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Involuntary placement and involuntary treatment of persons with mental health problems

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EUROPEAN UNION AGENCY FOR FUNDAMENTAL RIGHTS

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Involuntary placement and involuntary treatment of persons with mental health problems

Foreword

The entry into force of the United Nations (UN) Convention on the Rights of Persons with Disabilities (CRPD) in May 2008 represented a milestone in the development of human rights law. The first human rights treaty of the 21st century provides persons with disabilities with a wide range of fundamental rights guarantees covering all aspects of their lives. Although intended to reiterate existing rights enshrined in previous universal treaties rather than to create new rights, the principles of non-discrimination, autonomy and inclusion embedded in the convention ensure that it marks a paradigm shift in the concept of disability under international law.

The CRPD's combination of human rights and overarching non-discrimination guarantees serves one essential purpose: to ensure the equal treatment of persons with disabilities. This clear yet comprehensive goal helps to explain the overwhelming adherence of European Union (EU) Member States to the CRPD. All EU Member States have signed the convention and 20 have already ratified it, with more to come in the near future. Moreover, the European Union itself, by ratifying the convention in December 2010, is empowered to combat discrimination and protect the rights of persons with disabilities more effectively.

The legal framework is therefore in place. However, given its novelty, the CRPD needs to find its place in the legal systems of the European Union and its Member States. This report highlights this process.

Processes of involuntary placement and involuntary treatment of persons with mental health problems can affect the most fundamental rights, including the right to integrity of the person and the right to liberty. For this reason human rights standards, whether at United Nations or European level, have set out strict safeguards to limit undue interference in these rights. The CRPD strongly confirms these safeguards while calling for persons with mental health problems to be treated on an equal basis with others.

The report examines the current international and European legal standards and offers a comparative legal analysis of the EU Member States' legal frameworks. The legal analysis is supported by evidence from the results of fieldwork research conducted by the European Union Agency for Fundamental Rights in nine EU Member States, which shows how individuals interviewed actually experienced processes of involuntary treatment and involuntary placement. The report's findings point to the need for a renewed discussion of compulsory placement and treatment in the European Union.

Morten Kjaerum
Director

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Executive summary

International and national laws and policies set out a range of norms and safeguards concerning the involuntary placement and treatment of persons with disabilities. The approach to these issues is currently evolving following the entry into force of the United Nations (UN) Convention on the Rights of Persons with Disabilities (CRPD). The paradigm shift to a rights-based approach to disability encapsulated by the CRPD poses potential challenges for the existing legal frameworks governing involuntary placement and involuntary treatment. This has significant implications for the European Union (EU) and its Member States.

This report presents the European Union Agency for Fundamental Rights' (FRA) legal analysis of international and national standards and recounts the experiences of a small number of persons with mental health problems relating to involuntary placement and involuntary treatment. The research aims both to provide an overview of the current legal situation in an area of law marked by recent reforms and to give an insight into how individuals actually experience processes of involuntary placement and involuntary treatment.

The findings of FRA's legal research show that human rights law allows persons with mental health problems to be deprived of their liberty in certain circumstances, providing a number of safeguards are upheld. Specifically, the process of involuntary placement and involuntary treatment must follow established procedural safeguards, and a court or another independent body must review its lawfulness. The report analyses UN and Council of Europe standards in this area. It provides in particular a detailed analysis of the key guarantees offered by the CRPD.

At EU Member State level, this research illustrates that the laws regulating involuntary placement and involuntary treatment are very diverse. Nevertheless, the findings show a number of common features, which reflect existing human rights standards. All Member States specify minimum criteria that must be fulfilled for involuntary placement or involuntary treatment to be lawful. In addition, national legal frameworks give persons who have been involuntarily placed the right to appeal against the decision and to have their placement reviewed by a court.

Evidence from sociological fieldwork research with persons with mental health problems points to overwhelmingly negative experiences of involuntary placement or involuntary treatment. While the circumstances surrounding compulsory measures vary considerably, the trauma and fear, which persons with mental health problems associate with involuntary placement or involuntary treatment, emerge as recurrent themes of the research. Despite their largely negative experiences, only a few participants have attempted to challenge the lawfulness of their involuntary placement or involuntary treatment, a reluctance which often reflects individuals' lack of knowledge of their rights when being forcibly detained.

In contrast, participants evaluated experiences in a more positive light when admissions were voluntary and conducted in a way that granted them individual choice and control over the treatment. While not representative of the current situation either in the EU Member States themselves or across the EU as a whole, the findings shed light on how individuals experience laws on involuntary placement and involuntary treatment.

Introduction

"On almost every account people with mental health problems are among the most excluded groups in society and they consistently identify stigmatisation, discrimination and exclusion as major barriers to health, welfare and quality of life."

European Commission (2010a), The European Platform against Poverty and Social Exclusion: A European framework for social and territorial cohesion

The UN Convention on the Rights of Persons with Disabilities (CRPD) was adopted in December 2006 and entered into force in May 2008. The convention reaffirms a number of substantive rights for persons with disabilities, including persons with mental health problems. It represents an important paradigm shift recognising that persons with disabilities should not be seen merely as recipients of charity or medical attention, but as holders of rights[1] who have "inherent human dignity worthy of protection equal to that of other human beings".[2] Consequently, State Parties need to take measures ensuring that the needs of persons with disabilities are appropriately accommodated by society.[3]

CRPD

Article 1 (1) – Purpose

The purpose of the present Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.

Following the adoption of the CRPD, existing approaches and legislation regarding persons with mental health problems need to be re-examined in the light of its focus on non-discrimination and equal treatment. Ratified by 20 EU Member States and ratified by the European Union in December 2010, the CRPD has a bearing on the way EU Member States organise healthcare for persons with mental health problems. In this regard, recent national reforms have already taken the CRPD guarantees into consideration. Furthermore, the European Court of Human Rights (ECtHR) regularly cites the CRPD in its case law. The convention will thus serve as a reference point for future standard-setting in the Council of Europe and the European Union.[4]

The development of EU policy also reflects the re-conceptualisation of mental health problems. In June 2011, the Council of the European Union reviewed the implementation of the European Pact for Mental Health and Well-being,[5] launched in 2008, and invited EU Member States, among other matters, to "[m]ake mental health and well-being a priority of their health policies and to develop strategies and/or action plans on mental health including depression and suicide prevention; [...][p]romote, where possible and relevant, community-based, socially inclusive treatment and care models; [...] [t]ake measures against the stigmatisation and exclusion of and discrimination against people with mental health problems."[6]

These EU policy developments followed a series of initiatives taken in previous years in a wider European context. In 2004, the Council of Europe Committee of Ministers adopted a crucial Recommendation on the rights of persons with mental disorder; and in January 2005, the Health Ministers of the World Health Organization (WHO) European Region agreed on a wide-ranging Declaration and Action Plan on mental health for the region.[7] Meanwhile, the case law of the European Court of Human Rights documented across Europe specific violations of the human rights of persons with disabilities and, in particular, of persons with mental health problems.

Amid this broader reassessment of the rights of persons with mental health problems, two issues of core concern are the processes of involuntary placement and involuntary treatment. These are linked to two central fundamental rights: dignity and equality.[8]

There is no internationally accepted definition of involuntary placement or involuntary treatment. This report applies the standards set out in the Council of Europe's Recommendation Rec(2004)10[9] (hereafter Rec(2004)10). Article 16 of the Rec(2004)10 characterises involuntary placement and involuntary treatment as

1 For more on the paradigm shift in the concept of disability, see FRA (2011a).
2 Theresia Degener, cited in Kämpf, A. (2010), p. 133.
3 United Nations (UN), High Commissioner for Human Rights (2009).

4 European Commission (2010b).
5 European Commission (2009).
6 Council of the European Union (2011).
7 WHO (2005a), WHO (2005b).
8 Hartlev, M. (2009).
9 Council of Europe, Committee of Ministers, Recommendation Rec(2004)10 of the Committee of Ministers to member states concerning the protection of the human rights and dignity of persons with mental disorder, adopted on 22 September 2004.

those "measures [...] that are against the current will of the person concerned."[10]

Council of Europe Recommendation Rec(2004)10

Article 16 – Scope of chapter III

The provisions of this chapter apply to persons with mental disorder:

i. who have the capacity to consent and are refusing the placement or treatment concerned; or

ii. who do not have the capacity to consent and are objecting to the placement or treatment concerned.

The involuntary placement and involuntary treatment of persons with disabilities are sensitive, complex and topical issues. Sensitive because they may involve human rights violations, which remain largely unrevealed for long periods; complex because traditionally – reflecting the 'medical model' of disability – the need for treatment was considered to precede human rights considerations;[11] and topical because reforms are on-going in EU Member States and at the Council of Europe.

"Stigmatisation, discrimination and non-respect for the human rights and the dignity of mentally ill and disabled people still exist, challenging core European values."

European Commission (2005), Green paper Improving the mental health of the population: Towards a strategy on mental health for the European Union

A European Commission Green Paper on mental health from 2005 already acknowledged that compulsory placement and treatment "affect severely" "patients'" rights and "should only be applied as a last resort, where less restrictive alternatives have failed".[12] Accordingly, many EU Member States have recently reformed or are in the process of reforming their legal frameworks in this area. In 2013, the Council of Europe will start working on the first binding instrument in this area: an additional protocol to the Convention on Human Rights and Biomedicine (Oviedo Convention).[13]

10 Council of Europe, Committee of Ministers (2004a).
11 Research has shown that this shift in approach is still under research. For more information, see Kallert, T. W. (2011), p. 130.
12 European Commission (2005), p. 11.
13 Council of Europe (1997), see Council of Europe, Programme and Budget 2012–2013, p. 58.

Project background and scope of the report

The European Union Agency for Fundamental Rights (FRA) focused its attention on the fundamental rights of persons with disabilities immediately after its creation in 2007.[14] The FRA decided to start its work collecting evidence on the fundamental rights situation of two groups that have received scant research attention, namely persons with intellectual disabilities and persons with mental health problems.

The FRA carried out comparative legal research and analysis across the EU, examining the legal frameworks currently in place. In addition, it launched qualitative fieldwork research in nine EU Member States that reflect a mix of disability policies (Bulgaria, France, Germany, Greece, Hungary, Latvia, Romania, Sweden and the United Kingdom). The fieldwork research engaged directly with persons with intellectual disabilities and persons with mental health problems as well as those working with them. This allows for better understanding of how persons with mental health problems and persons with intellectual disabilities experience the fulfilment of their rights 'on the ground'.

The FRA report *The right to political participation of persons with mental health problems and persons with intellectual disabilities,* published in 2010, contains the first part of the legal analysis. This was followed in 2011 by a second report on *The legal protection of persons with mental health problems under non-discrimination law*.

The present report brings together the key findings of the legal and the fieldwork research on the issues of involuntary placement and involuntary treatment. The legal analysis is based on information provided by the FRA network of legal experts, FRALEX. Evidence presenting the actual experiences of persons with mental health problems concerning involuntary placement and involuntary treatment is based on 115 individual, semi-structured interviews with persons with mental health problems, and focus group interviews with relevant stakeholders in the nine EU Member States where fieldwork was conducted. This primary research complements and deepens the legal analysis by showing how individuals experience the consequences of these legal processes in practice.

Involuntary placement and involuntary treatment assume many forms in EU Member States legislation. This report focuses on civil law measures. Specific rules that apply in criminal or juvenile context are thus excluded from the scope of this research. Likewise, while

14 Council Regulation (EC) No. 168/2007 of 15 February 2007.

a direct link often exists between involuntary placement or involuntary treatment and the lack of legal capacity (see Article 16 Rec(2004)10), an analysis of this situation is beyond the scope of such a short report.[15]

The legal analysis does not assess the practical implementation of the relevant legislation, nor the extent to which the CRPD requires reforms at EU Member State level. Instead, it describes the way national parliaments take into account CRPD requirements and provide fundamental rights guarantees to persons with mental health problems. The report offers EU institutions and EU Member States comparable information on the current situation.

Further contextual information was provided by thematic reports on the situation of persons with intellectual disabilities and persons with mental health problems in each Member State.[16] Additional information was gathered through exchanges with key partners, including several delegations of the European Commission Disability High Level Group, the Health Determinants Unit at the European Commission Directorate-General for Health and Consumers, Council of Europe Committee for the Prevention of Torture Secretariat, Mental Health Europe and individual experts, including Prof. Peter Bartlett, Nottinghamshire Healthcare NHS Trust Professor of Mental Health Law, University of Nottingham; Dr. Zdenka Čebašek-Travnik, Human Rights Ombudsman of the Republic of Slovenia; Prof. Hans Joachim Salize, Mental Health Services Research Group, Central Institute of Mental Health, Mannheim; and Marianne Schulze. The FRA expresses its gratitude for these valuable contributions. The opinions and conclusions in this report do not necessarily represent the views of the organisations or the individual experts who helped develop the report.

Terminology

> **CRPD**
>
> Article 1 (2)
>
> Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

The preamble to the CRPD acknowledges that disability is an "evolving" concept and as such there are no commonly agreed terms to describe different groups of individuals with particular impairments. During the period this research was carried out, international bodies altered the terms they use. For example, the Council of Europe Commissioner for Human Rights in his 2009[17] and 2010[18] viewpoints used the collective term "persons with mental disabilities" to refer to "persons with mental health or intellectual disabilities". Later, in his 2012 *Human Rights Comment*, he referred to "persons with intellectual and psycho-social disabilities".[19] The European Commission's 'Pact for Mental Health and Well-Being' refers to "people with mental health problems",[20] while the European Commission's 'Disability Strategy 2010 – 2020' applies the CRPD term of "psycho-social disabilities".[21] Finally, the World Health Organization's *World Report on disability*[22] speaks of "people with mental health conditions". Despite the differences of terminology, all the organisations mentioned acknowledge that disability is a human rights issue and its consequences the result of an individual's interaction with society.[23]

In the absence of a common terminology the FRA decided after consultation with disabled persons' organisations (DPOs) to use the terms 'persons with intellectual disabilities' and 'persons with mental health problems' in its current research. The term 'persons with intellectual disabilities' is used by Inclusion Europe, an association of people with intellectual disabilities and their families in Europe,[24] and the European Platform of Self-Advocates,[25] a network of persons with intellectual disabilities; however, elsewhere the preferred term is "persons with learning disabilities"[26]. The term 'persons with mental health problems' was regarded as the most accessible to a multi-language readership, although the term 'psycho-social disability' is favoured by the World Network of Users and Survivors of Psychiatry,[27] the International Disability Alliance,[28] a world-wide disability non-governmental organisation (NGO) and the UN Committee on the Rights of Persons

15 Issues of legal capacity are addressed in FRA (2012) and in a further forthcoming FRA legal comparative report on legal capacity.
16 For additional information regarding the social research methodology, see: FRA (2012).

17 Council of Europe, Commissioner's Human Rights Comment (2009).
18 Council of Europe, Commissioner's Human Rights Comment (2010).
19 Council of Europe, Commissioner's Human Rights Comment (2012).
20 European Commission (2009).
21 European Commission (2010b).
22 WHO (2011).
23 *Ibid.*; Council of Europe, Committee of Ministers (2006); European Commission (2010b), European Commission (2009).
24 For more information, see: www.inclusion-europe.org/en/about-us.
25 For more information, see: www.inclusion-europe.org/en/self-advocacy.
26 For more information on the use of the term learning disability, see: www.nhs.uk/Livewell/Childrenwithalearningdisability/Pages/Whatislearningdisability.aspx.
27 For more information, see: www.wnusp.net/.
28 For more information, see: www.internationaldisabilityalliance.org/en.

with Disabilities.[29] That term, however, is not used by the European Network of (ex-) Users and Survivors of Psychiatry (ENUSP)[30] because of on-going debates about the relationship between conceptions of mental health and disability and the reluctance of many people with psychiatric diagnoses to identify themselves as disabled.

Intellectual disability and mental health problems are separate and distinct phenomena. They have generated different political movements, are associated with different types of experience and response, and often have quite different concerns. There is nevertheless some overlap and intersection between them. People with intellectual disabilities, like the rest of the population, may also have mental health problems.

In this report, in order to avoid repetition, reference is made to 'persons with disabilities' in the spirit of the CRPD; this is not intended in any way to undervalue the important differences between persons with intellectual disabilities and persons with mental health problems. The report also refers to 'groups of persons', although it is fully recognised that individual experiences vary greatly.

Issues related to involuntary placement and involuntary treatment affect both persons with mental health problems and persons with intellectual disabilities. The most developed standards, however, deal predominately with persons with mental health problems. This is the case of the Council of Europe Recommendation Rec(2004)10.

The report is divided into three chapters. It first presents a brief overview of international and European standards and safeguards for the protection of persons with mental health problems, providing the international legal context of involuntary placement and involuntary treatment. The second chapter describes EU Member States' national legislation. It looks at questions raised and examined in the report *Compulsory Admission and Involuntary Treatment of Mentally Ill Patients – Legislation and Practice in the EU-Member States*, co-financed by the European Commission and published in May 2002 (the 2002 report).[31] This report partially updates and complements data presented in the 2002 report. The third chapter presents evidence of the lived experience of persons with mental health problems related to involuntary placement, involuntary treatment, and seclusion and restraint.

29 United Nations Committee on the Rights of Persons with Disabilities (2011), para. 8.

30 For more information, see: www.enusp.org.

31 Salize, H. J. *et al.* (2002).

1

International and European standards

A discussion on involuntary placement and involuntary treatment of persons with disabilities is necessarily linked to several fundamental rights. The most relevant are the right to liberty, in particular in relation to involuntary placement, and the prohibition of torture and other forms of ill treatment along with the protection of the right to privacy in relation to involuntary treatment. This report does not present an exhaustive analysis of these fundamental rights, but rather underlines key principles linked to them. This serves to provide the international legal context of involuntary placement and involuntary treatment, and to present the framework in which national legislation rests.

At EU level, these rights are all guaranteed by the Charter of Fundamental Rights of the European Union. Article 3 (right to integrity of the person), Article 4 (prohibition of torture and inhuman or degrading treatment or punishment), Article 6 (right to liberty and security), Article 7 (respect for private and family life), Article 21 (non-discrimination), Article 26 (integration of persons with disabilities) and Article 35 (healthcare) are among the most relevant rights and principles set forth in the Charter. The Charter applies, however, only in the area of Union law and when EU Members States implement Union Law (Article 51 (1)).

Whereas the EU has a complementary competence to improve public health, prevent physical and mental illness and diseases, and remove sources of danger to physical and mental health, EU law does not deal with specific questions related to the involuntary placement and involuntary treatment of persons with disabilities. The latter issues can, however, raise questions of discrimination. In this sense, if secondary EU legislation were to protect individuals from discrimination on the grounds of disability as extensively as it protects from discrimination on the grounds of racial or ethnic origin, the Charter of Fundamental Rights and especially its Article 21 might affect how such involuntary placement and involuntary treatment measures are implemented at national level.

Moreover, EU institutions, in particular the European Commission, play an important coordinating role in the area of public health. They prepare strategies and policies some of which contain standards related to the right to liberty with regard to involuntary placement and involuntary treatment. The European Commission's Green Paper, a policy document, is a good example in this regard.[32] Furthermore, where the EU is complementing national policies or providing financial stimuli, the prohibition to discriminate on the basis of disability is taken into account.

The European Parliament resolution on improving the mental health of the population provides useful guidance on the rights of persons with mental health problems deprived of their liberty. It states that all forms of in-patient care and compulsory medication should "be regularly reviewed and subject to the patient's consent or, in the absence of such consent, to authorisation by the appropriate authorities used only as a last resort".[33] The resolution also states that "the use of force is counterproductive, as is compulsory medication" and that "all forms of in-patient care and compulsory medication should be of limited duration".[34] Therefore, "any restriction of personal freedoms should be avoided, with particular reference to physical containment".[35] In 2009, the European Parliament repeated these views

32 European Commission (2005), p. 11.

33 European Parliament (2006), para. 33. See also European Parliament (1996) which calls "on Member States to ban inhuman and degrading treatment of disabled people and to ensure that disabled people are never institutionalised because of their disabilities against their will and to ascertain that disabled people who choose to live in institutions enjoy full standards of human rights".

