his part against the hospital staff which explained why the staff had used coercive measures including the intra-muscular injection of sedatives and the use of handcuffs and the security bed. These measures had been agreed to by Mr. Herczegfalvy's curator [guardian], their sole aim had always been therapeutic, and they had been terminated as soon as the state of the patient permitted this." (paragraph 81 of the judgment) The Court therefore found no violation of Article 3.

It is noteworthy that the Court heard this case in 1992, and the applicant's treatment took place between 1978 and 1984. As the ECHR is a "living instrument": it is quite possible that today's Court would come to a different position.

Despite the negative conclusion in Herczegfalvy, the Court stated that the Court requires increased vigilance because of the increased vulnerability of patients with mental health problems. The Court went on to say that if medical experts assess a measure to be a "therapeutic necessity", the Court in general would not find a violation of Article 3. The Court must nevertheless satisfy itself that the medical necessity has been convincingly shown to exist. In other words, medical opinion can be challenged, and the Court reserves the power to form its own opinion.

The Court stated:

*82. The Court considers that the 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. While 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, such*

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<sup>10</sup> paragraph 168

<sup>11</sup> Application 30210/96 Judgment 26/10/00

<sup>12</sup> (1993) 15 EHRR 437

*patients nevertheless remain under the protection of Article 3, the requirements of which permit of no derogation. The established principles of medicine are admittedly in principle decisive in such cases; as a general rule, a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading. The Court must nevertheless satisfy itself that the medical necessity has been convincingly shown to exist.*

Since Herczegfalvy there have been no successful Article 3 challenges involving conditions or treatment in psychiatric facilities. Please look at the CPT's guidance (in Appendix 1 of this pack) and reports for examples of the sorts of issues which might be litigated.

The case of Price v. UK<sup>13</sup> is noteworthy because it confirms that a violation of Article 3 is possible even when the applicant did not suffer intentional humiliation, but suffered more than others because of a disability. In this case, the applicant, woman who uses a wheelchair, alleged a violation of Article 3 because of prison conditions. The Court stated:

*In considering whether treatment is “degrading” within the meaning of Article 3, one of the factors which the Court will take into account is the question whether its object was to humiliate and debase the person concerned, although the absence of any such purpose cannot conclusively rule out a finding of violation of Article 3 (see the Peers v. Greece judgment of 19 April 2001, §§ 67-68 and 74).*

*There is no evidence in this case of any positive intention to humiliate or debase the applicant. However, the Court considers that to detain a severely disabled person in conditions where she is dangerously cold, risks developing sores because her bed is too hard or unreachable, and is unable to go to the toilet or keep clean without the greatest of difficulty, constitutes degrading treatment contrary to Article 3. It therefore finds a violation of this provision in the present case.*

More generally the following sets out the Court's jurisprudence.

- The Court has stated that the **difference between torture and inhuman and degrading treatment** is the intensity of the suffering,<sup>14</sup> emphasising that there is a “special stigma”<sup>15</sup> attached to torture.
- Most probably, the majority of future cases brought by people with mental health problems or intellectual disabilities under Article 3 will involve an allegation of inhuman or degrading treatment. However, it is interesting to note that the Court has recently hinted that treatment currently classified as inhuman or degrading “**could be classified differently in the future**”. The Court stated that “the increasingly high standard being required in the area of the protection of human rights and fundamental liberties correspondingly and inevitably requires greater

<sup>13</sup> Application no. 33394/96 Judgment 10 July 2001

<sup>14</sup> Ireland v. United Kingdom – (paragraph 167)

<sup>15</sup> Selmouni v. France (2000) 29 EHRR 403

firmness in assessing breaches of the fundamental values of democratic societies”.<sup>16</sup>

- In Ireland v. United Kingdom the Court said that the acts which fell into the category of **inhuman treatment** within the meaning of Article 3 were applied for hours at a time, and “caused, if not actual bodily injury, at least intense physical and mental suffering to the persons subjected thereto”.
- In assessing whether a treatment or punishment is classed within the meaning of Article 3, “the question whether the purpose of the treatment was to **humiliate or debase the victim** is a factor further to be taken into account, but the absence of any such purpose cannot conclusively rule out a violation of Article 3.”<sup>17</sup>
- For an act to constitute inhuman or degrading **punishment**, the humiliation or debasement involved must attain a particular level and must in any event be other than that usual element of humiliation which can be expected when someone is punished judicially.<sup>18</sup> Punishments in private (such as flogging in a police station) are capable of constituting a violation of Article 3. The “mental anguish” of waiting for a punishment to be carried out will also be relevant in assessing whether the punishment breaches article 3.<sup>19</sup> The same arguments must be true also of degrading treatment: if a person is waiting for unmodified ECT, he will suffer mental anguish too.
- Authorities are under an obligation to protect the health of persons deprived of liberty.<sup>20</sup>
- The lack of appropriate medical treatment of a person deprived of his/her liberty may amount to treatment contrary to Article 3.<sup>21</sup>

In the case of Keenan v. UK, the Court concluded that when considering whether the treatment or punishment of people with mentally disability is incompatible with the standards of Article 3, the Court’s assessment “has to take into consideration the person’s vulnerability and their inability, in some cases, to complain coherently or at all about how they are being affected by any particular treatment”. Mark Keenan had a diagnosis of schizophrenia, suicidal feelings and depression. Whilst serving a 4-month prison sentence he was placed in an isolation room in the punishment block without any proper medical monitoring. He hanged himself and died. The ECtHR found violations of Article 3 because of the lack of monitoring and lack of informed psychiatric assessment and treatment in prison, coupled with the imposition of 7 days segregation which may have threatened Mark Keenan’s moral resistance and which the Court found was “not compatible with the standard of treatment required in respect of a mentally ill person”.(paragraph 115)

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<sup>16</sup> Selmouni v. France *ibid*

<sup>17</sup> Peers v. Greece, Application no. 28524/95, (paragraph 74)

<sup>18</sup> Tyrer v. United Kingdom (1978) 2 EHRR 1 (paragraph 30)

<sup>19</sup> Soering v. United Kingdom (1989) 11EHRR 439 (paragraph 100)

<sup>20</sup> Hurtado v. Switzerland, Comm. Report 8 July 1993, Series A no. 280, p. 16, § 79

<sup>21</sup> Ilhan v. Turkey [GC] no. 22277/93, ECHR 2000-VII, § 87

Importantly, the Court in Keenan noted that the “treatment of a mentally ill person may be incompatible with the standards imposed by Article 3 in the protection of fundamental human dignity, even though that person may not be able, or capable of, pointing to any specific ill-effects.” (paragraph 112)

## Evidence

Where the individual has sustained injuries during *arrest or detention* it is for the State to prove that they were not caused by its servants or agents.<sup>22</sup> “Detention” in this context would include a psychiatric institution such as a hospital or a social care home where it could be argued that patients are detained. In other cases, neither party bears the burden of proof; the Court will make its own assessment looking at all of the evidence.

The standard of proof is “beyond reasonable doubt” – a very high standard.<sup>23</sup> The Court observed in Ireland v. UK that proof “may follow from the coexistence of sufficiently strong, clear and concordant inferences or of similar unrebuttable presumptions of fact”. The conduct of the parties in the case is also a factor which the Court takes into account.

The Court has emphasised that “although it may prove difficult for detainees to obtain evidence of ill-treatment by their warders, allegations of ill-treatment must as far as possible be supported by appropriate evidence.”<sup>24</sup>

## Investigation of allegations of abuse

States are under an obligation to carry out an effective investigation where someone raises an arguable claim that he has been the victim of an article 3 abuse by state agents. In the landmark case of Assemov v Bulgaria,<sup>25</sup> the Court stated that:

*“where an individual raises an arguable claim that he has been seriously ill-treated by the police or other such agents of the State unlawfully and in breach of Article 3, that provision, read in conjunction with the State’s general duty under Article 1 of the Convention to “secure to everyone within their jurisdiction the rights and freedoms defined in ... [the] Convention, requires by implication that there should be an effective official investigation. This investigation, as with that under Article 2, should be capable of leading to the identification and punishment of those responsible ... If this were not the case, the general legal prohibition of torture and inhuman and degrading treatment and punishment, despite its fundamental importance ..., would be ineffective in practice and it would be possible in some cases for agents of the State to abuse the rights of those within their control with virtual impunity.”* (paragraph 102)

States have a positive duty to take those steps that could reasonably be expected of them to avoid a real and immediate risk of ill- treatment contrary to Article 3 of which they knew or ought to have had knowledge.

<sup>22</sup> Ribitsch v. Austria (1995) 21 EHRR 573 (paragraph 34)

<sup>23</sup> Ireland v. United Kingdom

<sup>24</sup> J.L. v. Finland, Judgment 16 November 2000

<sup>25</sup> (90/1997/874/1086) 28 October 1998

## Remedies

Compensation is not sufficient in itself as a remedy of an Article 3 abuse unless it is accompanied by measures to prevent violations of Article 3 in the future. If a State authority does not provide compensation for an Article 3 abuse, the failure to compensate could in itself be challengeable at Strasbourg. Criminal prosecution, together with a claim for damages will usually be a sufficient remedy.

Donnelly v. United Kingdom, Apps Nos 5577-5583/72; 4 D.R. 4 at paras 78- 79

[C]ompensation could not ... be deemed to have rectified a violation in a situation where the state had not taken reasonable measures to comply with its obligations under Article 3. The obligation to provide a remedy does not constitute a substitute for or alternative to those obligations, but rather an obligation to provide redress within the domestic system for violations which may, inevitably occur despite measures taken to ensure compliance with the substantive provisions of Article 3 ... [I]f the higher authorities of the state pursued a policy or administrative practice whereby they authorised or tolerated conduct in violation of Article 3, compensation would not of itself constitute an adequate remedy ... [C]ompensation can only be seen as an adequate remedy in a situation where the higher authorities have taken reasonable steps to comply with their obligations under Article 3 by preventing, as far as possible, the occurrence of repetition of the acts in question.

## The European Committee for the Prevention of Torture, Inhuman or Degrading Treatment or Punishment (CPT)

All Member States of the Council of Europe have ratified the ECHR. Additionally, they have all ratified the 1987 European Convention for the Prevention of Torture. The Torture Convention does not establish any new norms. Rather, it establishes the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (the CPT). Article 1 of the Torture Convention states that the CPT shall “by means of visits, examine the treatment of persons deprived of their liberty with a view to strengthening, if necessary, the protection of persons from torture and from inhuman or degrading treatment or punishment.”

The members of the CPT are drawn from the Member States of the Council of Europe – there is one committee member per State, but that person acts individually and impartially, not as a representative of his country. The committee members, usually lawyers, doctors or similar professionals, are supported by a secretariat in Strasbourg.

The CPT works by a system of visits, whereby some of its committee members plus members of the Secretariat arrive in a country and visit various institutions. Each member state has agreed to “permit visits ... to any place within its jurisdiction where persons are deprived of their liberty by a public authority”.<sup>26</sup> These visits may be announced or unannounced.<sup>27</sup> The power of the CPT to make unannounced visits to any place of detention is unique, and is its key strength.