34 *Ibid.*

35 *Ibid.*, para. 34.

when it considered that "de-stigmatising mental illness involves abandoning the use of invasive and inhumane practices as well as those practices based on the custodial approach."[36]

In an area of limited EU competence, fundamental rights standards are prescribed at the international level both by the UN[37] and the Council of Europe. The next sections will therefore describe the standards related first to involuntary placement and, second, to involuntary treatment. While involuntary placement and involuntary treatment will be presented separately to facilitate analysis, several guarantees, such as procedural rights developed at international level, apply to both involuntary placement and involuntary treatment. The UN and Council of Europe standards constitute a benchmark for the comparative analysis of EU Member State law that follows in Chapter 2.

1.1. Involuntary placement

Involuntary placement, which is also referred to as compulsory or coercive placement, is a concept integrated into and regulated by international human rights law treaties and jurisprudential interpretation. Non-binding documents have provided additional guarantees both at the UN and Council of Europe levels. The paradigm shift embodied by the CRPD sheds light on these standards which might pose some challenges to the States Parties.

The following discussion introduces the development and the understanding of the CRPD guarantees, and places them in the context of regional human rights law.

1.1.1. Right to liberty: United Nations standards

The right to liberty is one of the oldest human rights norms, and has been repeatedly enshrined in UN treaties. It is particularly relevant in the context of involuntary placement, since deprivation of liberty occurs when an individual is placed in an institution against his or her will and cannot leave it at his or her own leisure.

The 2006 adoption of the CRPD brought human rights guarantees with respect to disabilities into a new age. A new mind set informs the convention: persons with disabilities are holders of rights, not recipients of charity. In order to understand the importance of the changes with respect to involuntary placement, it is useful to chart briefly the evolution of the right to liberty, before examining the approach the CRPD takes. Older instruments need to be interpreted in light of the CRPD.[38] Furthermore, the UN Special Rapporteur on Torture published a report on disability and torture in 2008 in which it was made clear that the CRPD invalidates earlier norms, in particular the General Assembly's 1991 Resolution on the Principles for the protection of persons with mental illness and the improvement of mental healthcare (MI Principles), which allow for involuntary placement and treatment in certain cases.[39]

The earliest and most prominent document to guarantee the right to liberty, aside from the non-binding Universal Declaration of Human Rights, is the International Covenant on Civil and Political Rights (ICCPR). Article 9 (1) of the ICCPR says "Everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law". The Human Rights Committee acknowledged that Article 9 ICCPR applies to deprivation of liberty of persons with mental health problems. Where deprivation of liberty is sanctioned by law, the conditions stated in Article 9 (4) of the ICCPR apply. Article 9 (4) stipulates that "anyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings before a court, in order that that court may decide without delay on the lawfulness of his detention and order his release if the detention is not lawful". Furthermore, in accordance with Article 2 (3) of the ICCPR, States Parties must ensure that an effective remedy is provided to persons deprived of their liberty.[40]

The Human Rights Committee addressed the question of Article 9 in the context of mental health problems in the case of *A. v. New Zealand*.[41] The case concerns the detention of *A.* for nine years on the grounds that he was paranoid and a danger to himself and others. The Human Rights Committee took note that: a careful and lengthy psychiatric examination was carried out by three specialists; *A.* had the opportunity to challenge his placement before several courts; and detention was in compliance with national legislation. In the committee's view, therefore, "the deprivation of [*A's*] liberty was neither unlawful nor arbitrary and thus not in violation of Article 9, paragraph 1, of the Covenant". In addition, *A's* detention was regularly reviewed, which meant no violation of Article 9 (4) could be established on that grounds either. Nevertheless, the committee's jurisprudence specifically relating to persons with mental health problems is relatively underdeveloped.

Non-binding UN standards complement existing case law. Although, they need to be re-assessed in light of

36 European Parliament (2009), para. 47.
37 United Nations (UN), Office of High Commissioner for Human Rights (OHCHR) Regional Office Europe (2011a).
38 OHCHR, Regional Office for Europe (2011), p. 8.
39 UN, Special Rapporteur on Torture (2008), para. 44.
40 UN, Human Rights Committee (1982).
41 UN, Human Rights Committee, *A. v. New Zealand*, Communication No. 754/1997 of 3 August 1999.

the CRPD, a short mention is useful. The MI principles[42] provide detailed standards relating to the review of the deprivation of liberty of persons with mental health problems. Although they are non-binding, it is useful to refer to them to understand the legal developments at the UN level. Principle 16 (2) states that "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."[43] Principle 17 (1) stipulates that "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"; the MI principles further provide that the body "shall periodically review the cases of involuntary patients at reasonable intervals as specified by domestic law".[44] The procedural safeguards outlined in Principle 18 also provide that if a patient does not secure the services of a counsel to represent him or her, "a counsel shall be made available without payment by the patient to the extent that the patient lacks sufficient means to pay".

CRPD

Article 14 – Liberty and security of the person

1. States Parties shall ensure that persons with disabilities, on an equal basis with others:

(a) Enjoy the right to liberty and security of person;

(b) Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty. [...]

The CRPD itself does not refer explicitly to involuntary placement. Article 14 (1) of the convention reiterates the formulation of the right to liberty and security of the person and clearly states that the deprivation of liberty based on the existence of a disability would be contrary to the CRPD and in itself discriminatory.

This was also the conclusion of the Chair of the Ad Hoc Committee drafting the CRPD. The chair closed the discussions on Article 14 saying: "This is essentially a non-discrimination provision. The debate has focused on the treatment of PWD (persons with disabilities) on the same basis as others. PWD who represent a legitimate threat to someone else should be treated as any other person would be."[45]

The CRPD committee confirms this view by asking states in its reporting guidelines for Article 14 of the CRPD what measures they are taking "to ensure that all persons with all forms of disabilities enjoy the right to liberty and security of person and that no person is deprived of her/his liberty on the basis of her/his disability."[46] It also inquires as to what actions states are taking "to abolish any legislation that permits the institutionalization or the deprivation of liberty of all persons with all forms of disabilities".[47]

Moreover, in its concluding observations in relation to Tunisia, the CRPD committee said that "[w]ith reference to article 14 of the Convention, the Committee is concerned at the fact that having a disability, including an intellectual, or psychosocial disability, can constitute a basis for the deprivation of liberty under current legislation".[48] In the concluding observations on Spain, the CRPD Committee took "note of the legal regime allowing the institutionalization of persons with disabilities, including persons with intellectual and psychosocial disabilities ('mental illness')."[49] The committee also expressed its concern "at the reported trend of resorting to urgent measures of institutionalization which contain only ex post facto safeguards for the affected individuals."[50]

The CRPD Committee recommended to Spain a review of "its laws that allow for the deprivation of liberty on the basis of disability, including a psychosocial or intellectual disabilities; repeal provisions that authorize involuntary internment linked to an apparent or diagnosed disability; and adopt measures to ensure that health-care services, including all mental-health-care services, are based on the informed consent of the person concerned".[51] In its concluding observations on Tunisia, the CRPD committee recommended that pending the requested law reform "all cases of persons with disabilities who are deprived of their liberty in hospitals and specialized institutions should be reviewed and that the review should also include a possibility of appeal".[52]

These statements forcefully underline the guarantees in Article 14 of the CRPD. They would seem to support calls for abolishing or at least "extensive alterations"[53] of mental health legislation that allow for and organise

42 UN, General Assembly (1991). For more on the procedure related to review of involuntary placement or treatment, see Chapter 2.
43 *Ibid.*, Principle 16 (2).
44 *Ibid.*, Principle 17 (1) and 17 (3).
45 UN, Convention on the Human Rights of People with Disabilities, Ad Hoc Committee (2006).
46 See the answers from several states which reported to the CRPD Committee: Belgium: United Nations (UN), Committee on the Rights of Persons with Disabilities (2010c); Germany: United Nations (UN), Committee on the Rights of Persons with Disabilities (2011e) and the United Kingdom: United Nations (UN), Committee on the Rights of Persons with Disabilities (2011g).
47 Committee on the Rights of Persons with Disabilities (2009).
48 Committee on the Rights of Persons with Disabilities (2011a), para. 24.
49 Committee on the Rights of Persons with Disabilities (2011b), para. 35.
50 *Ibid.*, para. 35.
51 *Ibid.*, para. 36.
52 Committee on the Rights of Persons with Disabilities (2011a), para. 25.
53 Syse, A. (2011), p. 146.

involuntary placement specifically of persons with mental health problems.[54] Some commentators and advocates have argued that Article 14 of the CRPD means that no forced detention for mental health reasons or any other disability will be permitted in any circumstances.[55]

For the Office of High Commissioner of Human Rights (OHCHR), "unlawful detention encompasses situations where the deprivation of liberty is grounded in the combination between a mental or intellectual disability and other elements such as dangerousness, or care and treatment. Since such measures are partly justified by the person's disability, they are to be considered discriminatory and in violation of the prohibition of deprivation of liberty on the grounds of disability, and the right to liberty on an equal basis with others prescribed by Article 14 of the CRPD."[56] The OHCHR suggests the following interpretation:

> *"[Article 14] […] should not be interpreted to say that persons with disabilities cannot be lawfully subject to detention for care and treatment or to preventive detention, but that the legal grounds upon which restriction of liberty is determined must be de-linked from the disability and neutrally defined so as to apply to all persons on an equal basis."*[58]

So far, the CRPD Committee has not referred to a disability-neutral situation, for example, linked to the preservation of public order. No authoritative interpretation therefore exists. In order to establish with certainty the scope of the Article 14 guarantees, it will be crucial to see how the CRPD committee handles individual communications, based on the CRPD Optional Protocol, raising this specific situation. It will also be important to see how national monitoring frameworks, based on Article 33 of the CRPD, will handle Article 14 complaints.

In the absence of authoritative interpretation of Article 14 of the CRPD by the CRPD committee, State Parties are, based on their international obligations and in line with the Concluding Observations in relation to Spain, called to thoroughly review their legal framework and repeal any provisions that authorise involuntary placement linked to an apparent or diagnosed disability.[58] This represents a major challenge[59] since it would require a significant legal evolution at regional level. At present, it seems that Council of Europe Member States have adopted a view according to which current Council of Europe standards are CRPD compliant. The next section introduces these standards.

54 See Minkowitz, T. (2010), p. 167; see also Kallert, T. W. (2011), p. 137.
55 See Minkowitz, T. (2010), p. 167.
56 OHCHR (2009), para. 48; see also: Schulze, M. (2010), p. 96.
57 OHCHR (2009), para. 49.
58 See Committee on the Rights of Persons with Disabilities (2011b), para. 36; see also Syse A. (2011), p. 146.
59 See Trömel, S. (2009), p. 129.

1.1.2. Right to liberty: Council of Europe standards

ECHR

Article 5 – Right to liberty and security

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

(e) the lawful detention of […] persons of unsound mind […];

The European Convention on Human Rights (ECHR) explicitly allows liberty to be deprived on grounds of "unsound mind" (a phrase reflecting the terminology of the 1950s when the convention was adopted). The European Court of Human Rights has produced an extensive body of case law on the detention of persons with mental health problems, but has dealt with fewer cases on persons with intellectual disabilities.[60] These cases have established how the ECtHR understands the concept of "unsound mind",[61] and have defined deprivation of liberty taking into account "a range of criteria such as the type, duration, effects and manner of implementation of the measure in question".[62] There have been several cases which have turned on whether the applicant was, in Article 5 terms, detained.[63] Other cases have set out that a person can be detained if they have a mental health problem which warrants compulsory confinement. Such confinement may be necessary if a person needs treatment or if the person "needs control and supervision to prevent him, for example, causing harm to himself and others".[64] The court has dealt with the necessity to inform the patient of the reasons for detention (set out in Article 5 (2) of the ECHR),[65] and the need to have regular court-like reviews of the necessity of detention (required by Article 5 (4) of the ECHR).[66] Relevant cases include those focusing on the quality of the court adjudication,[67] the necessity for the patient

60 Bartlett, P., Lewis, O. and Thorold, O. (2007).
61 See, for example: ECtHR, *Winterwerp v. the Netherlands*, No. 6301/73, 24 October 1979; and ECtHR, *Rakevich v. Russia*, No. 58973/00, 28 October 2003.
62 ECtHR, *Ashingdane v. the United Kingdom*, No. 8225/78, 28 May 1985, para. 41.
63 See: for example: ECtHR, *H.M. v. Switzerland*, No. 39187/98, 26 February 2002; ECtHR, *Storck v.* Germany, No. 61603/00, 16 June 2005; and ECtHR, *H.L. v. the* United Kingdom, No. 45508/99, 5 October 2004 or ECtHR, *D.D. v. Lithuania*, No. 13469/06, 14 February 2012, para. 146.
64 ECtHR, *Hutchison Reid v. the United Kingdom,* No. 50272/99, 20 February 2003, para. 52.
65 See: for example: ECtHR, *Van der Leer v. the Netherlands*, 21 February 1990, paras.27-31.
66 See: for example: ECtHR, *D.D. v. Lithuania*, No.13469/06, 14 February 2012, para. 165.
67 ECtHR, *Gajcsi v. Hungary*, No. 34503/03, 3 October 2006.

to have a lawyer[68] and the need for effective legal assistance.[69] Article 5 (5) of the ECHR also guarantees a right to compensation in case of contravention of the right to liberty guarantees.

"Any restrictions of the rights of the individual must be tailor-made to the individual's needs, be genuinely justified and be the result of rights-based procedures and combined with effective safeguards."

Thomas Hammarberg, Council of Europe Commissioner for Human Rights, View Point, 21 September 2009

This body of case law was applied in the 17 January 2012 Grand Chamber judgment of *Stanev v. Bulgaria*.[70] In this report, it is not possible to cover the extended body of case law as developed by the ECtHR; it will be sufficient to summarise this landmark case since it not only refers explicitly to Article 14 of the CRPD, which addresses liberty and its deprivation in the context of disability, but also reiterates and develops the court's case law in the light of the evolution in human rights law. The following sections will therefore illustrate the way the ECtHR approaches this area of law.

The case deals with the involuntary placement of a man forced to live for years in a social care home for persons with mental health problems. The facts of the case can be summarised as follows: Rusi Stanev was put under partial guardianship and his guardian placed him in a social care home for men with mental health problems. Mr Stanev was allowed to leave the institution only with the director's permission. He tried to have his legal capacity restored, but the prosecutor, following a medical diagnosis of schizophrenia, refused to bring a case, finding that Mr Stanev could not cope alone and that the institution was the most suitable place for him. Mr Stanev then tried to have his partial guardianship over-turned, but this application too was unsuccessful. It was rejected on the grounds that the guardian should make the application. Mr Stanev made several oral requests to his guardian to apply for release, all of which were refused. A private psychiatric report found that Mr Stanev's diagnosis as a schizophrenic was incorrect. It also found that his mental health had improved and was not at risk of deteriorating and that the home's director thought he was capable of reintegration into society. Indeed, his stay in the home, where he risked becoming institutionalised, was damaging his health. Before the ECtHR, Mr Stanev complained that he was deprived of his liberty unlawfully and arbitrarily as a result of his placement in an institution against his will (Article 5 (1) of the ECHR) and that it was impossible under Bulgarian law to have the lawfulness of his deprivation of liberty examined or to seek compensation in court (Article 5 (4) and (5) of the ECHR).

The report will now consider the separate parts of Mr Stanev's complaint, as they relate to Article 5 (1) and Article 5 (4), in turn.

When liberty may be deprived

The protection from arbitrary deprivation of liberty under Article 5 of the ECHR applies when a person is deprived of his or her liberty. The application of Article 5 is triggered not by whether or not a person is in fact restrained or detained, but instead by whether he or she is placed in an institution against his or her will and cannot leave without authorisation. In the *Stanev* case, the ECtHR concluded that Mr Stanev "was under constant supervision and was not free to leave the home without permission whenever he wished".[71] The duration of Mr Stanev's placement, which "was not specified and was thus indefinite" was long enough for the applicant to perceive the "adverse effects of the restrictions imposed on him."[72] In other words, the ECtHR concluded that the applicant was deprived of his liberty. To be compatible with Article 5 (1) of the ECHR a deprivation of liberty must be imposed according to national law. As the decision by Mr Stanev's guardian to place him in an institution without his prior consent was invalid under Bulgarian law, his deprivation of liberty was in violation of Article 5 of the ECHR.

The court pursued its scrutiny of the case in order to assess whether the deprivation of liberty fell within the scope of the exceptions to the rule of personal freedom (Article 5 (1) paragraphs (a) to (f) of the ECHR) and whether the deprivation of liberty could be justified on the basis of those exceptions. Although Article 5 (1) (e) of the ECHR in principle allows for the detention of persons of "unsound mind",[73] a deprivation of liberty on such grounds is only justified in extreme cases. Either the person concerned constitutes a serious threat because of his or her violent behaviour, or the detention is required for therapeutic reasons.

In order to properly gauge the situation, ECtHR case law requires a qualified medical assessment based on the person's actual state of mental health and not solely on past events.[74] Further clarification regarding the thresholds which must be met for the deprivation of liberty to comply with Article 5 (1) (e) is set out in the *Winterwerp* case, where the court noted that: "The very nature of what has to be established before the competent national authority – that is, a true mental

68 ECtHR, *Megyeri v. Germany*, No. 13770/88, 12 May 1992.
69 ECtHR, *Magalhaes Pereira v. Portugal*, No. 44872/98, 26 February 2002.
70 ECtHR, GC, *Stanev v. Bulgaria*, No. 36760/06, 17 January 2012.
71 *Ibid.*, para. 128.
72 *Ibid.*, para. 129.
73 For more information on the ECtHR's assessment of the meaning of 'persons of unsound mind', see: ECtHR, *Winterwerp v. the Netherlands*, No. 6301/73, 24 October 1979, para. 37.
74 ECtHR, *Varbanov v. Bulgaria*, No. 31365/96, 5 October 2000.

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."[75]

The ECtHR was ready to apply Article 5 (1) (e) to the *Stanev* case since the placement decision was triggered by the applicant's state of mental health, the declaration of partial incapacity and placement under partial guardianship. The court considered that taking a placement decision on a two-year old medical record did not satisfy convention requirements.[76] Likewise it found that the placement was also incompliant with this provision, because a placement must rest on establishing that the individual's behaviour posed a danger to himself or others. Finally, the court underlined that the authorities did not perform the regular assessment of Mr Stanev's health needed to ensure that the need of confinement persisted.[77] As such, it concluded that there had been a violation of Article 5 (1) of the ECHR.

The court went further than previous judgments to set out additional safeguards against the deprivation of liberty. While recognising that in some cases the welfare of a person should be taken into account, the court insisted that: "the objective need for accommodation and social assistance must not automatically lead to the imposition of measures involving deprivation of liberty." It also stated that: "any protective measure should reflect as far as possible the wishes of persons capable of expressing their will. Failure to seek their opinion could give rise to situations of abuse and hamper the exercise of the rights of vulnerable persons. Therefore, any measure taken without prior consultation of the interested person will as a rule require careful scrutiny."[78]

Reviewing the lawfulness of detention

ECHR

Article 5 – Right to liberty and security

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.

The ECtHR has also provided interpretation of one of the essential guarantees of the right to liberty and security; that the lawfulness of the deprivation of liberty must be reviewable by a court. ECtHR case law has expanded on the practical implications of this right. In a number of cases, the court emphasised the requirement for a speedy determination of the lawfulness of the detention in situations where people are detained in psychiatric institutions as authorised, in principle, under Article 5 (1) (e).[79] This guarantee is echoed in the standards of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), which says: "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".[80]

In the *Gorshkov* case, the ECtHR emphasised that "a key guarantee under Article 5 (4) is that a patient compulsorily detained for psychiatric treatment must have the right to seek judicial review on his or her own motion", and that this provision therefore "requires, in the first place, an independent legal device by which the detainee may appear before a judge who will determine the lawfulness of the continued detention. The detainee's access to the judge should not depend on the good will of the detaining authority, activated at the discretion of the medical corps or the hospital administration": [81] even a mechanism providing for the automatic appearance of a mental health patient before a judge is not an appropriate substitute for the right to judicial review at the instigation of the individual.

In the *Stanev v. Bulgaria* case, the court observed that no remedy to challenge the lawfulness of Mr Stanev's placement was available in domestic law. No courts were

75 ECtHR, *Winterwerp v. the Netherlands*, No. 6301/73, 24 October 1979, para. 39.
76 Compare with ECtHR, *D.D. v. Lithuania*, 14 February 2012, No. 13469/06, para. 157, in which the applicant had been admitted to and examined at a psychiatric hospital just a few weeks before her placement. A medical panel of that hospital concluded that at that time the applicant suffered from "continuous paranoid schizophrenia".
77 ECtHR, GC, *Stanev v. Bulgaria*, No. 36760/06, 17 January 2012, para. 158.
78 *Ibid.*, para. 153.

79 See, for other examples: ECtHR, *Luberti v. Italy*, No. 9019/80, 23 February 1984; ECtHR, *Musial v. Poland*, No. 24557/94, 25 March 1999; ECtHR, *L.R. v. France*, No. 33395/96, 27 June 2002; ECtHR, *Pereira v. Portugal*, No. 44872/98, 26 February 2002; ECtHR, *Kolanis v. the* United Kingdom, No. 517/02, 21 June 2005, para. 82; and *Pereira v. Portugal (No. 2)*, No. 15996/02, 20 December 2005.
80 Council of Europe, CPT (2010), para. 53.
81 ECtHR, *Gorshkov v. Ukraine*, No. 67531/01, 8 November 2005, paras. 44-45.

involved at any time or in any way in the placement and the domestic legislation did not provide for automatic periodic judicial review of placement in a home for people with mental health problems. Furthermore, the validity of the placement could have been challenged on the grounds of lack of consent only on the guardian's initiative. The court therefore concluded that there had been a breach of Article 5 (4) ECHR.[82]

In addition to the ECtHR case law, the Council of Europe has adopted other important relevant standards that will be discussed next.

Common safeguards

The 1997 Oviedo Convention, or the Convention on Human Rights and Biomedicine,[83] alludes to the possibility of involuntary placement in its Article 7 on the protection of persons who have a mental disorder. Detailed guarantees, however, are to be found in a Council of Europe Recommendation of 2004.

The Recommendation Rec(2004)10 of the Committee of Ministers follows the interpretation of Article 5 of the ECHR and confirms the ECtHR's approach. It brings together the safeguards elaborated by the court, as discussed in earlier in Section 1.1.2, this lays out thresholds that should be met before a decision can be taken on involuntary placement or involuntary treatment. In doing so, it promotes common action and safeguards among Council of Europe Member States.

Article 17 (1) Rec(2004)10 requires the fulfilment of five conditions before a person can be involuntary placed.

Council of Europe Committee of Ministers Recommendation Rec(2004)10

Article 17 – Criteria for involuntary placement

1. A person may be subject to involuntary placement only if all the following conditions are met:

i. the person has a mental disorder;

ii. the person's condition represents a significant risk of serious harm to his or her health or to other persons;

iii. the placement includes a therapeutic purpose;

iv. no less restrictive means of providing appropriate care are available;

v. the opinion of the person concerned has been taken into consideration.[...]

These cumulative criteria should be applied in normal procedures of involuntary placement. According to Article 17 (2) Rec(2004)10, a person may exceptionally be held against his or her will in order to determine whether he or she has a mental disorder. This situation covers emergency situations but, since the criteria are less stringent that those applied in normal situation, the placement should be for only a minimum period of time.

A general safeguard clause is also enshrined in Article 24 Rec(2004)10. If any of the criteria are no longer met, involuntary placement should be terminated. The doctor charged with the person's care is responsible for assessing whether any of the relevant criteria are no longer met, unless a court has reserved the assessment of the risk of serious harm.

Moreover, the recommendation introduces the principle of least restriction.[84] Building on the longstanding legal principle of proportionality, Article 8 Rec(2004)10 states that "[p]ersons with mental disorders should have the right to be cared for in the least restrictive environment available and with the least restrictive or intrusive treatment available, taking into account their health needs and the need to protect the safety of others". This is reiterated in Article 10(ii) Rec(2004)10, which calls on Member States to "make alternatives to involuntary placement and to involuntary treatment as widely available as possible".

Once the basic criteria allowing for the possibility of involuntary placement have been met, the key issue becomes the procedures surrounding the admission decision. These procedural safeguards relate to who is

82 ECtHR, GC, *Stanev v. Bulgaria*, No. 36760/06, 17 January 2012, para. 172 ff., see also: ECtHR, *D.D. v. Lithuania*, No.13469/06, 14 February 2012, paras. 165-166.

83 Council of Europe (1997). The Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine (*Convention on Human Rights and Biomedicine*) entered into force on 1 December 1999. Sixteen EU Member States have ratified it. The EU itself has not ratified it, although Article 33 (1) of the Convention provides for the possibility of the EU acceding.

84 Confirmed by the ECtHR as of 2012, see: ECtHR, GC, *Stanev v. Bulgaria*, No. 36760/06, 17 January 2012, paras. 157-158.

able to take the decision to place a person involuntarily, and what their expertise must be.

Council of Europe Committee of Ministers Recommendation Rec(2004)10

Article 20 – Procedures for taking decisions on involuntary placement and/or involuntary treatment

Decision

1. The decision to subject a person to involuntary placement should be taken by a court or another competent body. The court or other competent body should:

i. take into account the opinion of the person concerned;

ii. act in accordance with procedures provided by law based on the principle that the person concerned should be seen and consulted.[...]

3. Decisions to subject a person to involuntary placement or to involuntary treatment should be documented and state the maximum period beyond which, according to law, they should be formally reviewed. [...]

Procedures prior to the decision

4. Involuntary placement, or its extension, should only take place on the basis of examination by a doctor having the requisite competence and experience, and in accordance with valid and reliable professional standards.
5. The doctor or the competent body should consult those close to the person concerned, unless the person objects, it is impractical to do so, or it is inappropriate for other reasons.
6. Any representative of the person should be informed and consulted.

Article 25 Rec(2004)10 elaborates on the right to review the deprivation of liberty. It requires Council of Europe Member States to ensure that persons subject to involuntary placement or involuntary treatment can: appeal against a decision; have the lawfulness of the measure, or its continuing application, reviewed by a court at reasonable interviews – regardless of whether the person, their personal advocate, or their representative requests such a review; and be heard in person or through a personal advocate or representative at such reviews or appeals. Moreover, this decision should be made promptly, and a procedure to appeal the court's decision must be provided.

In June 2011, the Council of Europe's Steering Committee on Bioethics (CDBI) agreed to begin work on an Additional Protocol to the Oviedo Convention. The Protocol will focus on the protection of the human rights and dignity of persons with mental disorders, in particular with regard to involuntary treatment and placement. The preparatory work is foreseen for 2013.[85]

In sum, under Council of Europe standards, for the deprivation of liberty of the person with a mental health problem to be authorised, the following conditions should be fulfilled:

- The decision of placement should be taken by an authority legally vested with competence to place a person in a psychiatric hospital or other establishment, and the decision must be founded on a conclusively proven state of mental health problem, unless there are urgent circumstances. It is not sufficient that the authority be presented with a request for placement of a person suffering from a mental health problem, rather it must be examined whether there are compelling reasons, related to the health of the person concerned or to the rights or interests of others, justifying the placement.
- The procedure leading to the placement decision should ensure that the person concerned has an opportunity to be heard, if necessary through a representative.
- The detention should not be prolonged beyond what is justified by the mental health of the person subjected to the placement measure.
- The regime of the condition should correspond to its therapeutic purpose. Finally, judicial review should at all times be available in order to assess the continued lawfulness of the detention.

To conclude, the question of compatibility of CRPD rights with the above-mentioned criteria has been debated in the CDBI. In November 2011, the CDBI adopted a statement of compatibility.

85 Council of Europe, Committee of Ministers (2011). The Steering Committee on Human Rights (CDDH) and the European Committee for the Prevention of Torture have supported this idea of an additional protocol to the Oviedo Convention.

Statement on the United Nations Convention on the Rights of Persons with Disabilities adopted by the Council of Europe's Steering Committee on Bioethics (CDBI) at its 41st meeting (2–4 November 2011)

1. The CDBI considered the United Nations Convention on the rights of persons with disabilities. It analysed in particular whether Articles 14, 15 and 17 were compatible with the possibility to subject under certain conditions a person who has a mental disorder of a serious nature to involuntary placement or involuntary treatment, as foreseen in other national and international texts. [...]
2. As a result of the discussion, the Committee concluded that the existence of a disability may not justify in itself a deprivation of liberty or an involuntary treatment. Involuntary treatment or placement may only be justified, in connection with a mental disorder of a serious nature, if from the absence of treatment or placement serious harm is likely to result to the person's health or to a third party.

In addition, these measures may only be taken subject to protective conditions prescribed by law, including supervisory, control and appeal procedures.[86]

In the absence of a fully elaborated authoritative interpretation by the Committee on the Rights of Persons with Disabilities of the meaning of the CRPD textual guarantees on the right to liberty, it is not possible to provide a definitive interpretation of the scope of CRPD protection. While some voices call for a review of older standards based on CRPD guarantees, at the Council of Europe level Member States recently confirmed that Council of Europe standards are fully compatible with CRPD norms. It is not the aim of this report to decide on such a question. It is enough to acknowledge the possibility that a challenge in securing compatibility might arise.

86 Council of Europe, Committee of Ministers (2012).

1.2. Involuntary treatment

Involuntary treatment can be directly linked to involuntary placement. Article 17 Rec(2004)10, for example, establishes a link between compulsory placement and its "therapeutic purpose". The latter is one of the pre-conditions that must be met legally to justify the former. In its interpretation of Article 5 of the ECHR, the European Court of Human Rights accepts that confinement can take place even when medical treatment is not necessary.[87] The pivotal element, which delineates the 'involuntary' aspect of the treatment, relates to the consent of the person to a specific treatment.

The notion of free and informed consent is also at the centre of legal developments at the United Nations (UN) level, and is an important criterion at the European level. The requirement to consent to medical treatment was integrated into Article 3, on the right to integrity of the person, of the Charter of Fundamental Rights of the European Union.[88]

Procedural safeguards that apply to both involuntary placement and involuntary treatment will not be repeated in the following discussion. Instead, the section will focus on the key fundamental rights that are at stake. These are freedom from torture, the protection of dignity and the right to privacy. Several important elements attached to the right to privacy, such as the access and confidentiality of medical data, will not be addressed here. The section will concentrate instead on core aspects of involuntary treatment, first stating the UN standards and then turning to those of the Council of Europe.

1.2.1. United Nations standards

This section considers the evolution of UN human rights standards relevant to medical treatment decisions. In order to understand the legal evolution encapsulated in the CRPD, a brief mention of previous instruments is necessary.

Article 7 of the ICCPR prescribes the prohibition of torture. Its second sentence states that "no one shall be subjected without his free consent to medical or scientific experimentation". This article is relevant in as much as it introduces the notion of consent. Its scope, however, is limited to experimentation and a prohibition of medical experimentation is narrower than a prohibition

87 See, for example: ECtHR, *Hutchison Reid v. United Kingdom*, No. 50272/99, 20 February 2003, para. 52.

88 Article 3 (2) of the Charter of Fundamental Rights of the European Union, provides that "in the fields of medicine and biology, the following must be respected in particular: the free and informed consent of the person concerned, according to the procedures laid down by law". The Explanations of the Charter by the Praesidium of the Convention which drafted it refers to the fact that these principles are already contained in the Oviedo Convention, and that "the Charter does not set out to depart from those principles". See European Union, Praesidium of the Convention (2007).

of medical treatment.[89] The language of Article 7 of the ICCPR was incorporated directly into Article 15 CRPD.

CRPD

Article 15 – Freedom from torture or cruel, inhuman or degrading treatment or punishment

1. No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his or her free consent to medical or scientific experimentation. [...]

Moreover, the CRPD Committee requests States Parties to report on "measures taken to protect effectively persons with disabilities from medical or scientific experimentation without their free and informed consent, including persons with disabilities who need support in exercising their legal capacity."[90] During the CRPD negotiations, a reference to forced interventions or forced institutionalisation was dropped from draft Article 15 since some States considered that these are permitted under national legislation.[91] Negotiators rejected a more detailed provision given the potential risk of affecting the definition of torture as enshrined in the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.[92] In this context, Article 15 needs to be read in conjunction with Articles 17 and 25 of the CRPD.

CRPD

Article 17 – Protecting the integrity of the person

Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others.

One of the goals of Article 17 of the CRPD was, according to the drafters, to address the issue of involuntary treatment. Draft Article 17 aimed at prohibiting such treatment.[93] The negotiators eventually agreed on a short formula that "does not explicitly permit involuntary treatment, nor does it prohibit it".[94] Still, the CRPD Committee asks States Parties to report on "measures taken to protect persons with disabilities from medical (or other) treatment given without the free and informed consent of the person."[95] In its Concluding Observations on Tunisia, the CRPD Committee expressed some concern "about the lack of clarity concerning the scope of legislation to protect persons with disabilities from being subjected to treatment without their free and informed consent, including forced treatment in mental health services." It further recommended that Tunisia "incorporate into the law the abolition of surgery and treatment without the full and informed consent of the patient."[96]

However, this approach seems to pose a serious challenge for some States Parties. Australia made the following formal declaration when it ratified the Convention:

> *"Australia recognizes that every person with disability has a right to respect for his or her physical and mental integrity on an equal basis with others. Australia further declares its understanding that the Convention allows for compulsory assistance or treatment of persons, including measures taken for the treatment of mental disability, where such treatment is necessary, as a last resort and subject to safeguards."*[97]

Article 17 of the CRPD is in turn closely related to Article 25 of the CRPD when it comes to consent to treatment.

CRPD

Article 25 – Health

States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall: [...]

(d) Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care;

Article 25 (d) of the CRPD brings the crucial concepts of human rights, dignity and autonomy together and links them to the notion of free and informed consent.

89 Joseph, S., Schultz, J. and Castan, M. (2004), p. 254; see also: UN Special Rapporteur on Torture (2008), para. 58.
90 Committee on the Rights of Persons with Disabilities (2009).
91 Trömel, S. (2009), p. 130.
92 Schulze, M. (2010), p. 99.
93 See Trömel, S. (2009), p. 131; Schulze, M. (2010), p. 109; Bartlett, P. (2012a).
94 Kämpf, A. (2010), p. 130.
95 Committee on the Rights of Persons with Disabilities (2009).
96 Committee on the Rights of Persons with Disabilities (2011a), paras. 28 and 29.
97 See United Nations Enable, Declarations and Reservations, available at: www.un.org/disabilities/default.asp?id=475.

Consent to treatment was tackled in other forums at the United Nations. In its General Comment on Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESR), the Committee on Economic, Social and Cultural Rights affirmed that states should refrain "from applying coercive medical treatments, unless on an exceptional basis for the treatment of mental illness. [...] Such exceptional cases should be subject to specific and restrictive conditions, respecting best practices and applicable international standards, including the [MI] Principles."[98]

The MI Principles provide guidance on the notion of consent. Principle 11 (2) specifies in particular 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; and (d) Possible pain or discomfort, risks and side-effects of the proposed treatment".*

However, as noted above, the MI Principles are the subject of criticism. According to the UN Special Rapporteur on Torture, the CRPD invalidates earlier norms (in particular the MI Principles), that allow for involuntary treatment in certain cases.[99]

The Special Rapporteur on Torture turned his attention to several forms of medical intervention. On electroconvulsive therapy (ECT), the Special Rapporteur refers to the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) standards (see the subsection 'European Committee for the Prevention of Torture (CPT) standards' in Section 1.2.2.) and concludes that "unmodified ECT may inflict severe pain and suffering and often leads to medical consequences, including bone, ligament and spinal fractures, cognitive deficits and possible loss of memory. It cannot be considered as an acceptable medical practice, and may constitute torture or ill-treatment. In its modified form [e.g. with anaesthesia, muscle relaxant or oxygenation], it is of vital importance that ECT be administered only with the free and informed consent of the person concerned, including on the basis of information on the secondary effects and related risks such as heart complications, confusion, loss of memory and even death."[100] The United Nations Committee Against Torture (CAT) concurred with this opinion. In its 2011 Concluding Observations in respect to Finland, it recommended that any administering of ECT be based on free and informed consent.[101]

The Special Rapporteur on Torture makes a number of other points relevant to this discussion. He argues that abuse of psychiatric treatment, "warrants greater attention",[102] a position justified by his finding that "[i]nside institutions, as well as in the context of forced outpatient treatment, psychiatric medication, including neuroleptics and other mind-altering drugs, may be administered to persons with mental disabilities without their free and informed consent or against their will, under coercion, or as a form of punishment".[103] Furthermore, the Special Rapporteur explicitly links side effects of medication with torture. He explains that side effects of psychiatric medication include "trembling, shivering and contractions and make the subject apathetic and dull his or her intelligence".[104] Noting that forced psychiatric medication has already been recognised as a form of torture,[105] he goes on to clarify that, "forced and non-consensual administration of psychiatric drugs, and in particular of neuroleptics, for the treatment of a mental condition needs to be closely scrutinized. Depending on the circumstances of the case, the suffering inflicted and the effects upon the individual's health may constitute a form of torture or ill-treatment".[106]

This section shows that the impact of the CRPD cannot be underestimated. Until the CRPD Committee develops a combined interpretation of Articles 15, 17 and 25 read together and applied specifically to involuntary treatment, it will be difficult to assess the exact scope of reforms that are required of States Parties. The next section looks at the standards developed by the Council of Europe.

98 UN, Committee on Economic, Social and Cultural Rights (2000), para. 34.
99 UN, Special Rapporteur on Torture (2008), para. 44. A similar point was made in the report of the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. See UN Rapporteur on Health (2005), para. 24.
100 UN, Special Rapporteur on Torture (2008), para. 61.
101 UN, Committee against Torture (2011), para. 11.
102 UN, Special Rapporteur on Torture (2008), para. 62.
103 *Ibid.*, para. 63.
104 *Ibid.*
105 UN, Special Rapporteur on Torture (1986), para. 119.
106 UN, Special Rapporteur on Torture (2008), para. 63.

1.2.2. Council of Europe standards

At the Council of Europe level, involuntary treatment affects two key fundamental rights; the right to freedom from cruel, inhuman or degrading treatment, and the right to respect for private life. These will be examined in turn, before the discussion focuses on the guarantees provided in the Oviedo Convention and the relevant Council of Europe recommendations.

ECHR

Article 3 – Prohibition of torture

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

Article 3 of the ECHR sets out a prohibition of torture and other forms of ill-treatment. There is relatively little case law, however, based on Article 3 related to involuntary treatment. The leading case concerned with mental health-related treatment is the 1992 *Herczegfalvy v. Austria* case. The applicant had been placed under guardianship, and the guardian had consented to treatment which the applicant challenged. He had been forcibly administered food and neuroleptics, isolated and handcuffed to a security bed. In this landmark case, the court set out some principles which have guided its subsequent jurisprudence:

> *"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 patients nevertheless remain under the protection of Article 3, whose requirements 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".*[107]

The court has not found so far an Article 3 violation in a case concerning mental health treatment.[108] Various criteria would need to be fulfilled, not least of which is that there is a minimum level of severity for ill-treatment to constitute degrading or inhuman treatment. The court has deemed treatment to be 'degrading' if it arouses in the victims feelings of fear, anguish and inferiority capable of humiliating and debasing them. The court has considered treatment to be 'inhuman' if, among other things, it is premeditated, is applied for hours at a time and causes either actual bodily injury or intense physical or mental suffering. In addition to this, "the Court has consistently stressed that the suffering and humiliation involved must in any event go beyond that inevitable element of suffering or humiliation connected with a given form of legitimate treatment or punishment".[109] It is still to be clarified what these inevitable elements would be in the context of involuntary treatment.