Typically, a visit by a CPT delegation involves visiting some prisons, immigration centres, children’s homes and psychiatric hospitals. The CPT has also visited psychiatric social care homes.<sup>28</sup> The CPT has for the first time recently visited a private psychiatric establishment.<sup>29</sup> The visits are intended to open dialogue with a State to discuss how torture and inhuman and degrading treatment can be prevented. After a CPT delegation visits a country it writes a report to the government. These reports are not publicly available unless the government gives its consent to the CPT to make the reports public. Therefore it is common that reports are published even two years after the visits – some are even longer. Reports of the CPT’s visits can be viewed at <http://www.cpt.coe.int/en/visits.htm>. The CPT encourages local NGOs to send them information which could be useful during their visits. During the visit the CPT meets officials at ministerial and local level, and also holds meetings with NGOs who are engaged in human rights monitoring. The CPT’s contact details are:

CPT  
Human Rights Building  
Council of Europe  
F-67075 Strasbourg Cedex, France

Tel.: France: 03 88 41 39 39, Int.: +33 3 88 41 39 39

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<sup>26</sup> Article 2 of the Torture Convention

<sup>27</sup> Unannounced visits are also called *ad hoc* visits.

<sup>28</sup> See the reports of the visits to Bulgaria (1999), Hungary (1997), Romania (1995) and the unpublished reports of the visit to Estonia (1997 and 1999)

<sup>29</sup> See report of the visit to Switzerland (2001), available in French, German and Italian.

Fax: France: 03 88 41 27 72, Int.: +33 3 88 41 27 72

E-mail: [cptdoc@coe.int](mailto:cptdoc@coe.int)

Internet: [www.cpt.coe.int](http://www.cpt.coe.int)

In addition to publishing reports of country visits, the CPT issues guidance on how different categories of people should be treated. One of these sections is dedicated to the treatment of people who are detained in psychiatric institutions. These “substantive sections” of the CPT annual reports are available in various languages on the CPT’s website<sup>30</sup> at and are reproduced within these training materials.

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<sup>30</sup> <http://www.cpt.coe.int/en/docssubstantive.htm>

## Article 8 ECHR – right to privacy

**Article 8 ECHR** provides:

- 1. Everyone has the right to respect for his private and family life, his home and his correspondence.*
- 2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.*

Article 8 protects individuals from arbitrary interference from the State. The State may have positive obligations in ensuring respect for family life.<sup>31</sup>

It may not be clear cut where the boundary between Article 3 and Article 8 lies. A case pleaded primarily under Article 8 may also raise issues under Article 3. Certainly the Court has found breaches of Article 3, and it has felt that it is unnecessary to consider whether the same actions also breached Article 8.<sup>32</sup>

### **Private life**

In Botta v. Italy<sup>33</sup> the Court defined the concept of private life as including “a person’s physical and psychological integrity; the guarantee afforded by Article 8 ... is primarily intended to ensure the development, without outside interference, of the personality of each individual in his relations with other human beings.”

The Court has held that “respect for private life must also comprise to a certain degree the right to establish and develop relationships with other human beings”.<sup>34</sup>

The right to private life includes the right to be free from unnecessary surveillance by State authorities.

### **“In accordance with the law”**

Any interference under Article 8 must be “in accordance with the law”, so that people are not subjected to arbitrary actions by State authorities. The restriction to the right to privacy must be established in domestic law, and the law must be sufficiently precise for an citizen to regulate his conduct.

In Herzgefalvy v. Austria the Court commented on the practice of regulating patients’ correspondence in a mental hospital by sending outgoing letters to the patients guardian to choose which ones to send on to the intended addressee. The Court said that:

<sup>31</sup> See Marckx v. Belgium (1979) 2 EHRR 330

<sup>32</sup> See, for example, Chatal v. United Kingdom (1996) 23 EHRR 413

<sup>33</sup> (1998) 26 EHRR 241

<sup>34</sup> Niemietz v. Germany, (1992) 16 EHRR 97 (paragraph 29)

*These very vaguely worded provisions .... do not specify the scope or conditions of exercise of the discretionary power which was the origin of the measures complained of. But the specifications appear all the more necessary in the field of detention in psychiatric institutions in that all persons concerned are frequently at the mercy of the medical authorities, so that their correspondence is their only contact with the outside world.*<sup>35</sup>

#### **“In pursuit of a legitimate aim”**

Any interference with privacy must be justified by the government in reference to one of the categories listed in Article 8(2): in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others. Once the government has claimed that the interference is in its opinion justified in one of these categories, the Court will examine whether the measure is necessary in a democratic society.

#### **“Necessary in a democratic society”**

The interference must pursue a legitimate aim and be proportionate to that aim. There must be a “pressing social need”.<sup>36</sup> The Court interprets the needs of a democratic society fairly liberally, stressing that included in the hallmarks of a democratic society are broadmindedness, tolerance and pluralism.

*Proportionality:* The Court will examine the extent to which the reasons which the State advances for justifying an interference are relevant and sufficient. The Court will examine the nature and degree of the interference of the person’s rights: the more interference with a person’s rights, the more justification there will have to be for any interference.

#### **Margin of appreciation**

The Court gives States some flexibility in deciding whether an interference is justified – this is the “margin of appreciation”. The margin of appreciation which the Court will allow will vary from case to case, depending on the nature of the activity, and the need and reasons given for restricting it.

#### **Correspondence from a mental disability institution**

Telephone or electronic communications fall within the scope of Article 8. Interception of any private communication is a prima facie violation of rights protected by Article 8. Governments may argue that the interception of communication is necessary in a democratic society, and therefore justified under Article 8(2).

The right to correspondence does not merely mean a right to be free from interference/interception, but also a right to communicate. Therefore States must not restrict communication.<sup>37</sup>

It is clear that patients who are receiving psychiatric care and treatment who are *not* detained, are able to send and receive mail as they wish.

<sup>35</sup> 15 EHRR 437 (paragraph 91)

<sup>36</sup> Dudgeon v. United Kingdom (1981) 4 EHRR 149 (paragraph 51)

<sup>37</sup> See Golder v. United Kingdom (1975) 1 EHRR 524 and Campbell and Fell v. United Kingdom (1984) 7 EHRR 165.

Patients sending mail. In a mental health institution there may be concern that patients who are suffering from a severe mental disability would send letters containing threatening or disturbing content which might cause distress to the recipient or put that person in danger. In a situation where a person with mental disability has committed a crime and is assessed as being dangerous the State's concern to protect other individuals is justifiable.

In cases about prisoners' rights, the Court has said that the State has a positive obligation to assist a prisoner in maintaining contact with his family. Therefore an absolute prohibition on communicating with the outside world will invariably be a violation of Article 8.

Patients receiving mail. It is generally agreed there can be no grounds to withhold mail from people who are detained in psychiatric institution which is not a high security institution.

If a person is detained in a forensic (criminal) institution, patients should be allowed to receive mail unless it is in the interests of safety of the patient or for the protection of others.

Corresponding with lawyers. The right to consult and correspond with a lawyer is privileged. The Court has said that "correspondence with lawyers ... concern matters of a private a confidential character. In principle, such letters are privileged under Article 8".<sup>38</sup>

Likewise, any interference with correspondence to or from a court (including the European Court of Human Rights) will be a violation of Article 8.

In the case of Campbell<sup>39</sup> the Court explained:

*This means that the prison authorities may open a letter from a lawyer to a prisoner when they have reasonable cause to believe that it contains an illicit enclosure which the normal means of detection have failed to disclose. The letter should, however, only be opened and should not be read. Suitable guarantees preventing the reading of the letter should be provided, e.g. opening the letter in the presence of the prisoner. The reading of a prisoner's mail to and from a lawyer, on the other hand, should only be permitted in exceptional circumstances when the authorities have reasonable cause to believe that the privilege is being abused in that the contents of the letter endanger prison security or the safety of others or are otherwise of a criminal nature. What may be regarded as "reasonable cause" will depend on all the circumstances but it presupposes the existence of facts or information which would satisfy an objective observer that the privileged channel of communication was being abused (see, mutatis mutandis, the Fox, Campbell and Hartley v. the United Kingdom judgment of 30 August 1990, Series A no. 182, p. 16, para. 32).*

Other issues which could engage Article 8 include the following.

<sup>38</sup> Campbell v. United Kingdom (1992) EHRR 137

<sup>39</sup> at paragraph 48

### **Medical treatment**

Any invasion of a person's body is an interference with private life. However, the invasion may be justified as medical treatment "for the protection of health" under Article 8(2). As discussed in the section about Article 3, the Court has emphasised the need for increased vigilance when assessing whether someone needs medical treatment. The Court has also said that "Mental health must also be regarded as a crucial part of private life associated with the aspect of moral integrity".<sup>40</sup>

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<sup>40</sup> Bensaid v. United Kingdom, 6 February 2001, paragraph 47

## Article 5 ECHR – right to liberty

**Article 5** of the European Convention on Human Rights, so far as relevant to mental disability, reads as follows:

5(1) Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:

- (a) the lawful detention of a person after conviction by a competent court;
- (b) the lawful arrest or detention of a person effected for the purpose of bringing him before the competent legal authority on reasonable suspicion of having committed an offence or when it is reasonably considered necessary to prevent his committing an offence or fleeing after having done so;
- (c) the lawful arrest or detention of a person for non-compliance with the lawful order of a court or in order to secure the fulfilment of any obligation prescribed by law;
- (d) ...
- (e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants;
- (f) ...

5(2) *Everyone who is arrested shall be informed promptly, in a language which he understands, of the reasons for his arrest and of any charge against him.*

5(3) .....

5(4) Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.

5(5) Everyone who has been the victim of arrest or detention in contravention of the provisions of this article shall have an enforceable right to compensation.

### Article 5 requirements

The jurisprudence of the European Court of Human Rights under Article 5 has since 1979 built on the terms of the Article to create a number of clear requirements. The following analysis reviews the cases and sets out the necessary features of a mental disability system to ensure compliance.