In less extreme cases, the imposition of a forced medical examination will be examined under Article 8 of the ECHR, which guarantees the right to respect for private life. The Court has held that "a person's body concerns the most intimate aspect of private life. Thus, a compulsory medical intervention, even if it is of minor importance, constitutes an interference with this right".[110] An intervention will be an Article 8 violation only if Article 8(2) of the ECHR requirements are not fulfilled. These include the necessity to demonstrate that the measure was not in accordance with domestic law, was not necessary in a democratic society and not in the interests of, among other things, the protection of health or for the protection of the rights and freedoms of others. Under this provision, forced medical treatment will only be allowable if necessary for the fulfilment of a legitimate aim, typically the protection of the rights of others or of the individual concerned and his/her health.[111] In the case of *Matter v. Slovakia,* the forced medical examination of the applicant in a mental hospital was considered to be justified and not disproportionate.[112] In the *Storck v. Germany* case, the court found a violation of Article 8 of the ECHR since the involuntary medical treatment was inflicted in circumstances in which the person concerned was detained arbitrarily and against her will.[113] Similarly, in the case of *Shopov v. Bulgaria*, the ECtHR found a violation of Article 8 since the compulsory treatment imposed on Mr Shopov had not been regularly reviewed by a court, contrary to national law.[114] In the case of *Fyodorov and Fyodorova v. Ukraine* case, the court found a violation of Article 8 on account of subjecting the first applicant to an unlawful psychiatric

107 ECtHR, *Herczegfalvy v. Austria*, No. 10533/83, 24 September 1992, para. 82.

108 See for example a recent application of settled case law: ECtHR, *D.D. v. Lithuania*, No.13469/06, 14 February 2012, paras. 174-175. See also Barlett, P. (2012).

109 ECtHR, *Kudla v. Poland*, No. 30210/96, 26 October 2000, para. 92.

110 ECtHR, *Y. F. v. Turkey*, No. 24209/94, 22 July 2003, para. 33.

111 See, for example: ECtHR (dec), *Schneiter v. Switzerland*, No.63062/00, 31 March 2005.

112 ECtHR, *Matter v. Slovakia*, No. 31534/96, 5 July 1999, para. 71-72.

113 ECtHR, *Storck v. Germany*, No. 61603/00, 16 June 2005.

114 ECtHR, *Shopov v. Bulgaria*, No. 11373/04, 2 September 2010.

examination against his will and diagnosing him with chronic delusional disorder.[115]

Other Council of Europe standards, namely the Oviedo Convention, Council of Europe Recommendations and the CPT standards take into account these developments at the ECtHR.

The 1997 Oviedo Convention clearly enunciated the principle of free and informed consent for any medical treatment.[116]

Council of Europe Convention on Human Rights and Biomedicine (Oviedo Convention)

Article 5 – General rule

An intervention in the health field may only be carried out after the person concerned has given free and informed consent to it.

This person shall beforehand be given appropriate information as to the purpose and nature of the intervention as well as on its consequences and risks.

The person concerned may freely withdraw consent at any time.

Article 5 defines the "patients' autonomy in their relationship with health care professionals and restrains the paternalist approaches which might ignore the wish of the patient."[117] Article 6 of the Oviedo Convention is aimed at protecting persons not able to consent. Article 6 (3) specifies that "where, according to law, an adult does not have the capacity to consent to an intervention because of a mental disability, a disease or for similar reasons, the intervention may only be carried out with the authorisation of his or her representative or an authority or a person or body provided for by law. The individual concerned shall as far as possible take part in the authorisation procedure". In order to ensure the meaningful participation of the person in the decision-taking, "it will be necessary to explain to them the significance and circumstances of the intervention and then obtain their opinion."[118]

115 ECtHR, *Fyodorov and Fyodorova v. Ukraine*, No. 39229/03, 7 July 2011.
116 Council of Europe (1997).
117 Council of Europe (1996), para. 34.
118 *Ibid.*, para. 46.

Recommendation Rec(2004)10 essentially reiterates these requirements.

Council of Europe Committee of Ministers Recommendation Rec(2004)10

Article 12 – General principles of treatment for mental disorder

2. […], treatment may only be provided to a person with mental disorder with his or her consent if he or she has the capacity to give such consent, or, when the person does not have the capacity to consent, with the authorisation of a representative, authority, person or body provided for by law.

The Explanatory Report to Recommendation Rec(2004)10 underlines that in case of a divergence of views between a representative and the doctor on a specific treatment, the matter should be referred to a court.[119] Moreover, where a treatment decision is taken at a time when the person is legally not able to give his or her consent, as soon as the legal situation changes, the person's own consent should be sought before continuing the treatment.[120]

Council of Europe Convention on Human Rights and Biomedicine (Oviedo Convention)

Article 7 – Protection of persons who have a mental disorder

Subject to protective conditions prescribed by law, including supervisory, control and appeal procedures, a person who has a mental disorder of a serious nature may be subjected, without his or her consent, to an intervention aimed at treating his or her mental disorder only where, without such treatment, serious harm is likely to result to his or her health.

Article 7 constitutes an exception to the general rule of consent enshrined in Article 5 of the Oviedo Convention. Three conditions need to be fulfilled: the person must have a serious mental health problem; the treatment must aim to alleviate the mental health problem; and without treatment of the mental health problem, serious harm to their health is likely to result. Treatment can take place without the individual's consent if the national legal framework, which needs to be observed, enables such intervention and if the failure to intervene would result

119 This issue was adjudicated by the ECtHR. See ECtHR, *Glass v. the United Kingdom*, No. 61827/00, 9 March 2004.
120 Council of Europe, Committee of Ministers (2004a).

in serious harm to the health of the individual. Read in conjunction with Article 26 of the Oviedo Convention, which sets out certain circumstances where restrictions can be placed on the exercise of the rights contained in the convention, an intervention could also take place if the result of the failure to intervene would be harm to the health and safety of others. The reference to national legislation in Article 7 of the Oviedo Convention suggests that all procedural conditions must be observed.

At this juncture, another Council of Europe Recommendation should be mentioned. Recommendation R(99)4 of the Committee of Ministers to Member States on principles concerning the legal protection of incapable adults contains a part V dedicated to interventions in the health field. It states that when adults are capable of giving free and informed consent to a given intervention in the health field, the intervention may only be carried out with that consent.

Recommendation Rec(2004)10 defines in detail the conditions under which a person may be subjected to compulsory medical treatment (Article 18) as well as the conditions which involuntary treatment should comply with (Article 19).

Council of Europe Committee of Ministers Recommendation Rec(2004)10

Article 18 – Criteria for involuntary treatment

A person may be subject to involuntary treatment only if all the following conditions are met:

i. the person has a mental disorder;

ii. the person's condition represents a significant risk of serious harm to his or her health or to other persons;

iii. no less intrusive means of providing appropriate care are available;

iv. the opinion of the person concerned has been taken into consideration.

Article 19 – Principles concerning involuntary treatment

1. Involuntary treatment should:

i. address specific clinical signs and symptoms;

ii. be proportionate to the person's state of health;

iii. form part of a written treatment plan;

iv. be documented;

v. where appropriate, aim to enable the use of treatment acceptable to the person as soon as possible.

The provisions of Recommendation Rec(2004)10 also go beyond the ECHR and the Oviedo Convention on a number of points. It recommends, for instance, that involuntary treatment form part of a written treatment plan, a safeguard that ensures improved monitoring of whether the medical decisions were based on sound evidence and whether the treatment was the least restrictive possible.[121] Articles 20 and 21 Rec(2004)10 contain procedural clauses stipulating the conditions the decision-making process should comply with prior to the imposition of involuntary treatment (Article 21 concerns emergency procedures, which Article 8 of the Convention on Human Rights and Biomedicine also addresses).

Article 22 of Rec(2004)10 states a right to information for the benefit of the patient. This is an essential safeguard for the rights of the individual. Insofar as these provisions refer to the situation of representatives – who should also be provided information about the rights and remedies available, and should be able to communicate with the person they represent – they should be read in accordance with the case law described above. Particularly significant are the cases of *Herczegfalvy v. Austria* – which insists on the need to safeguard the confidentiality of communication with the outside world – and *Vaudelle v. France*[122] – which sets out the need to inform not only the person concerned, but also his or her representative, in the context of judicial proceedings.

The European Committee for the Prevention of Torture standards

Finally, the position of the European Committee for the Prevention of Torture (CPT) standards is also relevant. The CPT developed a set of standards relating to compulsory treatment that are defined as follows:

> *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 [...]. 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.*[123]

121 See also: Council of Europe, Committee for the Prevention of Torture (CPT) (2010f), para. 37.

122 ECtHR, *Vaudelle v. France*, No.35683/97, 30 January 2001.

123 Council of Europe, CPT (2010f), para. 41.

The CPT does not exclude the possibility of medical treatment being imposed on the patient 'in exceptional circumstances'. However, these need to be prescribed by law and follow specific procedure. The CPT would, for instance, recommend:

"[…] procedures be reviewed with the aim of ensuring that all patients, whether voluntary or involuntary, are provided systematically with information about their condition and the treatment prescribed for them, and that doctors be instructed that they should always seek the patient's consent to treatment prior to its commencement. The form concerning informed consent to treatment should be signed by the patient […]. Relevant information should also be provided to patients (and their legal representatives) during and following treatment."[124]

The CPT is of the view that psychiatric treatment should be based on an "individualised approach", and that it constitutes more than medication and "should involve a wide range of rehabilitative and therapeutic activities, including access to occupational therapy, group therapy, individual psychotherapy, art, drama, music and sports".[124] The CPT points out that if staff lack training or if there is an inappropriate culture based on custody instead of recovery, then a situation can arise where the "fundamental components of effective psycho-social rehabilitative treatment are underdeveloped or even totally lacking", resulting in treatment mainly based on medication.[125]

The CPT standards issue a warning to states that it "will also be on the look-out for any indications of the misuse of medication".[126] The CPT has developed specific guidance on the use of electroconvulsive therapy (ECT), a measure which should always be provided with anaesthesia and muscle relaxants and which must be accompanied by appropriate safeguards including staff training and specific documentation of each incident.[127]

In sum, the norms described above do not exclude that, in exceptional circumstances, persons with a mental health problem may be treated against their own free will, where the person's condition represents a serious risk of harm to their health.

This chapter presented UN and Council of Europe standards and safeguards relating to the protection of persons with disabilities in the context of involuntary placement and treatment. With regard to involuntary placement, both sets of standards provide for circumstances in which persons with mental health problems can be deprived of their liberty, as long as procedures established by law are applied and the lawfulness of the detention is regularly reviewed. The CRPD specifically delinks deprivation of liberty from the existence of a disability, so that a disability does not itself justify placement. At both the UN and Council of Europe levels, standards relating to involuntary treatment involve the intersection of several interrelated rights, notably freedom from torture, the right to privacy and the protection of the integrity of the person. Council of Europe law clearly permits involuntary treatment for mental health problems if certain strict conditions are fulfilled. At the UN level, further interpretation by the CRPD Committee is needed to clarify the extent to which involuntary treatment is compatible with CRPD norms. Nevertheless, both UN and Council of Europe standards reiterate the importance of obtaining free and informed consent ahead of medical treatment.

The following chapter presents the findings of FRA research on the legal frameworks regarding involuntary placement and treatment in place in the 27 EU Member States. Focusing on the legal situation, the chapter will not address any measures or safeguards not prescribed by law. While recognising the importance of such measures for protecting individuals' rights in situations of compulsory detention or treatment, their analysis falls outside the scope of this report.

124 Council of Europe, CPT (2010e), para. 145.
125 *Ibid.*
126 *Ibid.*, para. 38.
127 *Ibid.*, para. 39.

2

EU Member States legal framework

This chapter takes as a starting point the 2002 report on *Compulsory Admission and Involuntary Treatment of Mentally Ill Patients – Legislation and Practice in the EU-Member States* co-financed by the European Commission.[128] The 2002 report provided a comparative analysis of the legal frameworks in place across the then 15 EU Member States. The present report, 10 years later, covers the situation in 27 EU Member States as of February 2012, and attempts a limited analysis of trends using similar questions as the 2002 report. The present report, however, relies on the criteria for involuntary placement and involuntary treatment set out in the Council of Europe Recommendation Rec(2004)10 which postdates the 2002 report. This discussion cannot embrace all situations governed by EU Member States' legal frameworks. For example, the analysis does not cover the deprivation of liberty of persons lacking legal capacity as this aspect will be addressed in a separate FRA report. Relying on existing Council of Europe standards also means that the analysis does not necessarily differentiate between involuntary placement and involuntary treatment when these standards apply to both situations.

The following chapter first examines the national legislative framework from a formal point of view (Section 2.1), before comparing the various criteria in place in EU Member States (Section 2.2). Finally, the chapter addresses some pivotal questions related to procedural rights in the context of the review and appeal process (Section 2.3).

128 Salize, H. J. *et al.* (2002).

2.1. Legislation

EU Member States' legal frameworks regulating involuntary placement and involuntary treatment are marked by great diversity. The 2002 report underlined this situation a decade ago,[129] and the FRA findings confirm that this remains true in 2012. As of 2013, the Council of Europe will start working on the elaboration of a Protocol to the Oviedo Convention, a legally binding instrument (see Chapter 1). Currently, however, only a non-binding instrument, namely Rec(2004)10, presents a set of specific standards for all Council of Europe, and consequently, EU Member States.

The 2002 report noted that 12 out of 15 EU Member States had special mental health laws regulating involuntary placement and involuntary treatment in 2002.[130] According to the 2002 report, the main reason for not specifically legislating in this area in **Greece**, **Italy** and **Spain**, is to prevent the stigmatising effect of a rule applied only to persons with mental health problems.[131] The discriminatory aspect of mental health-specific legislation has prompted calls of legal reform.[132] In the EU27, a majority of EU Member States (19) have specific laws on mental health regulating involuntary placement or involuntary treatment of persons with mental health problems (see Annex 1). In **Belgium**, for instance, the Act on the protection of persons with mental health problems of 1990 is a civil federal law;[133] in **Denmark** it is the 1989 Act, as amended in 2006, on deprivation of liberty and other coercion which regulates this area

129 *Ibid.*, p. 3, see also: Legemaate, J. (2005).
130 *Ibid.*, p. 18.
131 *Ibid.*, p. 18.
132 See, for instance: Szmukler, G. and Dawson, J. (2011).
133 Belgium, Act concerning the protection of persons with mental health problems (*Loi du 26 juin 1990, relative à la protection de la personne des malades mentaux*), 26 June 1990.

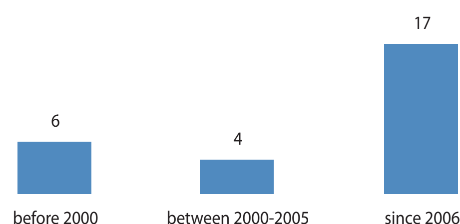
of law.[134] To take two more recent examples, in 2009 **Luxembourg** passed legislation in this field.[135] In **France**, the Law of 5 July 2011 profoundly reformed the system of involuntary placement and involuntary treatment.[136]

Eight EU Member States do not have specific mental health statutes regulating compulsory admissions and/or treatment of persons with mental health problems, instead general healthcare acts regulate these issues. The **Bulgarian** Health Act covers both placement and treatment, while in the **Czech Republic**, the Healthcare Act regulates involuntary treatment and the Code of Civil Procedure regulates involuntary placement.[137] In **Greece**, it is the Civil Code that is applicable to involuntary treatment, including involuntary placement.

The 2002 report highlighted the fact that many countries reformed their legislation during the 1990s. This trend has continued, with numerous amendments, new acts or planned reforms taking place in EU Member States since.[138] Developments in fundamental rights standards and particularly the entry into force of the CRPD triggered some of these reforms. This was the case, for example, in **Austria.** The explanatory report to the Bill amending the Compulsory Admission Act, passed in 2010, explicitly refers to the CRPD.[139] The ministerial presentation of the **French** Bill on rights and protection of persons under psychiatric care also set out, as part of the law's objectives, a better guarantee of the right to liberty of patients and refers to European standards.[140] In 2011, the **Czech** Ministry of Justice set up a working group to reform the law in the area of involuntary placement and involuntary treatment in order to enhance fundamental rights protection of persons with mental health problems.[141]

Although outside the scope of this report, reference should be made to national judicial decisions which also refer to the CRPD and which trigger legislative amendments or reform. A case in point is a 2011 **German** constitutional court decision.[142] This decision concerned compulsory treatment in forensic psychiatry as prescribed by *Länder* legislation. The constitutional court found that the relevant rule violated the German Basic Law. In reaching its conclusion, the constitutional court referred to the CRPD. According to the legal doctrine, this decision will prompt deep-seated reforms of the involuntary treatment legal framework in Germany.[143] While the decision was based on the German Basic Law, it referred as well to the CRPD. Figure 2.1 shows the date of adoption of the relevant statutes, taking into account their last significant reform, based on the table of legislation available in the Annex.

Figure 2.1: Date of EU27 adoption of legal framework, including latest significant reforms



Source: FRA, February 2012

In EU Member States with a federal political structure, specific regional acts are relevant. This is the case in **Germany** where the 16 federal states have their own laws, which in some cases differ considerably.[144] In other Member States such as **Italy** and **Spain**, regional or autonomous community acts contribute to shaping the national legal framework. Likewise, in the **United Kingdom** the Mental Health Act applies to England and Wales only. Scotland and Northern Ireland have different legal frameworks.[145]

The 2002 report addressed the question of whether national legislation specifically states the aim of compulsory placement and compulsory treatment.[146] The FRA findings show that EU Member States' legal frameworks generally define the overall aim of subjecting a person with mental health problems to involuntary placement or to involuntary treatment. The specificity of the aim varies from Member State to Member State. Placement is regularly linked to prevention of harm. For example, in **Hungary**, the aim of involuntary psychiatric treatment is to protect the patient and other persons from harm to life, health and personal integrity.[147] Similar wording is found in other countries, such as **Bulgaria**: "to

134 Denmark, Consolidated act on coercion in psychiatry (*om anvendelse af tvang i psykiatrien*), No. 1111 of 1 November 2006; see also: United Nations (UN), Committee on the Rights of Persons with Disabilities (2011d).
135 Luxembourg, Law on hospitalisation without their consent of persons with mental health problems (*Loi du 10 décembre 2009 relative à l'hospitalisation sans leur consentement de personnes atteintes de troubles mentaux*), 10 December 2009.
136 France, Law No. 2011-803 of 5 July 2011.
137 United Nations (UN), Committee on the Rights of Persons with Disabilities (2011c).
138 See for instance the various reforms in Sweden: United Nations (UN), Committee on the Rights of Persons with Disabilities (2011f).
139 Austria, BGBl. I Nr. 18/2010, 17 March 2010.
140 See parliamentary discussion preceeding the adoption of the Law No 2011-803 of 5 July 2011.
141 United Nations (UN), Committee on the Rights of Persons with Disabilities (2011c), p. 23
142 Germany, Federal Constitutional Court (*Bundesverfassungsgericht*, BVerfG), 2 BvR 882/09, 23 March 2011.
143 Marschner R. (2011).
144 United Nations (UN), Committee on the Rights of Persons with Disabilities (2011e).
145 United Nations (UN), Committee on the Rights of Persons with Disabilities (2011g).
146 Salize, H. J. et al (2002), p. 19.
147 Hungary, Healthcare Act (*1997 évi CLIV. törvény az egészségügyrõl),* 15 December 1997, Art. 191 (1) and 188; see also: United Nations (UN), Committee on the Rights of Persons with Disabilities (2010d).

treat the mental disorder and protect the disabled person and other people who might suffer the consequences of his/her psychotic behaviour."[148]

Sometimes, the objectives of the law are of a broader nature. In each of the jurisdictions within the **United Kingdom**, legislation sets out non-specific aims and provides decision makers with a variety of justifications for involuntary placement, based on one or more of the following grounds: the patient's health; the patient's welfare; and/or public protection.[149]

The delimitations of the aims are, to a large extent, reflected and mirrored in the concrete criteria for admission and treatment that are analysed in the next section.

2.2. Criteria for involuntary placement and involuntary treatment

Council of Europe Recommendation Rec(2004)10 specifies five cumulative criteria that should be met in order to subject a person to involuntary placement (Article 17 (1) Rec(2004)10, see Chapter 1, Section 1.2.2.). Aside from the therapeutic purpose, which is a criteria for involuntary placement, the other four criteria apply also to involuntary treatment (Article 18 Rec(2004)10, see Chapter 1, Section 1.2.2.). Annex 2 provides an overview of four criteria as prescribed by EU Member States' legislation. With regard to the criteria listed in Rec(2004)10, analysis of national regulation shows a heterogeneous picture.

Out of the five criteria for involuntary placement prescribed in Rec(2004)10, one is found in all national legislations: the presence of a mental health problem. The explanatory report to Rec(2004)10 adds that involuntary placement is considered appropriate to only the most severe type mental health problems.[150]

While a mental health problem is a pre-condition, it is not sufficient to justify a placement. The discussion below analyses EU Member States' legal framework in order to assess which additional criteria are found in the law. The person's condition, the risk of harm and the therapeutic purpose are first analysed (Section 2.2.1), then the existing alternatives (Section 2.2.2) and whether the opinion of the person is to be taken into account by law (Section 2.2.3).

2.2.1. The risk of harm and the therapeutic purpose

In 12 Member States, the existence of a significant risk of serious harm to oneself or others and a confirmed mental health problem are the two main conditions justifying involuntary placement. The need for a therapeutic purpose is not explicitly stipulated. This is the case, in **Austria, Belgium, Bulgaria, Cyprus,** the **Czech Republic, Germany, Estonia, Hungary, Lithuania, Luxembourg, Malta** and the **Netherlands**. In **Austria**, for instance, according to Section 3(1) of the Compulsory Admission Act (*Unterbringungsgesetz*), a person can be subjected to compulsory admission if he or she suffers from a mental health problem (*psychische Krankheit*) and therefore seriously and gravely endangers his or her health or the life of others.[151] Similarly, in **Lithuania**, besides a refusal to be hospitalised, which provides for the lack of consent, the Law on Mental Health Care requires two criteria to be fulfilled for an involuntary placement: a mental health problem and a risk of serious harm to his/her health or life or to the health or lives of others.[152]

In 13 Member States two criteria – the risk of harm *and* the need for treatment – are listed alongside having a mental health problem. This is the case in **Denmark, Greece, Finland, France, Ireland, Latvia, Poland, Portugal, Romania, Slovakia, Slovenia, Sweden** and the **United Kingdom**. In some legal frameworks, however, the need of treatment is not explicitly referred to. The notion is then more or less implied.

In many of these EU Member States, the legislation does not specify whether both criteria must be fulfilled or whether only one of them is sufficient to justify an involuntary placement. For example, in **Romania**, Article 45 of the Mental Health Law lists the following three conditions, which should be met for a lawful involuntary admission: serious mental disorder and reduced discernment; due to the mental disorder there is an imminent danger of causing injuries to himself/herself or to other persons; failure to be admitted to a psychiatric hospital would lead to a serious deterioration in health or would obstruct the administration of adequate treatment. In **Slovakia,** Article 6 (9) of the Healthcare Act provides two separate combinations of criteria to be fulfilled for the authorisation of involuntary placement to be lawful. First, a mental health problem or symptoms of a mental health problem plus the risk of danger to the person concerned and his/her vicinity;

148 Bulgaria, Health Act (*Закон за здравето*), 1 January 2005, Art. 146.
149 United Kingdom (England and Wales), Mental Health Act 1983 Sections 2(2) and 3(2). The availability of appropriate treatment is also necessary if the detention extends beyond 28 days.
150 Council of Europe, Committee of Ministers (2004a), para. 128.
151 Austria, Compulsory Admission Act (CAA) (*Unterbringungsgesetz*, UbG), BGBl 155/1990. Section 3 (2) adds as a third condition that less restrictive alternatives are not available; see also: United Nations (UN), Committee on the Rights of Persons with Disabilities (2010b), para. 162.
152 Lithuania, Law on Mental Health Care/1995, Nr. I-924, amendment 2005 (*Psichikos sveikatos priežiūros įstatymas, Žin.*, 1995, Nr. 53-1290), Art. 27.

or second, a mental health problem or symptoms of a mental health problem and the danger of a serious deterioration in the mental health status of the person concerned.

In a small number of these EU Member States, a condition relating to the need for treatment is explicitly stipulated in the legislation. This is the case, for instance, in **Denmark** where, according to Section 5 of the Act on Coercion,[153] forced hospitalisation in a mental hospital or being retained by force must only take place if the 'patient' has a mental health problem or is in a state that is similar to this because: it would be unjustifiable not to deprive the person of his/her liberty in preparation for treatment because the prospect of recovery or a significant and crucial improvement of the condition otherwise will be considerably reduced; or the person poses an immediate and essential danger to him/herself or others. Article 95 of the **Greek** Law 2071/1992, lists the following criteria: the person must have a mental disorder, the person must not be competent to reach a decision on his/her health welfare and the lack of treatment may lead to the impossibility of his/her cure or to the deterioration of his/her health. Alternatively, involuntary treatment is authorised if treatment is necessary to prevent violent actions of the person towards him/herself or third parties.

In a small group of EU Member States, the need for therapeutic treatment of the person, combined with a mental health problem, could justify involuntary placement. Legislation in these countries does not list the criteria of presenting a danger to oneself or others as a condition for involuntary placement. This is the case in **Italy** and **Spain**. In Italy, compulsory admission is possible only if: the patient requires urgent psychiatric care due to his/her mental health condition; the patient refuses to comply with any appropriate psychiatric treatment; and effective, focused, therapeutic interventions are possible only in a psychiatric in-patient facility.[154] The danger of harm to oneself or others is not a direct requirement: accordingly, no classification of danger in regard to risk levels or thresholds is mentioned. According to Article 763 (1) of the Spanish Civil Procedure Act,[155] the main criterion to be fulfilled in order to subject a person to involuntary treatment is the mental health problem of the person concerned. Article 763 of the Civil Procedure Act builds upon a clinical criterion. This means that any clinical circumstance that strongly requires the provision of treatment under hospital conditions would be sufficient to order an involuntary placement.[156]

As discussed above, an important criterion in a great majority of EU Member States is linked to the danger that a person could cause to himself or to others. The 2002 report presented a classification of the EU15 according to a definition of risk level, commenting that while some Member States require a specified level of danger, the defined thresholds are often vague.[157] The lack of precision that is to be found in many Member States' legislation seems to be linked to the fact that "risk assessment is not an exact science",[158] as the drafters of Rec(2004)10 recognised. A vast majority of Member States' legal frameworks use terms which underline that the probability of harm occurring is high, thereby covering a variety of situations. Few Member States opt for a more specific approach referring to precise situations.

A few examples will illustrate the situation. Section 5 of the **Danish** Act on Coercion in Psychiatry refers to "immediate and essential danger to oneself and others". There is no further clarification about how and against what criteria or standards the degree of 'essentiality' of the danger level should be assessed. The **Irish** Act speaks of "serious likelihood"[159] while the **Austrian** law refers to a serious and significant danger.[160] A similar situation can be found in **Spain**. In **Luxembourg**, the normal procedure – a placement upon request by a family member or a guardian – simply refers to a notion of 'danger' while, in exceptional cases, the placement can take place in situations of 'imminent danger'.[161] Similarly, the **Hungarian** Healthcare Act specifies a dividing line between dangerous behaviour and imminently dangerous behaviour. The latter represents *imminent and grave* danger which requires emergency treatment, while the former is a behaviour that could represent substantial danger, prompting mandatory treatment to be ordered.[162]

153 Denmark, Consolidated act on coercion in psychiatry (*om anvendelse af tvang i psykiatrien*), No. 1111 of 1 November 2006.
154 Italy, Law No. 833 of 23 December 1978 (*Istituzione del servizio sanitario nazional*), Art. 34 (4).
155 Art. 763 of the Civil Procedure Act was declared unconstitutional by the Spanish Constitutional Court because the Act should have been incorporated into primary, rather than secondary, law. It therefore violates Art. 17 (1) of the Constitution, which protects the right to freedom and security. See Spain, Constitutional Court Decision 132/2010 of 2 December 2010. Until the legislators amend this article and in order to avoid a legal void, however, Art. 763 is still applicable in practice.
156 The Spanish legal framework distinguishes between the two modalities and regulates them separately: involuntary placement (Article 763 of the Civil Procedure Act) and involuntary treatment (Article 9 of the Act on the Autonomy of the Patient). However, there is no legal definition of those terms. A great part of the legal doctrine assumes that the involuntary treatment is covered by the involuntary placement according to the principle *ad maiore ad minus*.
157 Salize, H. J. *et al.* (2002), p. 23.
158 Council of Europe, Committee of Ministers (2004a), para. 129.
159 Ireland, Mental Health Act 2001, 1 November 2006, Section 3.
160 Austria, Compulsory Admission Act (CAA) (*Unterbringungsgesetz,* UbG), BGBl 155/1990, Section 3 (1).
161 Luxembourg, Law on hospitalisation without their consent of persons with mental disorders (*relative à l'hospitalisation sans leur consentement de personnes atteintes de troubles mentaux*), 10 December 2009, Art. 3 and 8.
162 Hungary, Healthcare Act (*1997. évi CLIV. törvény az egészségügyről)*, 15 December 1997, Art. 188 b), 188 c), 119 and 200.

The **Dutch** Psychiatric Hospitals (Compulsory Admissions) Act does not provide a specific danger threshold, but Article 1 lists the following set of situations (not exhaustive): the possibility that the patient will kill him/herself or cause severe bodily harm; will completely ruin his/her social position and circumstances; or will seriously neglect him/herself. The list also includes the danger: that annoying behaviour by the patient will incite aggressive acts by others; that the patient will kill somebody else or will cause severe bodily harm to another person; to the mental well-being of others; or that the patient will harm a person who is under his/her care.[163] Section 1906 of the **German** Civil Code also specifically refers to a danger that the person may commit suicide or do serious damage to his/her health, without specifying the nature or immediacy of the danger.[164]

In short, the danger criterion takes various forms in EU Member States' legal frameworks. According to Rec(2004)10, involuntary measures should be proportionate; no less restrictive or intrusive alternative can be available. The extent to which Member States' legislation reflects this condition is now presented.

2.2.2. Less restrictive alternatives

Involuntary placement and involuntary treatment should be implemented when no alternatives are available. This is how the criteria of Article 17 (1) iv. and Article 18 iii. of Rec(2004)10 are explained in the Explanatory Report to the Recommendation: involuntary placement is inevitable either because it is not possible to provide the necessary care outside an institution or because alternative means are not available. Likewise, involuntary treatment should only be performed if no less intrusive means would be sufficient.[165] The 2002 report showed that in the EU15 an overwhelming majority of Member States specifically prescribed that coercive measures should be applied as a last resort.[166] In the EU27, this is still a criterion which must be met in a majority of countries before involuntary placement and involuntary treatment are permitted (see Annex 2).

In **Estonia**, for example, the law says that, next to other criteria that need to be fulfilled for placement in a social welfare institution, "the application of earlier measures has not been sufficient or the use of other measures is not possible."[167] Similarly, involuntary emergency psychiatric care is permitted, besides other criteria, if "other psychiatric care is not sufficient".[168] In **Germany**, a proportionality test of the measure is required by private and public law and has been upheld by the courts in all cases of placement and involuntary treatment. [169] Some German states' (*Länder*) laws on involuntary placement contain explicit provisions whereby the persons concerned should be provided with help specifically designed to avoid the placement. Article 39 of the **Slovenian** Mental Health Act allows for lawful detention if the described threats cannot be prevented by using other less intrusive means, such as: treatment in an open department of a psychiatric hospital, ambulant treatment or treatment under medical surveillance.[170]

In some EU Member States, this requirement is only prescribed in the context of emergency placement. The **Hungarian** Healthcare Act, for example, lists as one of the conditions of ordering emergency treatment that imminently dangerous behaviour can be averted only by committing the patient to institutional psychiatric care.[171] It is implicit in this criterion that if danger can be averted by other less intrusive means, the person should not be committed to a psychiatric institution. The law, however, does not specify what alternatives must be considered and exhausted before resorting to institutional care.

In other EU Member States, the use of less restrictive approaches applies only to involuntary treatment. Such is the case in **Malta**, where according to Section 14 (3) of the Mental Health Act the two medical practitioners applying for an involuntary treatment measure "must specify whether other methods of dealing with the patient are available and, if so, why such methods are not appropriate."[172] **Lithuania** and **Romania** have a similar legal framework.

In **Bulgaria**, **Cyprus**, the **Czech Republic**, **Greece**, **Ireland**, **Latvia**, **Slovakia** and **Spain** national legislation does not explicitly include a prerequisite of exhausting all less restrictive facilities. The law leaves the decision about whether to place someone involuntarily to the persons involved in the assessment of a person's condition.

163 Netherlands, The 1992 Psychiatric Hospitals (Compulsory Admissions) Act, Art. 1.
164 Germany, Civil Code (BGB) introduced by the *Betreuungsgesetz* (BtG) (Custodianship Act), 1 January 1992, Section 1906 (1) 1.
165 Council of Europe, Committee of Ministers (2004a), paras. 135 and 141.
166 Salize, H. J. et al (2002), p. 20.
167 Estonia, Social Welfare Act (*Sotsiaalhoolekande seadus*), 8 February 1995 as amended in 2008, Section 19 (1) 3.
168 Estonia, Mental Health Act (*Psühhiaatrilise abi seadus*), 12 February 1997 as amended in 2002, Section 11 (1) 3.
169 See, for example: Germany, Federal Supreme Court (*Bundesgerichtshof*), Judgment case no. XII ZB 236/05, 1 February 2006; see also: United Nations (UN), Committee on the Rights of Persons with Disabilities (2011e).
170 Slovenia, Mental Health Act 77/08, 28 July 2008, Art. 39.
171 Hungary, Healthcare Act (*1997. évi CLIV. törvény az egészségügyről*), 15 December 1997, Art. 199 (1).
172 Malta, Mental Health Act 1981.

2.2.3. Opinion of the patient taken into account

Coercive measures run per definition against the wish of the person.[173] Rec(2004)10, however, requires that the person's opinion be taken into consideration at several stages of the involuntary placement or involuntary treatment process. The Explanatory Report to Rec(2004)10 states clearly that during a placement measure, a "balance between respecting self-determination and the need to protect a person with mental [health problems] can be difficult and hence it is emphasised that the person's own opinion should be explicitly considered."[174] The opinion of the person must be considered both in case of involuntary placement and involuntary treatment. In any case a decision on involuntary placement should not cover a decision on involuntary treatment. They should remain separate decisions and the person's opinion should be sought in both cases.[175] The 2002 report addresses the question differently. It focuses on the informed consent that a person should give in case of involuntary treatment. In the EU15, it found that such consent was not required by law in 10 EU Member States,[176] although informed consent belongs to the essential principles advocated by the CPT (see Chapter 1, Section 1.2.2.). Informed consent contributes to the forming of an opinion, but it is slightly narrower that the general requirement of taking into consideration the person's opinion suggested by Rec(2004)10. The following analysis encompasses the two following situations as prescribed by law: the opinion of the person is taken into account by the doctor and by the judge before any formal hearing.

Many EU Member States laws refer to the persons' opinion at times with respect to involuntary placement and more often to treatment. This is the case, for example, in **Belgium, Denmark, Finland, Germany, Ireland** and **Italy**. Danish law imposes an obligation to seek to obtain the patient's consent before imposing a forced treatment measure.[177] The law stipulates that referral to a hospital ward and treatment must as much as possible be based on the patient's informed consent. This requires that the individual is provided with appropriate and individually tailored information that might help him/her to decide to accept the care voluntarily. The **Swedish**[178] and **Polish**[179] acts also require such information. In **France**, the law prescribes an obligation to seek the person's opinion on the treatment plan.[180] A similar requirement is imposed by the **Polish** Mental Health Act.[181]

A small number of EU Member States laws do not refer to the person's opinion in the course of an involuntary measure. This is the case in the **Czech Republic, Greece, Latvia, Malta**, **Slovakia** and the **United Kingdom**.

In several jurisdictions, such as in **Austria** or in **Poland**,[182] the judge who will eventually take a formal placement decision is asked to meet the individual before any hearing. Section 19 of the Austrian Act on compulsory admission requires a judge to meet with the person within four days of the beginning of a placement procedure, allowing him/her to shape a personal opinion.[183]

These sections reviewed the five key criteria to be met before subjecting a person to involuntary placement and involuntary treatment. Based on these criteria, an assessment is made and a decision to implement compulsory measures may be taken.

2.3. Assessment and decision procedures

Involuntary placement and involuntary treatment, in situations not linked to any emergency, generally follow a two-stage procedure: a risk assessment, or an observation period, is first undertaken, and then a decision confirming the placement and/or the treatment is handed down. The CPT underlined in various instances that the reasoning supporting the decision should not be stereotyped.[184] The standards for assessment and decision procedures set out in Article 20 of the Rec(2004)10 are reflected to varying degrees in the safeguards in place in EU Member States. The following analysis provides an overview of the way the assessment is carried out in normal situations as well as the actual procedure leading to a decision placement and/or treatment.

173 Council of Europe, Committee of Ministers (2004a), Art. 16.
174 *Ibid.*, para. 136.
175 See, for example: Belgium, Ministry of Health (2011), p. 3.
176 Salize, H. J. *et al.* (2002), p. 29.
177 Denmark, Administrative order no. 1499 of 14 December 2006 on compulsory treatment, forced immobilisation, forced records etc. on psychiatry ward (*om tvangsbehandling, fiksering, tvangsprotokoller m.v. på psykiatriske afdelinger*), Section 3; see also: UN, Committee on the Rights of Persons with Disabilities (2011d).
178 Sweden, Compulsory Psychiatric Care Act.
179 Poland, Law on the Protection of Mental Health, Article 23 (3).
180 France, Public Health Code, Art. L3211-2-1.
181 Poland, Law on the Protection of Mental Health, Article 33 (2).
182 Poland, Law on the Protection of Mental Health.
183 Austria, Compulsory Admission Act (CAA) (*Unterbringungsgesetz,* UbG)), BGBl 155/1990, Section 19.
184 See, for example: Council of Europe, CPT (2011), para. 189 or Council of Europe, CPT (2010b), para. 108.