## Admission and detention

In Winterwerp v. Netherlands<sup>41</sup>, the first mental health case to reach the ECtHR, three relatively undemanding requirements for a valid detention of a “person of unsound mind” were laid down in the following passage in the judgment:

*“In the Court’s opinion, except in emergency cases, the individual concerned should not be deprived of his liberty unless he has been reliably shown to be of ‘unsound mind’. The very nature of what has to be established before the competent national authority – that is, a true mental disorder – calls for objective medical expertise. Further, the mental disorder must be of a kind or degree warranting compulsory confinement. What is more, the validity of continued confinement depends upon the persistence of such a disorder”.* (paragraph 39)

In Varbanov v. Bulgaria,<sup>42</sup> the applicant’s detention had been decided upon by a prosecutor without medical input. The Court emphasized that a medical opinion must be obtained and the assessment of the individual must be based on the actual mental state of the person rather than solely on past events

The requirement that the deprivation of liberty should be “**in accordance with a procedure prescribed by law**”, was explained in Winterwerp thus:

*“the Court for its part considers that the words ‘in accordance with a procedure prescribed by law’ essentially refer back to domestic law; they state the need for compliance with the relevant procedure under that law.*

*However the domestic law must itself be in conformity with the Convention, including the general principles expressed or implied therein. The notion underlying the term in question is one of fair and proper procedure, namely that any measure depriving a person of his liberty should issue from and be executed by an appropriate authority, and should not be arbitrary ”.* (Paragraph 45)

Effectively it therefore requires that the procedure be codified. In the recent case of Kawka v Poland<sup>43</sup> the Court stressed, that:

*“where deprivation of liberty is concerned, it is particularly important that the general principle of legal certainty is satisfied. It is therefore essential that the conditions for deprivation of liberty under domestic law should be clearly defined, and that the law itself be foreseeable in its application, so that it meets the standard of “lawfulness” set by the Convention, a standard which requires that all law should be sufficiently precise to allow the person – if needed, to obtain the appropriate advice – to foresee, to a degree that is reasonable in the circumstances, the consequences which a given action may entail”* (Paragraph 49)

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<sup>41</sup> 2 EHRR 387

<sup>42</sup> Unreported, Application 31365/96, Judgment 5 October 2000

<sup>43</sup> Application no. 25874/94 - Judgment 9 January 2001

Countries enjoy some discretion in deciding what qualifies as “**unsoundness of mind.**” The Court in Winterwerp was unwilling to define what is essentially a medical definition, because:

*“.....in deciding whether an individual should be detained as a ‘person of unsound mind’, the national authorities are to be recognised as having a certain discretion, since it is in the first place for the national authorities to evaluate the evidence adduced before them in a particular case...”* (Paragraph 40)

Article 5 does not create a right to treatment,<sup>44</sup> nor a right to hospital care suitable for the patient.<sup>45</sup> However a person detained for unsoundness of mind will only be lawful for the purposes of Article 5(1)(e) if this takes place in a hospital, clinic or other appropriate therapeutic institution. A prison is not an acceptable location for civil psychiatric detention.<sup>46</sup>

### **Delay between examination and report**

If the doctor’s decision is based on medical information which did not necessarily reflect the applicant’s condition at the time of the decision, the “delay between clinical examination and preparation of a medical report is in itself capable of running counter to the principle underlying Article 5 of the Convention, namely the protection of individuals against arbitrariness as regards any measure depriving them of their liberty”. (see the above-mentioned Winterwerp judgment, p. 17, § 39).<sup>47</sup>

### **Giving reasons for detention**

In its early case-law, in the face of argument that “arrest” carried connotations of criminal detention, the ECtHR hesitated to construe the words of Article 5(2) “Everyone who is *arrested* ...” as applicable to the circumstances of a compulsory psychiatric detention. Thus in X v. United Kingdom<sup>48</sup> the ECtHR said it did not consider it necessary to decide the issue because:

*“...the need for the applicant to be appraised of the reasons for his recall necessarily followed in any event from Article 5(4): anyone entitled (as X was) to take proceedings to have the lawfulness of his detention speedily decided cannot make effective use of that right unless he is promptly and adequately informed of the facts and legal authority relied upon to deprive him of his liberty”* (Paragraph 66)

In more recent cases the ECtHR has held that Article 5(2) does apply to mental health detention. Thus in Van der Leer v. Netherlands<sup>49</sup> it held:

*“The Court is not unmindful of the criminal law connotation of the words used in Article 5(2). However it agrees with the Commission that they should be*

<sup>44</sup> See Winterwerp, para 51

<sup>45</sup> Ashingdane v. United Kingdom (1985) 7 EHRR 528

<sup>46</sup> Aerts v. Belgium (1998) 29 EHRR 50

<sup>47</sup> Musial v Poland, para 50

<sup>48</sup> (1981) 4 EHRR 188

<sup>49</sup> (1990) 12 EHRR 567

*interpreted ‘autonomously’, in particular in accordance with the aim and purpose of Article 5, which are to protect everyone from arbitrary deprivations of liberty” (Paragraph 27)*

The ECtHR has not said whether the information given at the time of detention need be in written form.

### **The right of access to a court**

A patient’s right, under Article 5(4), to take proceedings by which the lawfulness of his detention is decided speedily by a court is the most far reaching of the rights in Article 5. It may be satisfied in one of two ways: either by giving the patient a right to apply to a court at a time of his choosing, or by ‘automatic periodic review of a judicial character’. Issues which the ECtHR has addressed include (a) the powers which the reviewing court must possess and its judicial character, (b) the required frequency of the periodic review, (c) the speed necessary, (d) legal representation.

### **Powers and judicial character of the reviewing court**

In Winterwerp v. Netherlands<sup>50</sup> the ECtHR laid down the essential requirements of a court hearing under Article 5(4):

*“The judicial proceedings referred to in Article 5(4) need not, it is true, always be attended by the same guarantees as those required under Article 6(1) for civil or criminal litigation. Nonetheless, it is essential that the person concerned should have access to a court and the opportunity to be heard either in person or, where necessary, through some form of representation, failing which he will not have been afforded the ‘fundamental guarantees of procedure applied in matters of deprivation of liberty’. Mental illness may entail restricting or modifying the manner of exercise of such a right, but it cannot justify impairing the very essence of the right. Indeed special procedural safeguards may prove called for in order to protect the interests of persons who, on account of their mental disabilities, are not fully capable of acting for themselves.” (Paragraph 60)*

In X v. United Kingdom the ECtHR, expanding its earlier case law,<sup>51</sup> explained the notion of a ‘court’ in this context:

*“It is not within the province of the Court to enquire into what would be the best or most appropriate system of judicial review in this sphere, for the Contracting States are free to choose different methods of performing their obligation. Thus, in Article 5(4) the word ‘court’ is not necessarily to be understood as signifying a court of the classic kind, integrated within the standard judicial machinery of the country. This term, as employed in several Articles of the Convention (including Art. 5(4)), serves to denote-*

*bodies which exhibit not only common fundamental features, of which the most important is independence of the executive and of the parties to the case, but also the guarantees (‘appropriate to the kind of deprivation of liberty in question’)*

<sup>50</sup> 2 EHRR 387

<sup>51</sup> See Wassik v Netherlands judgment of 27/9/1990, Series A no. 185-A, para. 30

*of [a] judicial procedure the form of which may vary from one domain to another”*  
(Paragraph 53)

The review by the ‘court’ (however it is designated):

*“should ...be wide enough to bear on those conditions which, according to the Convention, are essential for the ‘lawful’ detention of a person on the ground of unsoundness of mind, especially as the reasons capable of initially justifying such a detention may cease to exist. This means that in the instant case Article 5(4) required an appropriate procedure allowing a court to examine whether the patient’s disorder still persisted and whether the Home Secretary was entitled to think that a continuation of the compulsory confinement was necessary in the interests of public safety”.* (Paragraph 58)

The court has also held that the court procedure must allow the lawyer access to information held about the client. In Nikolova v. Bulgaria<sup>52</sup> the ECtHR held that:

*“A court examining an appeal against detention must provide guarantees of a judicial procedure. The proceedings must be adversarial and must always ensure “equality of arms” between the parties, the prosecutor and the detained person ... Equality of arms is not ensured if counsel is denied access to those documents in the investigation file which are essential in order effectively to challenge the lawfulness of his client’s detention ...”*<sup>53</sup> (Paragraph 58)

In Rakevich v. Russia<sup>54</sup> the Court declared admissible a case which alleges a challenges the practice in a mental disability Article 5(4) court hearing, of refusing access by counsel representing a patient to the information held on the patient, including information upon which the initial decision to detain the patient was made.

In Johnson v. United Kingdom<sup>55</sup> the ECtHR considered decisions of three successive mental health review tribunals that a patient found no longer to be suffering from mental illness should be discharged subject to a condition that he reside in a staffed hostel. The tribunal lacked the power to implement this condition, and his detention continued. The ECtHR, having found a breach of Article 5(1)(e), found it unnecessary to decide the Applicant’s complaint that there was a also breach of Article 5(4) by reason of the tribunal’s lack of legal powers. However the Judgment strongly suggests that but for the finding under Article 5(1)(e) the ECtHR would have found a violation of Article 5(4).

In DN v. Swizerland<sup>56</sup> the Court recently affirmed the importance of judges’ independence in such hearings: “such impartiality is essential”.

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<sup>52</sup> (2001) 31 EHRR 3, Application 31195/96, Judgment 25 March 1999

<sup>53</sup> Beware, this is not a mental health case, but a criminal case in which articles 5(1)(c) and 5(4) were argued

<sup>54</sup> Application No. 58973/00, admissibility decision 5 March 2002

<sup>55</sup> (1998) 27 EHRR 296

<sup>56</sup> Unreported, application 27154/95, judgment 29 March 2001. Commentary at (2001) 5 EHRLR 589

## Frequency of reviews

The ECtHR has not yet stated definitively how frequently a patient must be able to exercise his 'periodic' right under Article 5(4). However in Herczegfalvy v. Austria<sup>57</sup>, it considered three intervals, the first of fifteen months, the second of two years and the third of nine months. It decided that the first two could not be regarded as reasonable intervals, but did not criticise the third interval of nine months. It therefore seems highly probable that the ECtHR would accept annual intervals, but no longer.

In E v. Norway<sup>58</sup> the ECtHR held that a period of 55 days (7 weeks and 6 days) between an application for review and a decision by a 'court' was insufficiently speedy to meet the requirements of Article 5(4). The maximum permissible time remains undecided, but could be held to be as little as four or six weeks.

Less urgency is required under Article 5(4) when a patient is exercising his right to a second or subsequent application. But in Koendjiharie v. Netherlands<sup>59</sup> the ECtHR found a delay of 4 months to be excessive.

In Musial v. Poland<sup>60</sup> the Court held that "Article 5(4), in guaranteeing to persons arrested or detained a right to institute proceedings to challenge the lawfulness of their detention, also proclaims their right, following the institution of such proceedings, to a speedy judicial decision concerning the lawfulness of detention and ordering its termination if it proves unlawful (see the Van der Leer v. the Netherlands judgment of 21 February 1990, Series A no. 170-A, p. 14, § 35)."<sup>61</sup>

In Musial the time between application for a review and the decision by the court was one year, eight months and eight days. The Court held that such a length of time would clearly be in breach of article 5(4) unless the government had exceptional grounds to justify it. In Musial the Court held that the Polish government had no exceptional grounds, and that there was a breach of article 5(4).