2.3.1. Qualification and number of experts involved in the assessment

> **CPT**
>
> The procedure by which involuntary placement is decided should offer guarantees of independence and impartiality as well as of objective medical expertise. […] the formal decision to place a person in a psychiatric hospital should always be based on the opinion of at least one doctor with psychiatric qualifications, and preferably two, and the actual placement decision should be taken by a different body from the one that recommended it.[185]

In a small number of EU Member States, any physician can perform the medical evaluation. **Belgian** law, for example, does not provide any specifications on the training of the doctor taking the decision: he/she does not have to be a psychiatrist or neurologist, and can be the doctor giving the treatment. The CPT commented on this rule and invited the Belgian authorities to reconsider the law in order to have the assessment performed by a trained psychiatrist.[186] Similarly, in **Slovakia**, the law does not explicitly require the physician preparing the medical evaluation to have any specific expertise in psychiatry. In **Luxembourg**, the request to have a person admitted should be accompanied by a medical certificate from a physician (*médecin*) who is not a member of staff of the admitting hospital's psychiatric ward.[187] In 2009, just before the legislative reform in Luxembourg, the CPT expressed some concerns about the lack of specialisation in psychiatry of the doctor performing the initial assessment.[188]

In the majority of EU Member States, however, the law provides that, in the regular procedure, only medical professionals with recognised qualifications and experience in psychiatry are qualified to perform the examination and prepare the medical assessment report. One example is **Romania**, where a "competent psychiatrist" makes a decision which is ultimately confirmed by a revision commission (*comisia de revizie*) formed of three members appointed by the hospital director – two psychiatrists, "if possible others than the one who took the decision in the first place," and one doctor of another specialty or a representative of civil society.[189]

Different situations can occur where both a generalist and a psychiatrist intervene in the assessment procedure. These situations are linked to the fact that EU Member States' laws often prescribe a phase where a request for involuntary placement and/or treatment is made by medical doctors that can be generalists. In **Austria**, for example, the preliminary assessment is made either by a doctor in the public health service or by a police doctor. They draft a certificate explaining why they believe the conditions for involuntary placement are fulfilled. However, it is the report prepared by the head of the psychiatric department, drafted after an examination of the person concerned, which authorises the placement.[190] In the **United Kingdom** (England and Wales), the application for placement is made by "two registered medical practitioners",[191] one of whom must be a trained psychiatrist.[192]

The decision process is regulated even further in some countries. In **Ireland**, a Mental Health Tribunal sits with a panel of three, composed of a consultant psychiatrist, a barrister or solicitor with at least seven years' experience in practice, and a layperson who cannot be a doctor or a nurse.

Another important standard which serves as a safeguard against arbitrary decisions is the number of expert opinions sought to authorise the involuntary placement as well as their independence from the institution where the person will be placed. This latter aspect is often reiterated in CPT reports.[193] While keeping this crucial aspect in mind, the next section analyses national legal provisions for the number of experts involved in the assessment procedure prior to the decision on involuntary admissions.

In nine EU Member States one expert opinion issued by a medical professional fulfils the legal requirement concerning the assessment of an individual's psychiatric condition. This is the case in **Belgium**, **Bulgaria**, the **Czech Republic**, **Germany**, **Denmark**, **Estonia**, **Luxembourg**, **Netherlands** and **Poland**. Whereas in some countries the deciding authority – in the majority of Member States, the court (see Section 2.3.2) – could require an additional opinion or appoint an additional independent expert, this protection measure is optional. In the **Netherlands**, for instance, the judge receives information from the patient's therapist (e.g. psychiatrist, psychologist, general practitioner) and in specific cases may appoint an additional independent expert. Similar provisions can be found in other domestic laws.

185 Council of Europe, CPT (2010g), para. 73.
186 Council of Europe, CPT (2010a), para. 205.
187 Luxembourg, Law on hospitalisation without their consent of persons with mental health problems (*relative à l'hospitalisation sans leur consentement de personnes atteintes de troubles mentaux*), 10 December 2009, Art. 9.
188 Council of Europe, CPT (2010b), para. 104.
189 Romania, Mental Health Law (Law 487/2002), Art. 52.
190 Austria, Compulsory Admission Act (CAA) (*Unterbringungsgesetz*, UbG), BGBl 155/1990, Sections 8 and 10.
191 United Kingdom, Mental Health Act 1983 c.2 0, ss 2(3), 3(3).
192 *Ibid.*, c.20, s145(1) as amended by the Mental Health Act 2007.
193 See, for example: Council of Europe, CPT (2010c), para. 61; Council of Europe, CPT (2009a), paras. 137-138; Council of Europe, CPT (2010d), paras. 44 and 46.

Almost half of the EU Member States require two expert opinions (medical certificates). Another four countries provide for a commission or the separate opinions of three or more 'doctors'. These can be seen as a crucial step to ensuring the impartiality of the medical opinion and preventing arbitrary decisions. As an example, in **Sweden**, the judgment as to whether the compulsory treatment certificate will be executed is the first step in a two-physician assessment regarding the need for compulsory care. The involuntary treatment order must be based on a treatment certificate issued by a physician other than the one deciding to admit the patient. The decision regarding admission is to be taken by the chief physician/psychiatrist at the facility where the patient will be treated. Furthermore, the administrative court reviews all compulsory admissions, and always has an independent specialist in psychiatry assess the patient.[194]

In **Finland**, **France**, **Ireland**, **Latvia**, **Lithuania** and **Romania**, the law requires more than two medical opinions. According to Section 1(6) of the **Latvian** Medical Treatment Law, a "doctors' council" is convened, which is defined as "a meeting of not fewer than three doctors in order to determine a diagnosis and the further tactics of medical treatment." Similarly, in **Finland**, in the process of ordering a person to be involuntarily treated on the basis of the Mental Health Act, the assessments of three independent physicians are decisive. Opinions are sought from: the referring physician, the physician in the hospital giving the treatment and the physician in charge of the hospital. In addition, when a person has been referred to observation, and before the observation has begun, a physician considers whether the requirements for involuntary treatment are likely to be met.[195] According to the Finnish authorities, the number of physicians involved (up to four) properly secures the patients' rights.[196] In **France** and **Lithuania**, two psychiatrists and one doctor contribute to the assessment: in France, a medical doctor performs, within the first 24 hours of observation, a physical examination;[197] in Lithuania, the doctor represents the mental health facility's administration.[198]

2.3.2. Authorities or persons authorised to decide on an involuntary placement

The intervention of a judge or another competent body is stated in all the standards developed at the Council of Europe level (see Section 1.2.2.). The Explanatory Memorandum to Rec(2004)10 clarifies that "the underlying principle is that a party that is independent of the person or body proposing the measure takes an independent decision" regarding involuntary placement.[199] The Council of Europe Recommendation does not exclude that the decision be taken by a doctor.[200] Both solutions – decision by a judge or decision by a doctor – are found in EU Member States' legislation.

In a large majority of EU Member States, the final decision is taken by a non-medical authority. There are different steps in the decision process. It usually starts with a medical certificate prepared by one or more medical professionals (see Section 2.3.1.). Based on the certificate, a judicial or quasi-judicial body decides on the placement.

In most EU Member States the involuntary placement decision under a regular admissions procedure is decided by a non-medical body, generally a court. In the 2002 report, the laws of 10 EU Members States of the then EU15 had this requirement. In the EU27, 21 Member States follow this approach. To give just a few examples: in **Belgium**, the decision on observation is made by a judge following a request from any interested party.[201] After the director of the institution sends the judge a report by the medical head of department, the judge takes a decision on extending the stay. In urgent cases, the public prosecutor decides, after which, and within 24 hours, he/she informs the judge.[202] In the **United Kingdom**, depending on the jurisdiction, the decision is not always a judicial one but always remains outside the scope of the medical authority and is taken by other independent authorities. In England and Wales, involuntary placement can be initiated by the "nearest relative" of the person to be detained.[203] The second possibility, which applies in the vast majority of cases, is that the decision is made by an "Approved Mental Health Professional". In order to be an Approved Mental Health Professional, a person must be one of the following: a social worker; a nurse with practical experience in mental health; a learning disability nurse; an occupational therapist; or a chartered psychologist.[204] That person must also have undertaken a government-approved course of training. A similar system applies in Northern Ireland, with the exception that the application of admission for assessment can be made only by the nearest relative or a social worker, and no other professional. In Scotland, all applications must be heard by the Mental Health Tribunal. The tribunal has

194 Sweden, Compulsory Psychiatric Care Act, Sections 4 to 13.
195 Finland, Mental Health Act, Section 9 (3).
196 Council of Europe, CPT (2009b), p. 53.
197 France, Public Health Code, Art. L. 3211-2-2. See also: Council of Europe, CPT (2012) para. 178.
198 Lithuania, Law on Mental Health Care/1995, Nr. I-924, amendment 2005 (*Psichikos sveikatos priežiūros įstatymas, Žin.*, 1995, Nr. 53-1290), Art. 16.

199 Council of Europe, Committee of Ministers (2004a), para. 151.
200 *Ibid.*, Art. 20 (2).
201 Belgium, Act concerning the protection of persons with mental health problems (*Loi du 26 juin 1990, relative à la protection de la personne des malades mentaux*), 26 June 1990, Art. 5.
202 *Ibid.*, Art. 9.
203 United Kingdom, Mental Health Act 1983, c.20, Section 11 (1).
204 United Kingdom, Mental Health (Approval of Persons to be Approved Mental Health Professionals) (England) Regulations 2008 SI 1206/2008, reg 3 (1) and schedule 1.

powers[205] to make various compulsory orders including involuntary placement and the provision of medical treatment. A Tribunal is made up of three persons, one of whom will be a lawyer, one a doctor and one a "general member".[206] The "general member" must have relevant training, skills or experience in dealing with mental disorder, and Regulations[207] provide that this person must be one of the following: a registered nurse, a clinical psychologist, a social worker, an occupational therapist, or another person employed in the care sector. In any case, the person concerned must have experience either as a service user or as a service provider.[208]

In **Luxembourg**, a specially-appointed judge in the district where the person is located decides on involuntary placement.[209] Each judicial district has a judge who is charged with monitoring the admission of persons to medical care facilities taking decisions related to keeping the persons under observation or releasing them, and who monitors possible future admission or placement. The judge is empowered to request reports from and hear anyone deemed necessary for a sufficiently clear understanding of the situation on which to base the decision.

In a few EU Member States the final decision remains a medical one. For example, in **Malta**, the decision is taken by the manager of the psychiatric hospital;[210] and in **Romania** by the "medical authority".[211] The **Finnish** Mental Health Act stipulates that the final decision on involuntary treatment – which requires involuntary placement – of a person after the initial four-day observation period must be taken by the hospital's leading psychiatrist. This decision is valid for three months. For a further extension, which is valid for up to six months, a second decision is taken, which is immediately subjected to confirmation by the administrative court.[212] In 2011, the Committee Against Torture (CAT) in its Concluding Observations with regard to Finland criticised the Finnish procedure and recommended reform of the Mental Health Act.[213] Psychiatrist or medical practitioners also take placement decisions in **Denmark**, **Ireland** and **Sweden**.

2.3.3. Mandatory hearing of the person

The 2002 report analysed the mandatory hearing of the person, specifically focusing on their presence (or representation) during hearings before a judge. In the EU15, 12 Member States' laws prescribed such hearing.[214] Rec(2004)10 also recommends that the judge takes into account the opinion of the person in the context of both an involuntary placement and an involuntary treatment procedure.[215]

The vast majority of EU Member States' laws require the person's presence at the hearing that will decide on their involuntary placement. This obligation can be of constitutional nature, like in **Germany**,[216] or reiterated in the specific legislation. In **Estonia**, for example, the person subject to possible involuntary placement must be heard before the court decision.[217] The Supreme Court has on numerous occasions said that courts must do everything possible to ensure that the interested person is present at the court hearing. The court must be active in determining the ability of the person to participate in court hearings and in guaranteeing the person's participation in court proceedings the object of which is to determine restrictions on his or her rights. The courts should "achieve the maximum possible level of certainty" in deciding whether the person concerned should personally attend the hearing or not.[218] Moreover, the court must provide objective and documented reasons for not hearing the person concerned in person. A similar obligation is prescribed by **Cypriot** law. However, the CPT noted that, in practice, the patient was virtually never present at the court hearing. Instead, the personal representative was often a family member and was indeed the same person who had requested the hospitalisation.[219]

In several EU Member States, the person might not be heard in formal hearing. For example, in the **Czech Republic**, the court takes the opinion of the patient but in the context of the formal decision, if it is decided that the person is deemed unable to participate in the proceedings, the initial placement decision can be taken in his/her absence.[220] In **Latvia**, a person has the right to be heard at review procedures if a judge considers it 'possible'.[221] The CPT commented on this suggesting

205 United Kingdom, Mental Health (Care and Treatment) (Scotland) Act 2003, asp. 13, s66.
206 *Ibid.*, asp. 13, Schedule 2, para 1.
207 United Kingdom, Mental Health Tribunal for Scotland (Appointment of General Members) Regulations 2004 SSI 2004 No. 375, 21 September 2009.
208 *Ibid.*, reg2(1)(a).
209 Luxembourg, Law on hospitalisation without their consent of persons with mental health problems (*relative à l'hospitalisation sans leur consentement de personnes atteintes de troubles mentaux*), 10 December 2009, Article 13.
210 Malta, Mental Health Act, Section 16(1).
211 Romania, Mental Health Law (Law 487/2002), Art. 52.
212 Finland, Mental Health Act, Section 10.
213 United Nations (UN), Committee against Torture (2011), para. 11.
214 Salize, H. J. et al (2002), p. 25.
215 Council of Europe, Committee of Ministers (2004a), Article 20 (1) i.
216 Germany, Basic Law (*Grundgesetz*), Art. 103 (1).
217 Estonia, Code of Civil Procedure (*Tsiviilkohtumenetluse seadustik*), 20 April 2005, §536(1).
218 See, for example: Estonia, Supreme Court (*Riigikohus*/3-2-3-14-05), 19 December 2005, para. 10; Estonia, Supreme Court (*Riigikohus*/3-2-3-10-05), 26 September 2005, para. 12; Estonia, (*Riigikohus*/3-2-3-11-05), 12 September 2005, para. 8; Estonia, (*Riigikohus*/3-2-3-8-05), 8 June 2005, para. 9.
219 Council of Europe, CPT (2008), para. 119.
220 Czech Republic, Civil Procedure Code (*Zákon č. 99/1963 Sb., občanský soudní řád*), Art. 191d (3).
221 Latvia, Medical Treatment Law (*Ārstniecības likums*), 26 February 1998, Section 68 (9).

to strenghthen the right to be heard of the person by a judge.[222] **Italian** law does not stipulate that the person needs to be heard. The hearing may take place before a guardianship judge and a tribunal, who are entitled to make any enquiry deemed necessary. [223]

2.3.4. Authorities or persons authorised to decide on termination of the measure

CPT standards

Involuntary placement in a psychiatric establishment should cease as soon as it is no longer required by the patient's mental state.

In the majority of EU Member States, the termination of an involuntary placement is initiated by the treating doctor. For example, Section 11 of the **Danish** Act on Coercion in Psychiatry stipulates that when the conditions for the coercive treatment are no longer present, involuntary placement must be terminated. This must happen regardless of whether or not the patient has initiated the decision by submitting a request to be discharged. As part of the review procedure the head doctor must establish that the conditions legitimising the involuntary placement are still met at the following intervals: three, 10, 20 and 30 days after involuntary detention and henceforth at least every 4 weeks.[225] In the **Czech Republic**, the institution is entitled to release the patient at any time, independently of the court order setting a specific time frame, if the situation changes.[226]

In many Member States termination of a compulsory placement or treatment is the result of collaboration between the medical staff and the court. In **Hungary** for example, the court generally decides on the termination of treatment. However, according to Article 199 (9) and Article 200 (8) of the Healthcare Act, the patient must be released from the institution if his/her mandatory treatment is no longer justified.[227] This gives authority to the institution's director to release the patient anytime between the mandatory court review hearings, if the treating doctors decide that the patient no longer needs to be treated in the institution. Article 763 (4) of the **Spanish** Civil Procedure Act likewise regulates the termination of involuntary placement as a medical decision, which should immediately be notified to the competent court. A similar provision is found in Article 99 (1) of the **Greek** Law 2071/1992 and Article 71 of the **Slovenian** Mental Health Act 77/08.

In **Germany**, there are different legal acts regulating involuntary placement and, likewise, different provisions can be found with regard to the termination of compulsory admissions. Involuntary placements under public law are terminated or revoked by the same court that originally ordered the placement. In many federal states placement ends automatically if it was ordered for a limited period of time and the court did not extend the time period before it elapsed. In private law placements under Article 1906 (3) Civil Code, placement must be terminated by the custodian as soon as the criteria for the placement no longer apply. In such cases the custodian merely informs the court about the termination of placement. The court rules only if it learns that the custodian has not fulfilled his/her obligation to terminate the placement. The court decides to terminate involuntary treatment only when it has been called on to do so.

In another group of EU Member States, only non-medical authorities can decide on the termination of involuntary placement. In the case of **Bulgaria** and **Estonia**, for example, this is the court. In **Italy**, where the mayor decides on involuntary placement, he/she also decides on the termination of compulsory medical treatment and its modification.[228] In **France**, Article L. 3211-12 of the Public Health Code stipulates that a judge may decide to terminate an involuntary placement at any time, either following a request to do so or based on information he has received. Section 31 of the **Austrian** Act takes a similar approach.[229]

In sum, independently of the deciding authority, EU Member States' laws follow Article 24 (1) Rec(2004) which states that: "involuntary placement or involuntary treatment should be terminated if any of the criteria for the measure are no longer met."

An overview of key procedural safeguards concludes this comparative overview.

222 Council of Europe, CPT (2009c), para.132.
223 Italy, Law no. 833/1878, 23 December 1978.
224 Council of Europe, CPT (2010f), para. 56.
225 Denmark, Consolidated act on coercion in psychiatry (*om anvendelse af tvang i psykiatrien*), No. 1111 of 1 November 2006, Section 21, Sub-section 2.
226 Czech Republic, Civil Procedure Code (*Zákon č. 99/1963 Sb., občanský soudní řád*), Art. 191e (2).
227 Hungary, Healthcare Act (*1997. évi CLIV. törvény az egészségügyről*), 15 December 1997, Art. 199 (9) and 200 (8).
228 Italy, Law no. 833/1878, 23 December 1978, Art. 33, paras. 3 and 8.
229 Austria, Compulsory Admission Act (CAA) (*Unterbringungsgesetz,* UbG), BGBl 155/1990, Section 31z.

2.4. Review and appeal of institutionalisation

Procedural safeguards constitute crucial guarantees against abuse. A complete analysis would require a discussion on several laws that organise national systems of review. The following developments focus on two key elements which exemplify the importance given to procedural safeguards in Member States: free legal support and the right to appeal against involuntary placement and involuntary treatment decisions.

2.4.1. Free legal support

Proper legal support is directly linked to effective access to justice. This is made clear by Article 47 (3) of the Charter of Fundamental Rights of the European Union and has been confirmed on numerous occasions by ECtHR case law.[230] Article 25(3) of the Rec(2004)10 sets out States' obligations to provide legal assistance for the review and appeal of institutionalisation, providing that "[w]here the person cannot act for him or herself, the person should have the right to a lawyer and, according to national law, to free legal aid". The 2002 report concludes that a small majority of Member States – eight – in the EU15 provided legal aid to persons with mental health problems.[231]

The FRA findings show that this requirement is reflected in the vast majority of EU Member States' laws, which provide for free legal support either in certain circumstances or automatically. In addition, in several Member States, comprehensive legal aid provisions require that a lawyer be automatically appointed (see for example **Belgium**, **Bulgaria**, **Hungary**, the **Netherlands** or **Slovenia**).[232]

If the free legal aid provision is not automatic, it is linked to the persons' ability to pay. For example, in **Cyprus**, the Law of Psychiatric Treatment of 1997 states that the court may, if it deems it necessary and bearing in mind the financial circumstances of the patient, order that the expenses of both the patient's lawyer and the patient's psychiatrist be paid out of public funds.[233] Similarly, in **Poland**, the Law on Protection of Mental Health does not provide free legal support to the person concerned in each case. The law says, however, that if the court considers participation of a lawyer is required it is allowed to grant free legal aid.[234]

In other countries, the provision of free legal support is determined by whether or not the person subject to involuntary placement chooses his/her own legal representative for the review or appeal process, or whether he/she relies on a state-appointed attorney. This is the case in the **Czech Republic** and **Denmark**, where the state covers the cost of representation in the case of court-appointed attorneys, but not in situations where a person has chosen their own representative.[235] A similar regulation can be found in **Ireland**,[236] **Latvia**[237] and **Lithuania**,[238] where a person receives free legal assistance if he/she does not have a legal representative.