## What constitutes exceptional grounds for delay?

A patient does not waive his procedural rights under article 5(4) if he insists on being examined by doctors outside the treating hospital and the court agrees. It is not permissible for the government to argue that the patient brought about the delay himself: the court is still obliged to adjudicate on the lawfulness of his detention speedily.<sup>62</sup>

Complexity of a case is no defence to delay. The Court has made it clear that "the complexity of a medical dossier, however exceptional, cannot absolve national authorities from their essential obligations" under Article 5(4).<sup>63</sup>

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<sup>57</sup> (1992) 15 EHRR 437

<sup>58</sup> (1990) 17 EHRR 30

<sup>59</sup> (1991) 13 EHRR 820

<sup>60</sup> Unreported. Application 24557/94, judgement 25/3/99

<sup>61</sup> Musial, para 43

<sup>62</sup> Musial, para 46

<sup>63</sup> Musial, para 47

The government may argue that there was another way which the applicant could have used to seek a remedy for the delay (for example, complaining to a public prosecutor). The court will allow such an argument to succeed only if the government can show that the body to which they say the applicant should have complained has “judicial character”.<sup>64</sup>

If there are proceedings before one court, the applicant need generally not apply to the Constitutional Court, as “[i]n principle, the intervention of one organ satisfies Article 5 § 4, on condition that the procedure followed has a judicial character and gives to the individual concerned guarantees appropriate to the kind of deprivation of liberty in question”.<sup>65</sup> In order to determine whether a court procedure provides adequate guarantees, regard must be had to the particular nature of the circumstances in which such proceeding takes place.<sup>66</sup>

### Legal representation

In Megyeri v. Germany<sup>67</sup> the ECtHR found a violation of Article 5(4) because the Applicant should have been given legal representation. After reviewing its earlier jurisprudence on this issue the Court said:

*“... that where a person is confined in a psychiatric institution on the ground of the commission of acts which constituted criminal offences but for which he could not be held responsible on account of mental illness, he should – unless there are special circumstances – receive legal assistance in subsequent proceedings relating to the continuation, suspension, or termination of his detention. The importance of what is at stake for him – personal liberty – taken together with the very nature of the affliction – diminished mental capacity – compels this conclusion.”* (Paragraph 23)

It cannot be assumed that legal representation is a right for all detained patients. Megyeri’s mental disorder appears to have been relatively severe at the relevant time. A criminal court had decided that he could not be held responsible for his acts because he was suffering from paranoid schizophrenia, and at the time of the hearing he was said to have deteriorated. Even if a right to representation funded by the State is not a general right, a ‘court’ reviewing detention clearly must always consider whether a particular patient is capable of acting for himself, e.g. whether he is able to marshal arguments and points in his favour, and understand any legal issues arising. If not, then legal representation must be provided.

In the case of Vaes v Netherlands,<sup>68</sup> the (now non-existent) European Commission of Human Rights considered “that the same principle (as Megyeri) should apply to proceedings which ... concern the initial detention of a person in a psychiatric institution.”

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<sup>64</sup> Vodenicarov v Slovakia, application 25430/94, judgement 21/12/2000, para 37

<sup>65</sup> Jecius v Lithuania, application 34578/97, judgment 31/7/00, para 100

<sup>66</sup> See Vodenicarov v Slovakia, para 33

<sup>67</sup> (1992) 15 EHRR 584

<sup>68</sup> Application No. 17581/90 Report of the Commission 2 September 1992

In the case of Pereira v. Portugal,<sup>69</sup> the Court noted that the applicant was suffering from a mental disorder that prevented him from conducting court proceedings satisfactorily, despite his legal training. The circumstances of the case therefore dictated the appointment of a lawyer to assist him in the proceedings concerning the periodic review of the lawfulness of his confinement. The judge responsible for the execution of sentences had assigned a lawyer at the outset of the proceedings but he had played no role in the proceedings. The Court found a violation of Article 5(4), emphasising that merely appointing counsel did not ensure that the client would receive effective legal assistance.

### **Detention ordered during criminal proceedings**

If a person is convicted of a criminal act and on account of his mental disorder, the court orders him to be detained in a hospital, his detention is referable both to Article 5(1)(a) and 5(1)(e). Consequently he has a right to periodic review of detention.

If a person charged with criminal offences is found not to be responsible by reason of mental disorder, and for that reason is acquitted or not convicted, then any detention ordered by the court will only be lawful if it is in a hospital, clinic or other appropriate institution<sup>70</sup>.

### **Right to compensation**

The right to compensation set out in Article 5(5) is a right enforceable by a court, leading to a legally binding award. A remedy before some body other than a court (for example, an ombudsman), or an *ex gratia* award, is not sufficient. A state is not prohibited from requiring proof of damage. The term 'victim of arrest or detention in contravention of the provisions of this article' includes contraventions of any of the paragraphs 5(1) – 5(4).

Note that the applicant need not have applied for or have been awarded compensation in order for the domestic remedies to have been exhausted. In Zdebski v Poland<sup>71</sup> the Court stressed that:

*“where lawfulness of detention is concerned, an action for damages against the State is not a remedy which has to be exhausted because the right to obtain release from detention and the right to obtain compensation for any deprivation of liberty incompatible with Article 5 are two separate rights.”*

### **Article 5 - summary**

The minimum requirements set by Article 5 of the ECHR are as follows:

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<sup>69</sup> Application No.44872/98, Judgment 26 February 2002

<sup>70</sup> Aerts v. Belgium 29 EHRR 50

<sup>71</sup> Zygmunt Zdebski, Janina Zdebska and Małgorzata Zdebska v. Poland Application no. 27748/95, Judgment 6 April 2000

1. Compulsory admission to a psychiatric hospital requires a codified mental health law.
2. There must be a prior medical examination showing “a true mental disorder” before compulsory admission, other than in an emergency.
3. The mental “disorder” must be sufficiently serious (“kind or degree” for compulsory admission.
4. A patient compulsorily admitted to hospital should in principle only be detained for as long as he has disorder of such a degree. However, discharge from detention following recovery need not be immediate and unconditional. A state may defer discharge for a reasonable time to make after-care arrangements (such as a place for the person to live).
5. A patient compulsorily admitted to hospital must be given the reasons for the admission promptly, in a language that he/she understands.
6. Following detention a patient must be given an opportunity to test the lawfulness of his/her detention before a court. This may be:
  - a) by providing an early automatic review, or
  - b) by giving the patient a right of application at a date of his/her choosing, or
  - c) both.
7. A patient must be given further opportunities to test the lawfulness of his/her detention at least annually.
8. A patient seeking a first review following detention must be able to obtain a decision with reasons from the court on the lawfulness of his/her detention speedily. This must certainly be in less than 8 weeks, and possibly within four weeks.
9. For a second or subsequent review a decision must be obtainable in less than 4 months, and possibly within two months.
10. A patient must have an opportunity to be heard, either in person, or where necessary through some form of representation.
11. A patient must be given legal representation where this is necessary on account of his/her mental disability. This need arises where a patient is unable adequately to marshal and present points in his favour, or address any legal issues arising.
12. A lawyer representing a patient must have access to information on the patient held by the hospital.
13. The court’s powers must be sufficient to decide on matters essential to justify detention, including therefore an ability to determine whether the

patient's disorder still persists to the extent warranting compulsory detention, and the Court must have the power to discharge the patient if detention is no longer justified.

14. If, having decided that the patient should be discharged, a court orders such discharge to be conditional on after-care arrangements being made, the court must have the power to compel such arrangements so that discharge is not unreasonably delayed.
15. Anybody who has been of victim of any breach of Article 5 must have a legally enforceable right to compensation before his/her national courts.

## Guardianship

The lives of thousands of people in the central and eastern Europe are affected in a fundamental way by the system of guardianship. Regulated by Civil Codes largely unchanged since Soviet times, guardianship attracts a low priority for legislators pressed by the international community to reform more visible areas of the legal system. Guardianship remains largely unmonitored whilst people under guardianship are locked away and forgotten: their very status preventing them from complaining. Human rights abuses may pervade the entire system: from judicial enquiry into incapacity, appointment of guardian, guardian's powers, oversight of the guardian and review of necessity of guardianship.

### Incapacity hearing

Families commonly ask the court to declare their relative incompetent because of financial reasons: "I want to sell his summer house" was the motive of an applicant in Estonia. If a person has no relatives the State applies for guardianship, and if granted, a local authority becomes the guardian.

Junior judges hear incapacity cases. Commonly the person whose capacity is in question is not informed of the application against them. Commonly, one written psychiatric opinion is enough for a judge to declare a person incapable, and in countries where there is a court hearing, the doctor is given the power to advise the judge that the person's presence is not required. In countries where the court appoints a lawyer or other person to represent the interests of the person, the representative rarely meets or takes instructions from the client. In other countries the person in question must attend, but no representation is provided.

There are often no live witnesses, and the psychiatrist's opinion is accepted as unquestionable scientific truth. Sometimes the person now under guardianship is not informed of the court's decision. In most jurisdictions the test that a judge has to apply when deeming someone incapable is not defined in law. Few applications for guardianship are refused.

In some countries a person can be involuntarily detained in a social care home in order for his capacity to be assessed.

These procedures may be in violation of **Article 6 ECHR**, which provides that "In the determination of his civil rights and obligations ... everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law". The meaning of a civil right is "determined by reference to the substantive content and effects of the right – and not its legal classification – under the domestic law of the state concerned."<sup>72</sup> Personal, private or economic rights are usually regarded as "civil rights".

### Appointment of guardian

If no family member is willing to be guardian, the guardianship office (an administrative body) will appoint someone who is paid per ward under his or her control. In many countries there is a pool of "professional" guardians, who often have over 100 wards each. In Hungary the legal maximum number of wards per guardian allowed in law is 40,

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<sup>72</sup> König v Germany (1978) 1 EHRR 170

but this rule is often breached. In other countries, director of a social care home may be appointed as a guardian, creating a situation which may be a conflict of interest.

It is common that the guardian never meets or speaks with the person under guardianship. Decisions taken by the guardian without seeking the person's opinion may violate Article 8, the right to respect for privacy.

### **Powers and duties of guardians**

The powers of guardians are immense. The State often divests its responsibility to protect its most vulnerable citizens by giving the decision to regulate many personal rights to another individual. Amongst the most common powers of the guardian are:

- Deciding on residence. In practice, this means that a guardian can decide to place the adult in a social care home (internat) – usually a huge, remote, overcrowded institution. The guardian also has the power to block the adult's discharge.
- Controlling finances. Guardians are given the authority to personally regulate the adult's financial affairs. This includes selling real estate and personal possessions; sole access to bank accounts; disposal of pension. This may be in breach of **Article 1 of Protocol 1 of the ECHR**: the protection of property.
- Restricting a person's access to a lawyer. Once a person is placed under guardianship, the person's signature becomes "invalid" in domestic law. Therefore the person cannot instruct a lawyer. A lawyer does not get paid if he acts for a client whose signature is invalid – the few lawyers working in this field are funded by NGOs or act *pro bono*.
- Regulating appeals against guardianship. If the adult wants to contest his placement under guardianship, the guardian has to consent. Inevitably consent is rarely given.
- In some countries, deciding on medical treatment.
- In some countries, regulating marriage or sexual relations.
- In some countries, regulating a ward's participation in elections.
- In some countries, restricting a ward's entitlement in domestic law to leave of absence (6 weeks "holiday" per year) from a social care home.