2.4.2. Review and appeal concerning lawfulness of involuntary placement and/or involuntary treatment

Article 25 of Rec(2004)10 requires EU Member States to ensure that persons subject to involuntary placement or treatment can: appeal against a decision; have the lawfulness of the measure, or its continuing application, reviewed by a court at reasonable intervals regardless of whether the person, their lawyer, or their representative requests such review; and be heard in person or through a lawyer or representative at such reviews or appeals. The 2002 report analysed this under the right to complaint procedure and concluded that all EU15 provided such safeguards.

In a great majority of EU Member States, domestic legislation in the area of mental health provides for an appeal against an involuntary placement decision. In **Luxembourg**, patients can appeal their placement at any time by requesting their release before the district court in the area where the establishment is located. Other interested parties can also petition the court for an appeal.[239] Under **Dutch** law, a 'patient' may ask a judge (in cases of involuntary placement) or a complaint committee (in cases of involuntary treatment) to end the placement or treatment. The decision of both the judge

230 See on legal aid: FRA (2011b), p. 47 ff.
231 Salize, H. J. *et al.* (2002), p. 35.
232 Belgium, Act concerning the protection of the person of the mentally ill (*Loi relative à la protection de la personne des malades mentaux*), 26 June 1990, Art. 7 (1); Bulgaria, Health Act (*Закон за здравето*), Art. 158 (4); Hungary, Healthcare Act (*1997. évi CLIV. törvény az egészségügyről*), 15 December 1997, Art. 201 (4); Netherlands, The 1992 Psychiatric Hospitals (Compulsory Admissions) Act, Art. 8 (3); and Slovenia, Mental Health Act 77/08, 28 July 2008, Art. 31 and 68.
233 Cyprus, Law No. 77(1) of 1997, Providing for the Establishment and Operation of Psychiatric Centres for the Care of Mentally-Ill Persons, the Safeguarding of such Persons' Rights and the Determination of Duties and Responsibilities of Relatives, Art. 10 (1) (h).
234 Poland, Law on the Protection of Mental Health, Art. 48.
235 Czech Republic, Civil Procedure Code (*Zákon č. 99/1963 Sb., občanský soudní řád*), Art. 191g; Denmark, Administration of Justice Act, Section 470, Subsection 2.
236 Ireland, Mental Health Act 2001, 1 November 2006, Section 17 (1) (b).
237 Latvia, Medical Treatment Law (*Ārstniecības likums*), 26 February 1998, Section 68 (7) and 68.
238 Lithuania, Law on Mental Health Care/1995, Nr. I-924, amendment 2005 (*Psichikos sveikatos priežiūros įstatymas, Žin.*, 1995, Nr. 53-1290), Art. 28.
239 Luxembourg, Law on hospitalisation without their consent of persons with mental health problems (*relative à l'hospitalisation sans leur consentement de personnes atteintes de troubles mentaux*), 10 December 2009, Art. 30.

and the complaint committee may be appealed by the patient to a higher court.[240]

In several EU Member States, national legislation defines a timeframe in which the appeal must be lodged. In many cases, this is matched by a specification on how quickly the appeal body must give its decision on the lawfulness of the placement order. In **Spain**, for example, a *habeas corpus* procedure to contest the lawfulness of a deprivation of liberty as a result of involuntary placement in a public psychiatric clinic can be instituted with the examining judge competent in the area where the medical centre is located. The judge must decide within 24 hours. Recognition of *habeas corpus* does not, however, necessarily imply an annulment of the measure, but may instead entail moving the patient to another medical centre which is more appropriate.

In almost all EU Member States, the law contains specific provisions to have the lawfulness of the measure, or its continuing application reviewed by a court at reasonable intervals. In **Ireland**, for example, Mental Health Tribunals review detention orders. These reviews happen in all cases where the decision to detain a person involuntarily occurs or where there is a renewal of an order of involuntary detention. Section 18(1) (a) of the Mental Health Act 2001 provides that if the Tribunal is satisfied that the patient is suffering from a mental health problem, it can confirm the order. Should that not be the case, under Section 18 (1) (b), the Tribunal can revoke the order and direct the patient to be discharged. In **Greece**, Article 99, paragraph 2 of Law 2071/1992 states that involuntary treatment cannot exceed six months. The necessity of the involuntary treatment is reviewed after the first three months by the public prosecutor, who receives a new psychiatric evaluation of the person. Based on this evaluation, the prosecutor may apply to the court of first instance to continue or terminate the involuntary treatment.

There are significant differences between Member States in the regularity of reviews prescribed by law. Independent of review processes, most legal frameworks prescribe a possibility for immediate suspension of the measures in case of a change in situation. Then, initial reviews of involuntary placement or treatment take place after a short period of time. Once the initial review has confirmed the placement measure, a timeframe for regular review of the decision is prescribed. In some Member States regular reviews of placement measures take place every three months (**Bulgaria**,[241] **Portugal**[242]), every six months (**Finland**,[243] **France**,[244] **Latvia**,[245] **Lithuania**[246]), after one year (**Estonia**,[247] **Slovenia**[248]), or after two years (**Belgium**,[249] **Luxembourg**[250]).

This discussion has highlighted only some of the key procedural safeguards in place in Member States' legislation. They are crucial since they limit the measure of coercion to what is strictly necessity.

This chapter analysed the legal frameworks in place across the 27 EU Member States with regard to involuntary placement and involuntary treatment. The chapter highlighted that the existing standards regarding assessment and decision procedures for involuntary placement and involuntary treatment are reflected in the safeguards in place in EU Member States to varying degrees. The next chapter will present evidence of the lived experience of persons with mental health problems related to involuntary placement or treatment, seclusion and restraint, and challenging the lawfulness of detention. These descriptions of individual experiences were gathered during FRA fieldwork research in nine EU Member States and are not intended to be representative of the current situation either in the Member States themselves or across the EU as a whole.

240 Netherlands, 1992 Psychiatric Hospitals (Compulsory Admissions) Act, Art. 49.

241 Bulgaria, Health Act (*Закон за здравето*), 1 January 2005, Art. 164, para. 3.
242 Portugal, Law on mental health 36/98, 11 July 2002, Art. 35.
243 Finland, Mental Health Act.
244 France, Public Health Code, Art. L3211-2-1.
245 Latvia, Medical Treatment Law (*Ārstniecības likums*), 26 February 1998.
246 Lithuania, Law on Mental Health Care/1995, Nr. I-924, amendment 2005 (*Psichikos sveikatos priežiūros įstatymas, Žin., 1995, Nr. 53-1290*), Art. 28.
247 Estonia, Code of Civil Procedure (*Tsiviilkohtumenetluse seadustik*), 20 April 2005, Art. 539 (1).
248 Slovenia, Mental Health Act 77/08, 28 July 2008, Art. 70 (3).
249 Belgium, Act concerning the protection of persons with mental health problems (*Loi relative à la protection de la personne des malades mentaux*), 26 June 1990, Art. 14.
250 Luxembourg, Law on hospitalisation without their consent of persons with mental health problems (*relative à l'hospitalisation sans leur consentement de personnes atteintes de troubles mentaux*), 10 December 2009.

3

Personal accounts – evidence from fieldwork research

The complex issues of involuntary placement and involuntary treatment require a better and deeper understanding of people's actual experiences. With this in mind, the FRA carried out in depth qualitative fieldwork research with persons with mental health problems and selected stakeholders with relevant expertise and experience.[251] This research provides a snapshot of the experiences of persons with disabilities of living independently and participating in community life. The research covered a broad range of issues which are presented in the FRA report *Choice and control: the right to independent living – Experiences of persons with intellectual disabilities and persons with mental health problems in nine EU Member States*.

This section draws from the results of this research focusing on the experiences of persons with mental health problems[252] regarding involuntary placement and involuntary treatment. Persons with intellectual disabilities interviewed in the course of the research also had experience of institutions, often for long periods and apparently with little choice over their placement, but their institutionalisation did not involve involuntary treatment. Moreover, the legal provisions and standards discussed in the previous sections of this report apply mainly to persons with mental health problems, making their experiences more relevant in this context.

The fieldwork was carried out using individual semi-structured interviews and focus groups with 115 persons with mental health problems in nine EU Member States (Bulgaria, France, Germany, Greece, Hungary, Latvia, Romania, Sweden and the United Kingdom) between November 2010 and July 2011. Additional focus group interviews were conducted in each EU Member State with selected stakeholders with relevant expertise and experience relating to persons with mental health problems, such as representatives of relevant organisations or bodies with an interest in the topics studied. The organisations represented varied between EU Member States and, wherever possible, included: a representative of a user-led organisation or group, representatives of government departments, representatives of ombudsman offices or national human rights institutions, and representatives of relevant professional bodies, such as psychiatrists and social workers. At a two-day peer review meeting in Vienna, organisations and groups representing persons with mental health problems and persons with intellectual disabilities from the EU Member States covered by the research discussed the initial results of the fieldwork research.

The qualitative nature of the research required the selection of a small sample of individuals, which was not intended to be representative of the total population of persons with mental health problems. Moreover, as none of the respondents lived in long-term stay institutions at the time of the interviews, all of the events relating to such institutions occurred in the past and many took place several decades ago.

The following sections (3.1. to 3.4.) provide an overview of interviewees' responses. These do not exactly parallel the report's earlier legal analysis, because the respondents do not categorise their experiences in this way. Nonetheless, the participants addressed many of the key legal issues presented while relating their experiences on such topics as: the process involuntary placement and treatment, consultation and informed consent, seclusion and restraint, and challenging the

251 For more detailed information on the methodology used in the fieldwork element of the FRA project *The fundamental rights of persons with mental health problems and persons with intellectual disabilities*, including an analysis of methodological challenges and limitations, see FRA (2012).

252 Persons with mental health problems will be referred to in the following sections as 'research participants' or 'interviewees' interchangeably to avoid repetition.

lawfulness of involuntary placements and treatments. Their answers help contextualise the legal framework offering an inside view of how the legal system affects those on the ground and providing input into how safeguards might be further strengthened.

3.1. Involuntary placement

Most of the research respondents with mental health problems had previous experience of living or being treated in institutions, either in long-term care homes or psychiatric facilities, frequently on an involuntary basis. In Germany and Hungary all the respondents had previously stayed for long periods in psychiatric hospitals. In Bulgaria, Greece, France, Latvia, Romania and the United Kingdom, more than half of the interviewees had experienced institutional living in one form or another. Some of their experiences were recent, but others referred to events that took place in previous decades, which did not necessarily reflect the current situation.

3.1.1. Experiences of involuntary placement

Respondents frequently spoke of their own involuntary admission to hospital in past years as a negative and frightening experience and pointed to the lack of control they felt they had over their situation. Others complained of a lack of information and an atmosphere of violence. Few respondents recalled positive experiences. This may, however, reflect the fact that much of the evidence refers to the moment of compulsory detention rather than to the entire period of hospitalisation more generally. Respondents also referred to voluntary placements, indicating that they sometimes felt hospitalisation to be useful and necessary, provided their participation in the decision-making process about treatment was ensured.

Respondents described their involuntary placement as a traumatic experience, one in which they felt caught up in a "machine" that they could neither influence nor stop:

"There was one word said against my mother and suddenly the machinery was in motion and I didn't have a chance."

Man, 56, Germany

Other respondents echoed such feelings of lack of control. One woman, now 55 years old, recounted how she was driven at the age of 28 to a psychiatric clinic by her father, sister and a psychiatrist family friend, forcibly given an injection immediately and locked in an isolation room. The lack of explanation or discussion of what was happening and why exacerbated her fear and confusion, she recalled.

Others also mentioned the lack of information. When asked whether she had been informed of her rights at the moment of involuntary placement, one woman replied:

"Absolutely not. That is the biggest criticism I would make. The way the psychiatrist threatened me was as good as a straitjacket. [...] It was really threatening. The psychiatrist was threatening."

Woman, 65, France

In Latvia, several respondents said that they did not receive any explanation about where they were being taken during the journey to the psychiatric hospital.

Respondents pointed to an atmosphere of violence as well as a lack of information:

"It was extraordinarily violent there. I was totally destroyed and shocked [...] they didn't leave me a choice, and they didn't explain anything to me [...] [I would describe it as] an arrest [...] And I didn't like my psychiatrist as he wanted to treat me but I wanted freedom."

Woman, 65, France

Nevertheless, some interviewees said that in retrospect their involuntary placement might have been necessary, and one respondent said that compulsory placement was advisable, in principle. He also observed, however, that clinic admissions could have been avoided throughout his psychiatric history:

"The judge was there and the whole thing went to the police two or three times, I certainly experienced coercion enough, but looking back I would have been unstoppable with my temper. But my previous history – if they'd looked more closely then I wouldn't have ended up in the clinic under the circumstances."

Man, Germany

Being consulted and listened to

Few respondents said that they had been consulted or that their opinion was taken into account, either in advance of being involuntarily placed or during the process of placement itself. In Romania, some said that they had recently been asked to sign a document in very small print upon admission, but that they were not given much information on its content. A number of respondents noted that medical staff did not distinguish between consent to admission and consent to drug treatment.

Several respondents recalled having been involuntarily placed by their own families. One woman described her first hospitalisation in 1996 when she was 50. Without previously discussing a possible clinic admission with her, her husband and daughter drove her to a psychiatric clinic to see a doctor:

"It was not voluntary at all! Then there was a problem. I had the impression of a funnel. I think that it was the doctors who asked the family. I felt like I was being swallowed up in a funnel. And I met the psychiatrist who said to me: give your car keys to your daughter and go up. I'm hospitalising you."

Woman, 65, France

Another explained:

"In 2002, I was hospitalised in [...] [public hospital]. My mother and my stepfather requested my hospitalisation with a court order. I reacted to their decision. In 2004, I was voluntarily hospitalised because my condition regressed."

Greece

Being adequately consulted was seen as especially important given that the person placed has little power to influence the placement:

"A lot of people who treat you and accompany you along the way aren't completely aware of how important the roles of power and powerlessness are in relationships and the role identity of professionals is often abused to wipe out any objection, any patients' concerns, however justified they may be."

Germany

In contrast, where initial treatment by staff was good and the appropriate information was supplied, the experience of admission was much more favourable. A 22-year-old man who was taken to hospital in Latvia said that he did not want to stay in the hospital initially, but ended up signing the consent form, because he was treated well in the admissions department and the staff explained where he was and why he was there.

3.1.2. Experiences of 'voluntary' placements without choice and control

Respondents were often unaware of possibilities to challenge their hospital admission, for example the right to refuse to be admitted as inpatients. Such experiences were relayed by Hungarian respondents, as well as by a number of Latvian respondents who had been hospitalised since 2005, suggesting that this remains an issue. This raises questions about how much choice is really available when admission is technically voluntary, but in practice there is little choice or opportunity to refuse it.

Lack of awareness of opportunities to refuse to be admitted or to challenge an admission often resulted from the unavailability of accessible information. In the words of a woman who did not know, for quite some time, that she was in a hospital and was being treated without her consent:

"No, no one said anything to me about where I was or why I was there, I did not know a thing. And I spent a whole year in that hospital."

Woman, 47, Latvia

In addition to being given information at the time of admission, respondents from the United Kingdom suggested that it would have been helpful if someone, about a week after admission when the newly admitted were more stable emotionally, had taken the time to explain clearly what was happening and why they were there, as well as their rights and entitlements, such as the right to refuse consent.

All Romanian respondents who were asked to provide consent had done so. Most of them said, however, that they had not been asked to give their consent to admission. In cases where consent was sought, respondents did not generally remember having been provided with accessible information or explanation of what this meant, or of the possibility of challenging what was happening to them.

A number of respondents, in other countries, said that their doctors insisted that they sign the consent forms, warning them that their refusal might result in unsuccessful or potentially damaging legal proceedings. A respondent referring to a placement in 2009 said:

"I was given the choice between agreeing and signing and spending some time here and taking some medication, or staying for longer until the court hearing and being medicated anyway and then having the court order me to stay anyway and be medicated. I chose the lesser of two evils."

Man, 23, Latvia

3.1.3. Opportunities to exercise choice and control over stays in hospital or other establishments

Opinion was divided among respondents about whether time spent in hospital could be beneficial. Many respondents held very negative views about psychiatric hospitals and said clearly that they would not choose to

return to one. These views were often linked to previous experiences within psychiatric hospitals, which had persuaded them that such experiences were harmful, rather than helpful to recovery. According to one woman who was involuntarily readmitted a year after voluntarily deciding to receive treatment in a psychiatric hospital:

"I [...] knew that nothing good could be expected there. I hated it there and I did not want to go back to that hospital."

Woman, 53, Latvia

Similarly, respondents in Bulgaria had different experiences in hospitals, but none wanted to be institutionalised again in the future.

Others identified periods of hospitalisation that they felt – particularly in retrospect – had been necessary. They said that there were times that they needed access to inpatient care but did not always receive it. One woman explained that she had had difficulties being voluntarily admitted to hospital at times when she felt this to be essential. She described visiting the hospital and asking staff to be admitted:

"If you can't let me in I will destroy my family, I can't be at home. Then they came with a big bloody [medication] and then I got completely crazy. I wanted to talk to somebody! So I thought, now I must fight for myself [...]. If you don't let me in I will get myself a big carving knife, go to the big city square and scream [...] I have never been violent or threatening to other people, but now I thought I must protest and come forward in my process. Then they offered me to go to [...] hospital, a ward for compulsory care despite the fact that I was there voluntarily."

Woman, Sweden

Positive attitudes to hospital treatment were linked to experiences where treatment and admission into hospital had been voluntary and not forced:

"I've got a wonderful clinic, I can turn up straight away in a crisis and I feel very comfortable there."

Woman, 50, Germany)

On this basis, respondents recommended that people should have a wider range of choice about where to go at times of crisis. Respondents in the United Kingdom suggested that the crisis support system should be reformed to include a short-term place for respite – a 'home away from home' – where people can take a break but still remain in the community, rather than being automatically admitted to a hospital. Such places of refuge do not appear to have been available to many of the respondents – a point which may have relevance to the perception, amongst a number of them, of a need to spend time in hospital from time to time.

Some interviewees stressed that, when people are admitted to hospital, clear communication providing and explaining relevant information is likely to increase their sense of choice and control over what is happening. This in turn could reduce the anxiety and fear associated with hospitalisation and might alleviate the need for it to be forced or compulsory.

3.2. Involuntary treatment

A number of respondents had experiences of involuntary treatment ranging over a considerable period of time. Forced or non-consensual treatment was generally experienced in hospital settings. This will be discussed in Section 3.2.1.

In the United Kingdom, Sweden and France a person can be allowed to leave hospital if they comply with certain conditions. Adherence to these conditions is a requirement for remaining an outpatient and living in the community. Two respondents from the United Kingdom had experience of this arrangement which will be discussed in Section 3.2.2.

Respondents were overwhelmingly negative about involuntary treatment. However, their views on psychiatric medical treatment generally – including in hospitals – were more balanced, with a number of respondents explaining that medication can be useful and that they had willingly taken it provided the treatment options were discussed with them and alternatives presented. A more detailed analysis of their responses in regard to non-compulsory treatment is available in the FRA report *Choice and control: the right to independent living – Experiences of persons with intellectual disabilities and persons with mental health problems in nine EU Member States*.