Often the powers of the guardian are not legally regulated. There is no duty on a guardian to meet with the adult or to take into account the wishes of the person under guardianship. Clearly there are privacy concerns if a stranger is given intimate access to another person's personal and financial details without their consent.

### **Supervision of a guardian**

In most countries the local government's guardianship office has the responsibility of regulating guardians. In many countries the guardianship office carries out its duties superficially, which is partly explained by the lack of criteria for evaluating guardians. Financial accounts submitted by guardians are rarely checked or questioned. In some countries there is no such regulatory body. Displacement of a guardian (meaning changing the guardian due to, for example, under-performance) is mostly unregulated in law.

**Death of a person under guardianship**

Guardians have the power to ask the State to investigate the death of their ward; a power which an uninterested guardian is unlikely to invoke. In almost every country in the region there is a lack of investigative machinery, invariably a violation of **Article 2 ECHR**.

## APPENDIX 1 - CPT

### ***Substantive Sections - VI. Involuntary placement in psychiatric establishments***

#### ***Extract from the 8th General Report [CPT/Inf (98) 12]***

#### **A. Preliminary remarks**

25. The CPT is called upon to examine the treatment of all categories of persons deprived of their liberty by a public authority, including persons with mental health problems. Consequently, the Committee is a frequent visitor to psychiatric establishments of various types.

Establishments visited include mental hospitals accommodating, in addition to voluntary patients, persons who have been hospitalised on an involuntary basis pursuant to civil proceedings in order to receive psychiatric treatment. The CPT also visits facilities (special hospitals, distinct units in civil hospitals, etc) for persons whose admission to a psychiatric establishment has been ordered in the context of criminal proceedings. Psychiatric facilities for prisoners who develop a mental illness in the course of their imprisonment, whether located within the prison system or in civil psychiatric institutions, also receive close attention from the CPT.

26. When examining the issue of health-care services in prisons in its 3rd General Report (cf. CPT/Inf (93) 12, paragraphs 30 to 77), the CPT identified a number of general criteria which have guided its work (access to a doctor; equivalence of care; patient's consent and confidentiality; preventive health care; professional independence and professional competence). Those criteria also apply to involuntary placement in psychiatric establishments.

In the following paragraphs, some of the specific issues pursued by the CPT in relation to persons who are placed involuntarily in psychiatric establishments are described<sup>73</sup>. The CPT hopes in this way to give a clear advance indication to national authorities of its views concerning the treatment of such persons; the Committee would welcome comments on this section of its General Report.

#### **B. Prevention of ill-treatment**

27. In view of its mandate, the CPT's first priority when visiting a psychiatric establishment must be to ascertain whether there are any indications of the deliberate ill-treatment of patients. Such indications are seldom found. More generally, the CPT wishes to place on record the dedication to patient care observed among the overwhelming majority of staff in most psychiatric establishments visited by its delegations. This situation is on occasion all the more commendable in the light of the low staffing levels and paucity of resources at the staff's disposal.

Nevertheless, the CPT's own on-site observations and reports received from other sources indicate that the deliberate ill-treatment of patients in psychiatric establishments

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<sup>73</sup> As regards psychiatric care for prisoners, reference should also be made to paragraphs 41 to 44 of the Committee's 3rd General Report.

does occur from time to time. A number of questions will be addressed subsequently which are closely-linked to the issue of the prevention of ill-treatment (e.g. means of restraint; complaints procedures; contact with the outside world; external supervision). However, some remarks should be made at this stage as regards the choice of staff and staff supervision.

28. Working with the mentally ill and mentally handicapped will always be a difficult task for all categories of staff involved. In this connection it should be noted that health-care staff in psychiatric establishments are frequently assisted in their day-to-day work by orderlies; further, in some establishments a considerable number of personnel are assigned to security-related tasks. The information at the CPT's disposal suggests that when deliberate ill-treatment by staff in psychiatric establishments does occur, such auxiliary staff rather than medical or qualified nursing staff are often the persons at fault.

Bearing in mind the challenging nature of their work, it is of crucial importance that auxiliary staff be carefully selected and that they receive both appropriate training before taking up their duties and in-service courses. Further, during the performance of their tasks, they should be closely supervised by - and be subject to the authority of - qualified health-care staff.

29. In some countries, the CPT has encountered the practice of using certain patients, or inmates from neighbouring prison establishments, as auxiliary staff in psychiatric facilities. The Committee has serious misgivings about this approach, which should be seen as a measure of last resort. If such appointments are unavoidable, the activities of the persons concerned should be supervised on an on-going basis by qualified health-care staff.

30. It is also essential that appropriate procedures be in place in order to protect certain psychiatric patients from other patients who might cause them harm. This requires inter alia an adequate staff presence at all times, including at night and weekends. Further, specific arrangements should be made for particularly vulnerable patients; for example, mentally handicapped and/or mentally disturbed adolescents should not be accommodated together with adult patients.

31. Proper managerial control of all categories of staff can also contribute significantly to the prevention of ill-treatment. Obviously, the clear message must be given that the physical or psychological ill-treatment of patients is not acceptable and will be dealt with severely. More generally, management should ensure that the therapeutic role of staff in psychiatric establishments does not come to be considered as secondary to security considerations.

Similarly, rules and practices capable of generating a climate of tension between staff and patients should be revised accordingly. The imposition of fines on staff in the event of an escape by a patient is precisely the kind of measure which can have a negative effect on the ethos within a psychiatric establishment.

### **C. Patients' living conditions and treatment**

32. The CPT closely examines patients' living conditions and treatment; inadequacies in these areas can rapidly lead to situations falling within the scope of the term "inhuman and degrading treatment". The aim should be to offer material conditions which are

conducive to the treatment and welfare of patients; in psychiatric terms, a positive therapeutic environment. This is of importance not only for patients but also for staff working in psychiatric establishments. Further, adequate treatment and care, both psychiatric and somatic, must be provided to patients; having regard to the principle of the equivalence of care, the medical treatment and nursing care received by persons who are placed involuntarily in a psychiatric establishment should be comparable to that enjoyed by voluntary psychiatric patients.

33. The quality of patients' living conditions and treatment inevitably depends to a considerable extent on available resources. The CPT recognises that in times of grave economic difficulties, sacrifices may have to be made, including in health establishments. However, in the light of the facts found during some visits, the Committee wishes to stress that the provision of certain basic necessities of life must always be guaranteed in institutions where the State has persons under its care and/or custody. These include adequate food, heating and clothing as well as - in health establishments - appropriate medication.

### **living conditions**

34. Creating a positive therapeutic environment involves, first of all, providing sufficient living space per patient as well as adequate lighting, heating and ventilation, maintaining the establishment in a satisfactory state of repair and meeting hospital hygiene requirements.

Particular attention should be given to the decoration of both patients' rooms and recreation areas, in order to give patients visual stimulation. The provision of bedside tables and wardrobes is highly desirable, and patients should be allowed to keep certain personal belongings (photographs, books, etc). The importance of providing patients with lockable space in which they can keep their belongings should also be underlined; the failure to provide such a facility can impinge upon a patient's sense of security and autonomy.

Sanitary facilities should allow patients some privacy. Further, the needs of elderly and/or handicapped patients in this respect should be given due consideration; for example, lavatories of a design which do not allow the user to sit are not suitable for such patients. Similarly, basic hospital equipment enabling staff to provide adequate care (including personal hygiene) to bedridden patients must be made available; the absence of such equipment can lead to wretched conditions.

It should also be noted that the practice observed in some psychiatric establishments of continuously dressing patients in pyjamas/nightgowns is not conducive to strengthening personal identity and self-esteem; individualisation of clothing should form part of the therapeutic process.

35. Patients' food is another aspect of their living conditions which is of particular concern to the CPT. Food must be not only adequate from the standpoints of quantity and quality, but also provided to patients under satisfactory conditions. The necessary equipment should exist enabling food to be served at the correct temperature. Further, eating arrangements should be decent; in this regard it should be stressed that enabling patients to accomplish acts of daily life - such as eating with proper utensils whilst seated

at a table - represents an integral part of programmes for the psycho-social rehabilitation of patients. Similarly, food presentation is a factor which should not be overlooked.

The particular needs of disabled persons in relation to catering arrangements should also be taken into account.

36. The CPT also wishes to make clear its support for the trend observed in several countries towards the closure of large-capacity dormitories in psychiatric establishments; such facilities are scarcely compatible with the norms of modern psychiatry. Provision of accommodation structures based on small groups is a crucial factor in preserving/restoring patients' dignity, and also a key element of any policy for the psychological and social rehabilitation of patients. Structures of this type also facilitate the allocation of patients to relevant categories for therapeutic purposes.

Similarly, the CPT favours the approach increasingly being adopted of allowing patients who so wish to have access to their room during the day, rather than being obliged to remain assembled together with other patients in communal areas.

### **treatment**

37. Psychiatric treatment should be based on an individualised approach, which implies the drawing up of a treatment plan for each patient. It should involve a wide range of rehabilitative and therapeutic activities, including access to occupational therapy, group therapy, individual psychotherapy, art, drama, music and sports. Patients should have regular access to suitably-equipped recreation rooms and have the possibility to take outdoor exercise on a daily basis; it is also desirable for them to be offered education and suitable work.

The CPT all too often finds that these fundamental components of effective psycho-social rehabilitative treatment are underdeveloped or even totally lacking, and that the treatment provided to patients consists essentially of pharmacotherapy. This situation can be the result of the absence of suitably qualified staff and appropriate facilities or of a lingering philosophy based on the custody of patients.

38. Of course, psychopharmacologic medication often forms a necessary part of the treatment given to patients with mental disorders. Procedures must be in place to ensure that medication prescribed is in fact provided, and that a regular supply of appropriate medicines is guaranteed. The CPT will also be on the look-out for any indications of the misuse of medication.

39. Electroconvulsive therapy (ECT) is a recognised form of treatment for psychiatric patients suffering from some particular disorders. However, care should be taken that ECT fits into the patient's treatment plan, and its administration must be accompanied by appropriate safeguards.

The CPT is particularly concerned when it encounters the administration of ECT in its unmodified form (i.e. without anaesthetic and muscle relaxants); this method can no longer be considered as acceptable in modern psychiatric practice. Apart from the risk of fractures and other untoward medical consequences, the process as such is degrading for both the patients and the staff concerned. Consequently, ECT should always be administered in a modified form.

ECT must be administered out of the view of other patients (preferably in a room which has been set aside and equipped for this purpose), by staff who have been specifically trained to provide this treatment. Further, recourse to ECT should be recorded in detail in a specific register. It is only in this way that any undesirable practices can be clearly identified by hospital management and discussed with staff.

40. Regular reviews of a patient's state of health and of any medication prescribed is another basic requirement. This will inter alia enable informed decisions to be taken as regards a possible dehospitalisation or transfer to a less restrictive environment.

A personal and confidential medical file should be opened for each patient. The file should contain diagnostic information (including the results of any special examinations which the patient has undergone) as well as an ongoing record of the patient's mental and somatic state of health and of his treatment. The patient should be able to consult his file, unless this is unadvisable from a therapeutic standpoint, and to request that the information it contains be made available to his family or lawyer. Further, in the event of a transfer, the file should be forwarded to the doctors in the receiving establishment; in the event of discharge, the file should be forwarded - with the patient's consent - to a treating doctor in the outside community.

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

Of course, consent to treatment can only be qualified as free and informed if it is based on full, accurate and comprehensible information about the patient's condition and the treatment proposed; to describe ECT as "sleep therapy" is an example of less than full and accurate information about the treatment concerned. Consequently, all patients should be provided systematically with relevant information about their condition and the treatment which it is proposed to prescribe for them. Relevant information (results, etc.) should also be provided following treatment.

#### **D. Staff**

42. Staff resources should be adequate in terms of numbers, categories of staff (psychiatrists, general practitioners, nurses, psychologists, occupational therapists, social workers, etc.), and experience and training. Deficiencies in staff resources will often seriously undermine attempts to offer activities of the kind described in paragraph 37; further, they can lead to high-risk situations for patients, notwithstanding the good intentions and genuine efforts of the staff in service.

43. In some countries, the CPT has been particularly struck by the small number of qualified psychiatric nurses among the nursing staff in psychiatric establishments, and by the shortage of personnel qualified to conduct social therapy activities (in particular, occupational therapists). The development of specialised psychiatric nursing training and a greater emphasis on social therapy would have a considerable impact upon the quality of

care. In particular, they would lead to the emergence of a therapeutic milieu less centred on drug-based and physical treatments.

44. A number of remarks concerning staff issues and, more particularly, auxiliary staff, have already been made in an earlier section (cf. paragraphs 28 to 31). However, the CPT also pays close attention to the attitude of doctors and nursing staff. In particular, the Committee will look for evidence of a genuine interest in establishing a therapeutic relationship with patients. It will also verify that patients who might be considered as burdensome or lacking rehabilitative potential are not being neglected.

45. As in other health-care services, it is important that the different categories of staff working in a psychiatric unit meet regularly and form a team under the authority of a senior doctor. This will allow day-to-day problems to be identified and discussed, and guidance to be given. The lack of such a possibility could well engender frustration and resentment among staff members.

46. External stimulation and support are also necessary to ensure that the staff of psychiatric establishments do not become too isolated. In this connection, it is highly desirable for such staff to be offered training possibilities outside their establishment as well as secondment opportunities. Similarly, the presence in psychiatric establishments of independent persons (e.g. students and researchers) and external bodies (cf paragraph 55) should be encouraged.

## **E. Means of restraint**

47. In any psychiatric establishment, the restraint of agitated and/or violent patients may on occasion be necessary. This is an area of particular concern to the CPT, given the potential for abuse and ill-treatment.

The restraint of patients should be the subject of a clearly-defined policy. That policy should make clear that initial attempts to restrain agitated or violent patients should, as far as possible, be non-physical (e.g. verbal instruction) and that where physical restraint is necessary, it should in principle be limited to manual control.

Staff in psychiatric establishments should receive training in both non-physical and manual control techniques vis-à-vis agitated or violent patients. The possession of such skills will enable staff to choose the most appropriate response when confronted by difficult situations, thereby significantly reducing the risk of injuries to patients and staff.

48. Resort to instruments of physical restraint (straps, straight jackets, etc.) shall only very rarely be justified and must always be either expressly ordered by a doctor or immediately brought to the attention of a doctor with a view to seeking his approval. If, exceptionally, recourse is had to instruments of physical restraint, they should be removed at the earliest opportunity; they should never be applied, or their application prolonged, as a punishment.

The CPT has on occasion encountered psychiatric patients to whom instruments of physical restraint have been applied for a period of days; the Committee must emphasise that such a state of affairs cannot have any therapeutic justification and amounts, in its view, to ill-treatment.

49. Reference should also be made in this context to the seclusion (i.e. confinement alone in a room) of violent or otherwise "unmanageable" patients, a procedure which has a long history in psychiatry.

There is a clear trend in modern psychiatric practice in favour of avoiding seclusion of patients, and the CPT is pleased to note that it is being phased out in many countries. For so long as seclusion remains in use, it should be the subject of a detailed policy spelling out, in particular: the types of cases in which it may be used; the objectives sought; its duration and the need for regular reviews; the existence of appropriate human contact; the need for staff to be especially attentive.

Seclusion should never be used as a punishment.

50. Every instance of the physical restraint of a patient (manual control, use of instruments of physical restraint, seclusion) should be recorded in a specific register established for this purpose (as well as in the patient's file). The entry should include the times at which the measure began and ended, the circumstances of the case, the reasons for resorting to the measure, the name of the doctor who ordered or approved it, and an account of any injuries sustained by patients or staff.

This will greatly facilitate both the management of such incidents and the oversight of the extent of their occurrence.

## **F. Safeguards in the context of involuntary placement**

51. On account of their vulnerability, the mentally ill and mentally handicapped warrant much attention in order to prevent any form of conduct - or avoid any omission - contrary to their well-being. It follows that involuntary placement in a psychiatric establishment should always be surrounded by appropriate safeguards. One of the most important of those safeguards - free and informed consent to treatment - has already been highlighted (cf. paragraph 41).

### **the initial placement decision**

52. The procedure by which involuntary placement is decided should offer guarantees of independence and impartiality as well as of objective medical expertise.

As regards, more particularly, involuntary placement of a civil nature, in many countries the decision regarding placement must be taken by a judicial authority (or confirmed by such an authority within a short time-limit), in the light of psychiatric opinions. However, the automatic involvement of a judicial authority in the initial decision on placement is not foreseen in all countries. Committee of Ministers Recommendation N° R (83) 2 on the legal protection of persons suffering from mental disorder placed as involuntary patients allows for both approaches (albeit setting out special safeguards in the event of the placement decision being entrusted to a non-judicial authority). The Parliamentary Assembly has nevertheless reopened the debate on this subject via its Recommendation 1235 (1994) on psychiatry and human rights, calling for decisions regarding involuntary placement to be taken by a judge.

In any event, a person who is involuntarily placed in a psychiatric establishment by a non-judicial authority must have the right to bring proceedings by which the lawfulness of his detention shall be decided speedily by a court.

### **safeguards during placement**

53. An introductory brochure setting out the establishment's routine and patients' rights should be issued to each patient on admission, as well as to their families. Any patients unable to understand this brochure should receive appropriate assistance.

Further, as in any place of deprivation of liberty, an effective complaints procedure is a basic safeguard against ill-treatment in psychiatric establishments. Specific arrangements should exist enabling patients to lodge formal complaints with a clearly-designated body, and to communicate on a confidential basis with an appropriate authority outside the establishment.

54. The maintenance of contact with the outside world is essential, not only for the prevention of ill-treatment but also from a therapeutic standpoint.

Patients should be able to send and receive correspondence, to have access to the telephone, and to receive visits from their family and friends. Confidential access to a lawyer should also be guaranteed.

55. The CPT also attaches considerable importance to psychiatric establishments being visited on a regular basis by an independent outside body (eg. a judge or supervisory committee) which is responsible for the inspection of patients' care. This body should be authorised, in particular, to talk privately with patients, receive directly any complaints which they might have and make any necessary recommendations.

### **discharge**

56. Involuntary placement in a psychiatric establishment should cease as soon as it is no longer required by the patient's mental state. Consequently, the need for such a placement should be reviewed at regular intervals.

When involuntary placement is for a specified period, renewable in the light of psychiatric evidence, such a review will flow from the very terms of the placement. However, involuntary placement might be for an unspecified period, especially in the case of persons who have been compulsorily admitted to a psychiatric establishment pursuant to criminal proceedings and who are considered to be dangerous. If the period of involuntary placement is unspecified, there should be an automatic review at regular intervals of the need to continue the placement.

In addition, the patient himself should be able to request at reasonable intervals that the necessity for placement be considered by a judicial authority.

57. Although no longer requiring involuntary placement, a patient may nevertheless still need treatment and/or a protected environment in the outside community. In this connection, the CPT has found, in a number of countries, that patients whose mental state no longer required them to be detained in a psychiatric establishment nevertheless remained in such establishments, due to a lack of adequate care/accommodation in the

outside community. For persons to remain deprived of their liberty as a result of the absence of appropriate external facilities is a highly questionable state of affairs.

## **G. Final remarks**

58. The organisational structure of health-care services for persons with psychiatric disorders varies from country to country, and is certainly a matter for each State to determine. Nevertheless, the CPT wishes to draw attention to the tendency in a number of countries to reduce the number of beds in large psychiatric establishments and to develop community-based mental health units. The Committee considers this is a very favourable development, on condition that such units provide a satisfactory quality of care.

It is now widely accepted that large psychiatric establishments pose a significant risk of institutionalisation for both patients and staff, the more so if they are situated in isolated locations. This can have a detrimental effect on patient treatment. Care programmes drawing on the full range of psychiatric treatment are much easier to implement in small units located close to the main urban centres.

## **APPENDIX 2 – “MI Principles”**

### **Principles for the Protection of Persons with Mental Illness**

Adopted by General Assembly resolution 46/119 of 17 December 1991

The General Assembly,

Mindful of the provisions of the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights and other relevant instruments, such as the Declaration on the Rights of Disabled Persons and the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment,

Recalling its resolution 33/53 of 14 December 1978, in which it requested the Commission on Human Rights to urge the Subcommittee on Prevention of Discrimination and Protection of Minorities to undertake, as a matter of priority, a study of the question of the protection of those detained on the grounds of mental ill-health, with a view to formulating guidelines,

Recalling also its resolution 45/92 of 14 December 1990, in which it welcomed the progress made by the working group of the Commission on Human Rights in elaborating a draft body of principles for the protection of persons with mental illness and for the improvement of mental health care on the basis of a draft submitted to the Commission by the Subcommittee on Prevention of Discrimination and Protection of Minorities,

Taking note of Commission on Human Rights resolution 1991/46 of 5 March 1991, in which the Commission endorsed the draft body of principles that had been submitted to it by the working group and decided to transmit it, as well as the report of the working group, to the General Assembly, through the Economic and Social Council,

Taking note also of Economic and Social Council resolution 1991/29 of 31 May 1991, in which the Council decided to submit the draft body of principles and the report of the working group to the General Assembly,

Taking note further of the recommendations of the Commission on Human Rights in its resolution 1991/46 and of the Economic and Social Council in its resolution 1991/29 that, on the adoption by the General Assembly of the draft body of principles, the full text thereof should be given the widest possible dissemination and that the introduction to the body of principles should at the same time be published as an accompanying document for the benefit of Governments and the public at large,

Taking note of the note by the Secretary-General, the annex to which contains the draft body of principles and the introduction to the body of principles,

1. Adopts the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care, the text of which is contained in the annex to the present resolution;
2. Requests the Secretary-General to include the text of the Principles, together with the introduction, in the next edition of the publication entitled "Human Rights: A Compilation of International Instruments";

3. Requests the Secretary-General to give the Principles the widest possible dissemination and to ensure that the introduction is published at the same time as an accompanying document for the benefit of Governments and the public at large.

## **ANNEX**

### **Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care**

#### ***Application***

The present Principles shall be applied without discrimination on any grounds, such as disability, race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, legal or social status, age, property or birth.

#### ***Definitions***

In the present Principles:

- (a) "Counsel" means a legal or other qualified representative;
- (b) "Independent authority" means a competent and independent authority prescribed by domestic law;
- (c) "Mental health care" includes analysis and diagnosis of a person's mental condition, and treatment, care and rehabilitation for a mental illness or suspected mental illness;
- (d) "Mental health facility" means any establishment, or any unit of an establishment, which as its primary function provides mental health care;
- (e) "Mental health practitioner" means a medical doctor, clinical psychologist, nurse, social worker or other appropriately trained and qualified person with specific skills relevant to mental health care;
- (f) "Patient" means a person receiving mental health care and includes all persons who are admitted to a mental health facility;
- (g) "Personal representative" means a person charged by law with the duty of representing a patient's interests in any specified respect or of exercising specified rights on the patient's behalf, and includes the parent or legal guardian of a minor unless otherwise provided by domestic law;
- (h) "The review body" means the body established in accordance with principle 17 to review the involuntary admission or retention of a patient in a mental health facility.

#### ***General limitation clause***

The exercise of the rights set forth in the present Principles may be subject only to such limitations as are prescribed by law and are necessary to protect the health or safety of

the person concerned or of others, or otherwise to protect public safety, order, health or morals or the fundamental rights and freedoms of others.

### ***Principle 1***

#### ***Fundamental freedoms and basic rights***

1. All persons have the right to the best available mental health care, which shall be part of the health and social care system.
2. All persons with a mental illness, or who are being treated as such persons, shall be treated with humanity and respect for the inherent dignity of the human person.
3. All persons with a mental illness, or who are being treated as such persons, have the right to protection from economic, sexual and other forms of exploitation, physical or other abuse and degrading treatment.
4. There shall be no discrimination on the grounds of mental illness. "Discrimination" means any distinction, exclusion or preference that has the effect of nullifying or impairing equal enjoyment of rights. Special measures solely to protect the rights, or secure the advancement, of persons with mental illness shall not be deemed to be discriminatory. Discrimination does not include any distinction, exclusion or preference undertaken in accordance with the provisions of the present Principles and necessary to protect the human rights of a person with a mental illness or of other individuals.
5. Every person with a mental illness shall have the right to exercise all civil, political, economic, social and cultural rights as recognized in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights and in other relevant instruments, such as the Declaration on the Rights of Disabled Persons and the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment.
6. Any decision that, by reason of his or her mental illness, a person lacks legal capacity, and any decision that, in consequence of such incapacity, a personal representative shall be appointed, shall be made only after a fair hearing by an independent and impartial tribunal established by domestic law. The person whose capacity is at issue shall be entitled to be represented by a counsel. If the person whose capacity is at issue does not himself or herself secure such representation, it shall be made available without payment by that person to the extent that he or she does not have sufficient means to pay for it. The counsel shall not in the same proceedings represent a mental health facility or its personnel and shall not also represent a member of the family of the person whose capacity is at issue unless the tribunal is satisfied that there is no conflict of interest. Decisions regarding capacity and the need for a personal representative shall be reviewed at reasonable intervals prescribed by domestic law. The person whose capacity is at issue, his or her personal representative, if any, and any other interested person shall have the right to appeal to a higher court against any such decision.

7. Where a court or other competent tribunal finds that a person with mental illness is unable to manage his or her own affairs, measures shall be taken, so far as is necessary and appropriate to that person's condition, to ensure the protection of his or her interests.

## ***Principle 2***

### ***Protection of minors***

Special care should be given within the purposes of the Principles and within the context of domestic law relating to the protection of minors to protect the rights of minors, including, if necessary, the appointment of a personal representative other than a family member.

## ***Principle 3***

### ***Life in the community***

Every person with a mental illness shall have the right to live and work, to the extent possible, in the community.

## ***Principle 4***

### ***Determination of mental illness***

1. A determination that a person has a mental illness shall be made in accordance with internationally accepted medical standards.
2. A determination of mental illness shall never be made on the basis of political, economic or social status, or membership in a cultural, racial or religious group, or for any other reason not directly relevant to mental health status.
3. Family or professional conflict, or non-conformity with moral, social, cultural or political values or religious beliefs prevailing in a person's community, shall never be a determining factor in the diagnosis of mental illness.
4. A background of past treatment or hospitalization as a patient shall not of itself justify any present or future determination of mental illness.
5. No person or authority shall classify a person as having, or otherwise indicate that a person has, a mental illness except for purposes directly relating to mental illness or the consequences of mental illness.

## ***Principle 5***

### ***Medical examination***

No person shall be compelled to undergo medical examination with a view to determining whether or not he or she has a mental illness except in accordance with a procedure authorized by domestic law.

## ***Principle 6***

### ***Confidentiality***

The right of confidentiality of information concerning all persons to whom the present Principles apply shall be respected.

### ***Principle 7***

#### ***Role of community and culture***

1. Every patient shall have the right to be treated and cared for, as far as possible, in the community in which he or she lives.
2. Where treatment takes place in a mental health facility, a patient shall have the right, whenever possible, to be treated near his or her home or the home of his or her relatives or friends and shall have the right to return to the community as soon as possible.
3. Every patient shall have the right to treatment suited to his or her cultural background.

### ***Principle 8***

#### ***Standards of care***

1. Every patient shall have the right to receive such health and social care as is appropriate to his or her health needs, and is entitled to care and treatment in accordance with the same standards as other ill persons.
2. Every patient shall be protected from harm, including unjustified medication, abuse by other patients, staff or others or other acts causing mental distress or physical discomfort.

### ***Principle 9***

#### ***Treatment***

1. Every patient shall have the right to 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.
2. The treatment and care of every patient shall be based on an individually prescribed plan, discussed with the patient, reviewed regularly, revised as necessary and provided by qualified professional staff.
3. Mental health care shall always be provided in accordance with applicable standards of ethics for mental health practitioners, including internationally accepted standards such as the Principles of Medical Ethics relevant to the role of health personnel, particularly physicians, in the protection of prisoners and detainees against torture and other cruel, inhuman or degrading treatment or punishment, adopted by the United Nations General Assembly. Mental health knowledge and skills shall never be abused.
4. The treatment of every patient shall be directed towards preserving and enhancing personal autonomy.

### ***Principle 10***

### **Medication**

1. Medication shall meet the best health needs of the patient, shall be given to a patient only for therapeutic or diagnostic purposes and shall never be administered as a punishment or for the convenience of others. Subject to the provisions of paragraph 15 of principle 11 below, mental health practitioners shall only administer medication of known or demonstrated efficacy.
2. All medication shall be prescribed by a mental health practitioner authorized by law and shall be recorded in the patient's records.

### **Principle 11**

#### **Consent to treatment**

1. No treatment shall be given to a patient without his or her informed consent, except as provided for in paragraphs 6, 7, 8, 13 and 15 of the present principle.
2. Informed consent is 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 on:
  - (a) The diagnostic assessment;
  - (b) The purpose, method, likely duration and expected benefit of the proposed treatment;
  - (c) Alternative modes of treatment, including those less intrusive;
  - (d) Possible pain or discomfort, risks and side-effects of the proposed treatment.
3. A patient may request the presence of a person or persons of the patient's choosing during the procedure for granting consent.
4. A patient has the right to refuse or stop treatment, except as provided for in paragraphs 6, 7, 8, 13 and 15 of the present principle. The consequences of refusing or stopping treatment must be explained to the patient.
5. A patient shall never be invited or induced to waive the right to informed consent. If the patient should seek to do so, it shall be explained to the patient that the treatment cannot be given without informed consent.
6. Except as provided in paragraphs 7, 8, 12, 13, 14 and 15 of the present principle, a proposed plan of treatment may be given to a patient without a patient's informed consent if the following conditions are satisfied:
  - (a) The patient is, at the relevant time, held as an involuntary patient;
  - (b) An independent authority, having in its possession all relevant information, including the information specified in paragraph 2 of the present principle, is satisfied that, at the relevant time, the patient lacks the capacity to give or withhold informed consent to

the proposed plan of treatment or, if domestic legislation so provides, that, having regard to the patient's own safety or the safety of others, the patient unreasonably withholds such consent;

(c) The independent authority is satisfied that the proposed plan of treatment is in the best interest of the patient's health needs.

7. Paragraph 6 above does not apply to a patient with a personal representative empowered by law to consent to treatment for the patient; but, except as provided in paragraphs 12, 13, 14 and 15 of the present principle, treatment may be given to such a patient without his or her informed consent if the personal representative, having been given the information described in paragraph 2 of the present principle, consents on the patient's behalf.
8. Except as provided in paragraphs 12, 13, 14 and 15 of the present principle, treatment may also be given to any patient without the patient's informed consent if a qualified mental health practitioner authorized by law determines that it is urgently necessary in order to prevent immediate or imminent harm to the patient or to other persons. Such treatment shall not be prolonged beyond the period that is strictly necessary for this purpose.
9. Where any treatment is authorized without the patient's informed consent, every effort shall nevertheless be made to inform the patient about the nature of the treatment and any possible alternatives and to involve the patient as far as practicable in the development of the treatment plan.
10. All treatment shall be immediately recorded in the patient's medical records, with an indication of whether involuntary or voluntary.
11. Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose. All instances of physical restraint or involuntary seclusion, the reasons for them and their nature and extent shall be recorded in the patient's medical record. A patient who is restrained or secluded shall be kept under humane conditions and be under the care and close and regular supervision of qualified members of the staff. A personal representative, if any and if relevant, shall be given prompt notice of any physical restraint or involuntary seclusion of the patient.
12. Sterilization shall never be carried out as a treatment for mental illness.
13. A major medical or surgical procedure may be carried out on a person with mental illness only where it is permitted by domestic law, where it is considered that it would best serve the health needs of the patient and where the patient gives informed consent, except that, where the patient is unable to give informed consent, the procedure shall be authorized only after independent review.
14. Psychosurgery and other intrusive and irreversible treatments for mental illness shall never be carried out on a patient who is an involuntary patient in a mental health facility and, to the extent that domestic law permits them to be carried out, they may be carried out on any other patient only where the patient has given

informed consent and an independent external body has satisfied itself that there is genuine informed consent and that the treatment best serves the health needs of the patient.

15. Clinical trials and experimental treatment shall never be carried out on any patient without informed consent, except that a patient who is unable to give informed consent may be admitted to a clinical trial or given experimental treatment, but only with the approval of a competent, independent review body specifically constituted for this purpose.
16. In the cases specified in paragraphs 6, 7, 8, 13, 14 and 15 of the present principle, the patient or his or her personal representative, or any interested person, shall have the right to appeal to a judicial or other independent authority concerning any treatment given to him or her.

### ***Principle 12***

#### ***Notice of rights***

1. A patient in a mental health facility shall be informed as soon as possible after admission, in a form and a language which the patient understands, of all his or her rights in accordance with the present Principles and under domestic law, and the information shall include an explanation of those rights and how to exercise them.
2. If and for so long as a patient is unable to understand such information, the rights of the patient shall be communicated to the personal representative, if any and if appropriate, and to the person or persons best able to represent the patient's interests and willing to do so.
3. A patient who has the necessary capacity has the right to nominate a person who should be informed on his or her behalf, as well as a person to represent his or her interests to the authorities of the facility.

### ***Principle 13***

#### ***Rights and conditions in mental health facilities***

1. Every patient in a mental health facility shall, in particular, have the right to full respect for his or her:
  - (a) Recognition everywhere as a person before the law;
  - (b) Privacy;
  - (c) Freedom of communication, which includes freedom to communicate with other persons in the facility; freedom to send and receive uncensored private communications; freedom to receive, in private, visits from a counsel or personal representative and, at all reasonable times, from other visitors; and freedom of access to postal and telephone services and to newspapers, radio and television;
  - (d) Freedom of religion or belief.

2. The environment and living conditions in mental health facilities shall be as close as possible to those of the normal life of persons of similar age and in particular shall include:
  - (a) Facilities for recreational and leisure activities;
  - (b) Facilities for education;
  - (c) Facilities to purchase or receive items for daily living, recreation and communication;
  - (d) Facilities, and encouragement to use such facilities, for a patient's engagement in active occupation suited to his or her social and cultural background, and for appropriate vocational rehabilitation measures to promote reintegration in the community. These measures should include vocational guidance, vocational training and placement services to enable patients to secure or retain employment in the community.
3. In no circumstances shall a patient be subject to forced labour. Within the limits compatible with the needs of the patient and with the requirements of institutional administration, a patient shall be able to choose the type of work he or she wishes to perform.
4. The labour of a patient in a mental health facility shall not be exploited. Every such patient shall have the right to receive the same remuneration for any work which he or she does as would, according to domestic law or custom, be paid for such work to a non-patient. Every such patient shall, in any event, have the right to receive a fair share of any remuneration which is paid to the mental health facility for his or her work.

#### ***Principle 14***

##### ***Resources for mental health facilities***

1. A mental health facility shall have access to the same level of resources as any other health establishment, and in particular:
  - (a) Qualified medical and other appropriate professional staff in sufficient numbers and with adequate space to provide each patient with privacy and a programme of appropriate and active therapy;
  - (b) Diagnostic and therapeutic equipment for the patient;
  - (c) Appropriate professional care;
  - (d) Adequate, regular and comprehensive treatment, including supplies of medication.
2. Every mental health facility shall be inspected by the competent authorities with sufficient frequency to ensure that the conditions, treatment and care of patients comply with the present Principles.

## ***Principle 15***

### ***Admission principles***

1. Where a person needs treatment in a mental health facility, every effort shall be made to avoid involuntary admission.
2. Access to a mental health facility shall be administered in the same way as access to any other facility for any other illness.
3. Every patient not admitted involuntarily shall have the right to leave the mental health facility at any time unless the criteria for his or her retention as an involuntary patient, as set forth in principle 16 below, apply, and he or she shall be informed of that right.

## ***Principle 16***

### ***Involuntary admission***

1. 1. A person may (a) be admitted involuntarily to a mental health facility as a patient; or (b) having already been admitted voluntarily as a patient, be retained as an involuntary patient in the mental health facility if, and only if, a qualified mental health practitioner authorized by law for that purpose determines, in accordance with principle 4 above, that that person has a mental illness and considers:
  - (a) That, because of that mental illness, there is a serious likelihood of immediate or imminent harm to that person or to other persons; or
  - (b) That, in the case of a person whose mental illness is severe and whose judgement is impaired, failure to admit or retain that person is likely to lead to a serious deterioration in his or her condition or will prevent the giving of appropriate treatment that can only be given by admission to a mental health facility in accordance with the principle of the least restrictive alternative.

In the case referred to in subparagraph (b), a second such mental health practitioner, independent of the first, should be consulted where possible. If such consultation takes place, the involuntary admission or retention may not take place unless the second mental health practitioner concurs.

2. Involuntary admission or retention shall initially be for a short period as specified by domestic law for observation and preliminary treatment pending review of the admission or retention by the review body. The grounds of the admission shall be communicated to the patient without delay and the fact of the admission and the grounds for it shall also be communicated promptly and in detail to the review body, to the patient's personal representative, if any, and, unless the patient objects, to the patient's family.
3. A mental health facility may receive involuntarily admitted patients only if the facility has been designated to do so by a competent authority prescribed by domestic law.

## ***Principle 17***

### ***Review body***

1. The review body shall be a judicial or other independent and impartial body established by domestic law and functioning in accordance with procedures laid down by domestic law. It shall, in formulating its decisions, have the assistance of one or more qualified and independent mental health practitioners and take their advice into account.
2. The initial review of the review body, as required by paragraph 2 of principle 16 above, of a decision to admit or retain a person as an involuntary patient shall take place as soon as possible after that decision and shall be conducted in accordance with simple and expeditious procedures as specified by domestic law.
3. The review body shall periodically review the cases of involuntary patients at reasonable intervals as specified by domestic law.
4. An involuntary patient may apply to the review body for release or voluntary status, at reasonable intervals as specified by domestic law.
5. At each review, the review body shall consider whether the criteria for involuntary admission set out in paragraph 1 of principle 16 above are still satisfied, and, if not, the patient shall be discharged as an involuntary patient.
6. If at any time the mental health practitioner responsible for the case is satisfied that the conditions for the retention of a person as an involuntary patient are no longer satisfied, he or she shall order the discharge of that person as such a patient.
7. A patient or his personal representative or any interested person shall have the right to appeal to a higher court against a decision that the patient be admitted to, or be retained in, a mental health facility.

## ***Principle 18***

### ***Procedural safeguards***

1. The patient shall be entitled to choose and appoint a counsel to represent the patient as such, including representation in any complaint procedure or appeal. If the patient does not secure such services, a counsel shall be made available without payment by the patient to the extent that the patient lacks sufficient means to pay.
2. The patient shall also be entitled to the assistance, if necessary, of the services of an interpreter. Where such services are necessary and the patient does not secure them, they shall be made available without payment by the patient to the extent that the patient lacks sufficient means to pay.
3. The patient and the patient's counsel may request and produce at any hearing an independent mental health report and any other reports and oral, written and other evidence that are relevant and admissible.

4. Copies of the patient's records and any reports and documents to be submitted shall be given to the patient and to the patient's counsel, except in special cases where it is determined that a specific disclosure to the patient would cause serious harm to the patient's health or put at risk the safety of others. As domestic law may provide, any document not given to the patient should, when this can be done in confidence, be given to the patient's personal representative and counsel. When any part of a document is withheld from a patient, the patient or the patient's counsel, if any, shall receive notice of the withholding and the reasons for it and it shall be subject to judicial review.
5. The patient and the patient's personal representative and counsel shall be entitled to attend, participate and be heard personally in any hearing.
6. If the patient or the patient's personal representative or counsel requests that a particular person be present at a hearing, that person shall be admitted unless it is determined that the person's presence could cause serious harm to the patient's health or put at risk the safety of others.
7. Any decision on whether the hearing or any part of it shall be in public or in private and may be publicly reported shall give full consideration to the patient's own wishes, to the need to respect the privacy of the patient and of other persons and to the need to prevent serious harm to the patient's health or to avoid putting at risk the safety of others.
8. The decision arising out of the hearing and the reasons for it shall be expressed in writing. Copies shall be given to the patient and his or her personal representative and counsel. In deciding whether the decision shall be published in whole or in part, full consideration shall be given to the patient's own wishes, to the need to respect his or her privacy and that of other persons, to the public interest in the open administration of justice and to the need to prevent serious harm to the patient's health or to avoid putting at risk the safety of others.

## ***Principle 19***

### ***Access to information***

1. A patient (which term in the present Principle includes a former patient) shall be entitled to have access to the information concerning the patient in his or her health and personal records maintained by a mental health facility. This right may be subject to restrictions in order to prevent serious harm to the patient's health and avoid putting at risk the safety of others. As domestic law may provide, any such information not given to the patient should, when this can be done in confidence, be given to the patient's personal representative and counsel. When any of the information is withheld from a patient, the patient or the patient's counsel, if any, shall receive notice of the withholding and the reasons for it and it shall be subject to judicial review.
2. Any written comments by the patient or the patient's personal representative or counsel shall, on request, be inserted in the patient's file.

## ***Principle 20***

### ***Criminal offenders***

1. The present Principle applies to persons serving sentences of imprisonment for criminal offences, or who are otherwise detained in the course of criminal proceedings or investigations against them, and who are determined to have a mental illness or who it is believed may have such an illness.
2. All such persons should receive the best available mental health care as provided in principle 1 above. The present Principles shall apply to them to the fullest extent possible, with only such limited modifications and exceptions as are necessary in the circumstances. No such modifications and exceptions shall prejudice the persons' rights under the instruments noted in paragraph 5 of principle 1 above.
3. Domestic law may authorize a court or other competent authority, acting on the basis of competent and independent medical advice, to order that such persons be admitted to a mental health facility.
4. Treatment of persons determined to have a mental illness shall in all circumstances be consistent with principle 11 above.

### ***Principle 21***

#### ***Complaints***

Every patient and former patient shall have the right to make a complaint through procedures as specified by domestic law.

### ***Principle 22***

#### ***Monitoring and remedies***

States shall ensure that appropriate mechanisms are in force to promote compliance with the present Principles, for the inspection of mental health facilities, for the submission, investigation and resolution of complaints and for the institution of appropriate disciplinary or judicial proceedings for professional misconduct or violation of the rights of a patient.

### ***Principle 23***

#### ***Implementation***

1. States should implement the present Principles through appropriate legislative, judicial, administrative, educational and other measures, which they shall review periodically.
2. States shall make the present Principles widely known by appropriate and active means.

### ***Principle 24***

#### ***Scope of principles relating to mental health facilities***

The present Principles apply to all persons who are admitted to a mental health facility.

### ***Principle 25***

***Saving of existing rights***

There shall be no restriction upon or derogation from any existing rights of patients, including rights recognized in applicable international or domestic law, on the pretext that the present Principles do not recognize such rights or that they recognize them to a lesser extent.