3.2.1. Involuntary treatment in hospitals

Forced or involuntary treatment in hospital had been experienced by respondents in all nine countries. They all considered it as a frightening and humiliating experience, but a few respondents said that, in retrospect, they believed that it was necessary. If the treatment was resisted, respondents said that force and restraint measures were used:

"I stood banging on the window and was about to jump down. Then two guards wrestled me down, sat on me, and gave me an injection. It was four men all in all who forced me into bed. It was extremely humiliating."

Woman, Sweden

Types of forced treatment varied and respondents spoke about the administration of sedation and other drugs, as well as electroconvulsive therapy (ECT):

"They probably injected me in the hand but I don't remember now and I fell immediately asleep; my eyes closed. Right after they did electric shocks without me knowing about it. I found out later. They ruined my life."

Man, 55, Greece

"In the mouth and washed down with water. If you do not take it like that they will inject you, end of story."

Man, 47, Latvia

In several cases, interviewees questioned if the treatment given was appropriate for their condition. Several respondents in Hungary, for example, said that regardless of their symptoms or diagnosis they were heavily sedated for the first few days after admission.

Interviewees agreed that being involuntarily treated often had long-term effects on their personality, lifestyle and social life after discharge:

"They didn't explain anything to me at all. I had injections of a neuroleptic at once. I went up. The psychiatrist went up at once. There. And after that there was no-one. Later you fall to the ground because it throws you to the ground. You are destroyed, and I suffered from that really very very badly. [But] I felt good that I was not the same any more. I thought it was the disease. I said to myself, I am sick because they hospitalised me. So it must be the disease."

"A colleague said to me: stop your treatment. You are not the same person any more. And suddenly it clicked! And then I said to myself: after all, I should try to stop. And then I became aware of that sensation again. I found pleasure in working again; I had taken no pleasure in my work before. I was a bit schizophrenic. It was the treatment that made me schizophrenic."

Woman, 65, France

When treatment was administered voluntarily some respondents recounted positive experiences during periods spent in psychiatric hospitals:

"In the hospital I was never forced to do anything."

Greece

Moreover, a few respondents did acknowledge the potential benefits of psychiatric medication in general:

"Now, it's a difficult one because some patients can deal without medication and sometimes I think if I'd never had any medication that I would have been OK. But in hindsight, there's a lot of science behind it and as long as the side effects aren't too bad, I don't mind taking it. [...] I know that medication helps, it's not a cure all but it is a help, like an assisting aid."

Man, 44, United Kingdom

"I agree to take my medication because I know that it is good for me."

Greece

Informed consent

In most countries respondents described their experiences of treatment without their informed consent. Others said that they had no opportunity to discuss the treatment with a doctor. In Bulgaria some respondents claimed that they were not asked to sign informed consent forms for treatment, although sometimes their relatives were asked. On occasion they were admitted involuntarily into hospital and were later asked to sign a consent form to avoid subsequent legal proceedings:

"It happened to me several times – when I am in crisis, my relatives bring me to the doctor, the general practitioner decides that I need to be placed in a hospital and I am placed in a hospital. For example, I have mania or depression and do not agree to the placement. While I am in the hospital – injections, then when I am a bit calmer, I have enlightenment, then they made me sign a document to confirm that I am placed in the hospital voluntarily in order to avoid the clumsy court and prosecution proceedings [...]. The doctors themselves told me: 'You have been placed in the hospital anyway and instead of going to the court, just sign'."

Woman, 51, Bulgaria

Several respondents explained that they had been given no opportunity to discuss their treatment or potential alternatives and were not asked to consent to their treatment:

"I could not make any choices. The doctor just made the decisions for me. It is not as if they call me back and say, those drugs are not what you need, we will use these ones instead – it has never been like that."

Latvia

"I had two crises – the first in 2000, the second in 2005. Then nobody asked me, they talked to my mother and she gave consent and signed the document but nobody had explained to me what exactly electroconvulsive therapy is like. Initially I thought it was anaesthesia which helps the medication to reach all parts of the body, but after that I realised it is not this."

Woman, 29, Bulgaria

"The problem was that nothing was discussed with me. [...] The doctor said that if my condition did not improve, I will be given three injections a day. [...] I simply could not discuss it with the doctor, that I would rather take pills, then she could have said to try the pills, or ask whether I agree, or what to do. Thus, we did not have that kind of doctor-patient relationship, but she just gave instructions out of the blue, like 'it will be an injection and that is it'. I was really scared."

Woman, 36, Hungary

In Germany, stakeholders suggested ways of ensuring that informed consent was given before treatment began. They favoured a public campaign for voluntary treatment agreements with regional mental health clinics to be discussed with people with mental health problems during periods of good mental health. Parents and organisations of family members also indicated that an accessible 24-hour regional crisis intervention service could be a first step towards reducing the use of forced treatment.

Communication and explanation of treatment

Respondents often linked the humiliation and fear associated with their compulsory treatment to the lack of any explanation about their treatment and its potential side effects:

"When they give you medication, no-one tells you exactly what it is. They give you four or five pills. No-one explains anything."

Man, 47, Bulgaria

"When you are hospitalised, no one informs you about the medication and the side effects."

Greece

Interviewer: *"Were you informed about the side effects or any consequences of the medication?"*

Woman: *"Not at all, [...], not at all. How to say that? It was really bad, because sometimes I felt incontinence, so much that I could hardly get to the toilet."*

Woman, 36, Hungary

"They decide on a treatment. You say to them that it does not suit you because it makes you fat, it makes you drool and it makes you restless. [They say] ah well, let's talk about other things."

Woman, France

Being given no information or opportunity to ask questions about the treatment and its side effects was associated by respondents with a lack of concern for the views of individual:

"I felt at their mercy."

Man, 66, Germany

"There is nobody who pays attention to the person."

Woman, Sweden

Several respondents said that they had found out about their diagnosis and treatment not from doctors but from various other sources. In Latvia, for example, one woman discovered her diagnosis was paranoid schizophrenia when she looked at the papers on her doctor's desk while he was out of the room. Another respondent said that most of her information came from patients rather than medical staff. Several interviewees were told about their diagnosis in hospital but without explanation. The situation in Latvia, however, appears to be improving: doctors had informed the majority of the interviewees who were hospitalised in the last five years of their diagnosis. Nevertheless, in Greece many respondents said they had not been told what their diagnosis was.

The lack of information and communication about treatment seems to be part of a broader gap in communication efforts with patients in psychiatric hospitals. Closing this gap would enable them to have more control over their own lives, including choice of treatment. Stakeholders in Latvia and Sweden said that people with mental health problems are frequently not informed of their diagnosis. In Sweden, a psychiatrist at the stakeholder focus group observed that compulsion is used more frequently than communication largely as a result of staff time constraints. In Germany, participants suggested that communication should start before a person is admitted to hospital, when their condition is stable.

3.2.2. Involuntary treatment in the community

In France, Sweden and the United Kingdom, a person can leave in-patient psychiatric care on certain conditions. In the United Kingdom, for example, such conditions may include attending a clinic for regular health monitoring,

not drinking alcohol and avoiding specified activities or situations considered likely to affect the person's mental health.

Two of the United Kingdom respondents had experienced such community treatment orders (CTOs) shortly before their interviews. One understood that the order required that he take the medication prescribed as a condition for hospital discharge. This blurred the distinction between voluntary and involuntary treatment, as his strong aversion to returning to hospital left him with little meaningful choice about taking the medicine:

"I don't like the idea of it being forced on me because if I hadn't have taken medication I would have been brought back into hospital."

Man, 44, United Kingdom

He contrasted this experience with his feelings when the CTO was lifted:

"But I'm much happier with the situation now that it's my choice. If I want to go off medication I won't have to take it, I won't be taken back into hospital."

Man, 44, United Kingdom

In the United Kingdom, a number of respondents in the stakeholders' focus group claimed that the exact nature and requirements of CTOs are frequently not well understood. Taking particular medication is not binding under the terms of CTOs, but this is not the common perception among many persons subject to such orders. While they were, in theory, entitled to have access to an independent mental health advocate who might help in this regard, in practice, access to such advocates for people outside hospitals was often limited.

In France, stakeholders discussed a new law that authorises involuntary psychiatric treatment at home. While this could help to avoid hospitalisation, it was felt that it could potentially conflict with the aim of encouraging voluntary treatment when the patient leaves a closed hospital unit. Stakeholders also stressed the importance of early and on-going communication with patients.

3.3. Seclusion and restraint

Respondents in all nine countries had experienced seclusion or restraint in psychiatric settings often in connection with the administration of involuntary medical treatment. This was frequently accompanied by what they perceived as hostility or lack of compassion by staff. Some respondents, in the United Kingdom, Romania and Latvia had experienced restraint or seclusion themselves, while others had witnessed it.

One respondent described being secluded overnight in a room without her clothes, any furniture or bedding, and another similarly reported how 15 years earlier, aged 17, she was locked alone in a room. The use of forcible restraint was described by all who had experienced it as traumatic, unforgettable and as, sometimes, causing physical injury:

"And because I resisted they tied me to the bed. It was horrible, awful! That was hard on a person. To tie you up to the bed so tightly you cannot move. And I asked for a drink, there was one person there, it was night time, and I was left alone in the corner moaning. And so I lay there in the dark, one orderly occasionally showed up and I asked her for a drink, and she brought a glass of water and I asked – can she untie one of my hands? Then she poured the glass of water in my face."

Woman, 53, Latvia

"The last time there were two women and three men [...] the men were very firm and aggressive. [...] It is only one woman who looked me in the eyes in this traumatic moment. [...] I think they ought to give the patient a feeling of having control, even in such a miserable moment. It is humiliating to be put in belt restraints on a plank bed with your legs spread; not even Jesus was crucified with his legs spread!"

Woman, 42, Sweden

Respondents explained that being tied to the bed prevented them from using the toilet:

"I was in a room with a man who was tied to his bed and during the night he defecated involuntarily because of the medication they gave him. I went to call a nurse but they did not come to help him."

Man, 47, Bulgaria

Another described the humiliation he felt when he was required to spend time in a seclusion unit in which there were no toilet facilities of any kind.

The need for restraint or the time it would last was not necessarily explained:

"Restraint, that was very traumatic because there was no debriefing and the whole process of restraint, er, in my eyes it was bad."

Man, 56, Germany

Other respondents highlighted their disappointment that other less restrictive methods had not been tried before resorting to restraint. One respondent who had spent time as a patient in psychiatric hospitals observed that restraint was used as a means of dealing with distress or agitation:

"I didn't like the fact that sometimes the patients were strapped down. The staff should not have tied them down to calm them. They should have talked to them. This made me sad."

Man, 36, Greece

A number of respondents referred to the practice of involving other patients in restraint procedures. According to one man, who had spent time in psychiatric hospitals since the 1980s:

"Each ward had to assign two people to be on duty every night. Not just doctors but two people generally, and you had to be ready at any time of night. [...] And then the message comes – disturbances in such and such a ward. If there are disturbances in the women's ward it is a piece of cake, you go in there and if they are still yelling and cursing you give them a shot in the kidneys. In the women's wards you tie them up with stockings and old socks, in the men's you use these special canvas ropes. Or you take a sheet of canvas and cover them with it, all sorts of ways. Tie them up, everything is under control."

Man, 47, Latvia

He added that such practices had become less common than they were in the 1980s and that canvas was no longer used. Another man admitted into a psychiatric hospital in 2010, however, indicated that he had often seen patients assisting staff to immobilise a patient before they were injected.

Some respondents said that restraint was sometimes used for no discernible reason:

"One person was chucked on his bed. He was really chucked like that, his arms were held down, they tied him, strapped him, and I don't know what else they did. However, he did not do anything bad; he was just talking at the window. There was nobody there though."

Man, 40, Hungary

"They could have just taken away the safety pin if it was not allowed, because I did not know. But why did they have to tie me to the bed for that? I did not understand."

Woman, Latvia

Some respondents claimed that staff misused physical restraint and seclusion. This was linked to a sense that staff were hostile to rather than supportive of patients:

"They did not hit me, but I saw very many violent gestures in the hospital, which revolted me, violent gestures from the staff, which should not exist in [...] society."

Man, 44, Romania

"The ringleader forced me to my knees. And he smashed my face against the floor. It was a vicious, sadistic attack and he could have broken my skull [...]. I went to the ward manager and said 'Look what they've done to me' and he said 'We'd better get rid of the carpet!' So he was concerned about getting rid of the evidence rather than getting rid of sadistic nurses."

Man, 54, United Kingdom

3.4. Challenging the lawfulness of involuntary placement or treatment

Few respondents in any country had attempted to challenge the lawfulness of their involuntary placement or treatment, either during the initial placement procedure or after detention had begun. For many, this reflected a lack of knowledge of their rights when they were forcibly detained. Those who were aware of their rights were reluctant to challenge their detention or treatment because of fear of victimisation or concern that complaining could result in worse treatment. Other interviewees said that their placement or treatment had not been reviewed at regular intervals.

In Romania none of the respondents were aware of legal provisions on measures involving deprivation of freedom, and none had been informed of their right to request a second medical opinion. The only exception was a woman who knew that physical restraint or seclusion could only be ordered by a psychiatrist. Even those respondents who had heard of the Romanian Mental Health Law, however, felt that this could not improve the situation because there were no implementation mechanisms that would guarantee them access to their rights as patients in practice.

"Being detained in a hospital and thinking that you can benefit from legal assistance is absolutely utopian."

Man, 44, Romania

Other respondents highlighted that hospitalisation could prevent access to court proceedings. One respondent claimed that he could not fully exercise his rights during court proceedings about his compulsory treatment in a psychiatric hospital, because his doctor gave him medication that prevented him from understanding the court hearings and he did not realise their effect:

"I was sleepy and they did not try to explain anything to me."

Man, 41, Bulgaria

While a number of respondents were aware of the potential to challenge the decisions or behaviour of staff and doctors, they chose not to for fear of unfavourable outcomes:

"I didn't dare to [make a complaint]. [...] I was afraid of being sedated, and then I would have been sleeping for 24 hours out of 24, being unconscious, [...] I was afraid of these kinds of things."

Man, 40, Hungary

"I remember [the consultant doctor] telling me back then, that if we wanted to change my medication, stop one or anything like this, then I had to go to hospital. That is why I did not say anything [about the medication not being appropriate], and I am not going there. I am more than happy not to see [the mental health institution]."

Woman, Hungary

Many respondents spoke of the struggles to have their involuntary placement or treatment reviewed by the authorities. In Greece, for example, most respondents were unable to have their original diagnosis reviewed.

"I continued with my medication after my hospitalisation. Both the doctors and I agree on the treatment. The decision was made in 1999. It has not been reviewed since then."

Man, 63, Greece

Stakeholders mentioned various obstacles that are faced by people with mental health problems when trying to challenge involuntary placement or treatment decisions. For example, in Sweden, if compulsory care is to be provided beyond a six-month period, a court decision is required, in accordance with the Compulsory Psychiatric Care Act. The viewpoint of user organisations taking part in this focus group was that when the issue of further compulsory care was discussed in court, although an individual had access to justice, in practice they were not usually given the opportunity to choose a lawyer or the special psychiatrist who provided information to the court. The representative of a psychiatric care organisation, on the other hand, said that court proceedings were an adequate control measure and a guarantor of legal justice for the patient adding that in many cases court decisions were in favour of patients.

Focus group participants in Greece highlighted the need to provide more information, better awareness and specialised education on mental health issues and the rights of people with mental health problems to judges, police officers and other officials involved deciding on involuntary placement or treatment. However, they also said that important steps had been taken in the last few years to improve complementarity with mental health services.

The way forward

This report brings together an analysis of existing legal standards at the United Nations, European and national levels in the area of involuntary placement and involuntary treatment, and personal testimonies shedding light on how individuals experience the laws in place. The comparative legal analysis shows that although there are some common features, the frameworks in place across EU Member States reflect their different approaches to the issue. Despite these differences, the trauma and fear people associate with compulsory measures is the recurring theme of the in depth interviews conducted for this research. The largely negative personal experiences described in this report underscore the importance of developing legal frameworks which can minimise such outcomes.

Following the entry into force of the CRPD, legislation in the EU and Member States, both those that have already ratified the CRPD and those which are soon expected to do so, will need to be harmonised with the convention. A crucial element of the harmonisation process will be to bring involuntary placement and involuntray treatment legislation in line with CRPD standards. This report's legal findings illustrate the challenges that the EU and its Member States may face in reconciling the non-discrimination principles of the CRPD with traditional mental health care and human rights provisions. Its sociological findings highlight the positive impact reform processes are already having on the lives of persons with mental health problems. Taken together, the socio-legal evidence provides an in depth understanding of the situation which serves to illuminate the informed discussion that should now take place within the EU.

In the area of public health, the European Union and the Member States have complementary competence. This framework facilitates an exchange on how the varied perspectives and rights associated with involuntary placement and involuntary treatment could be reconciled. The CRPD ratification process has already had some significant implications for this discussion. As the CRPD Committee starts to develop its interpretation of the convention on the basis of State Party reports, the key fundamental rights questions associated with compulsory placement and treatment will be brought into ever sharper focus. These questions will have to be addressed by EU Member States as they assess the compliance of their current and proposed legislation with the CRPD. The further development of EU law and policy, including in the area of non-discrimination, could play a major role in this process.

The CRPD requires that States Parties closely consult and actively involve persons with disabilities in the development and implementation of legislation and policies to implement it. The effective implementation of the convention thus requires that legislative reforms reach out to persons with disabilities, particularly through their representative organisations, to ensure that they are part of the process. Meaningful and practicable reform also rests on the participation of the service providers, support persons and local officials responsible for implementing the CRPD in their daily work. By highlighting some of the legal challenges ahead and giving a platform to those whose voices are seldom heard, this report contributes to the reform process.

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Annex 1

Legislation on involuntary placement and involuntary treatment (civil law)

EU MEMBER STATE	LEGISLATION	LAST SIGNIFICANT AMENDMENT
AT	Compulsory Admission Act (CAA) (*Unterbringungsgesetz*, UbG), BGBl 155/1990	BGBl I 18/2010 (17 March 2010)
BE	Act concerning the protection of the person of the mentally ill (26 June 1990) (*Loi relative à la protection de la personne des malades mentaux*) Patient's rights Act (22 August 2002) (*Loi relative aux droits des patients*)	No significant amendments affecting the civil commitment, while the criminal commitment was amended in 2007 (the reform entered into force in 2012)
BG	Chapter II Health Act (*Закон за здравето*), 1 January 2005	Although it has been amended several times, the provisions in Chapter II concerning involuntary placement and treatment have not changed
CY	Law No. 77(1) of 1997 Providing for the Establishment and Operation of Psychiatric Centres for the Car e of Mentally-Ill Persons, the Safeguarding of such Persons' Rights and the Determination of Duties and Responsibilities of Relatives	Amended between 2003-2007
	A Law providing for the safeguarding and protection of the patients' rights and for related matters N° 1(I)/2005, 7 April 2005	No amendments
CZ	Healthcare Act *Zákon č. 20/1966 Sb., o péči o zdraví lidu* (1 July 1966)	2004
	Civil Procedure Code *(Zákon č. 99/1963 Sb., občanský soudní řád),* Act No. 99/1963 Coll.	2011
DE	§ 1906 Civil Code (BGB) introduced by the *Betreuungsgesetz* (BtG) (Custodianship Act) of 12 September 1990, (enforced 1 January 1992)	Amended in 2009
	Placement under public law governed by states *(Länder)* laws	
DK	Act No. 331, 24 May 1989 on deprivation of liberty and other coercion in psychiatry	Consolidated act on the coercion in psychiatry (*om anvendelse af tvang i psykiatrien*), No. 1111 of 1 November 2006
EE	§§ 19-20 Social Welfare Act (SWA) (*Riigikantselei* (6 March 1995) *Riigi Teataja I*), 21, 323, (8 February 1995)	15 June 2005
	§§ 533-543 Code of Civil Procedure (CCP) *(Tsiviilkohtumenetluse seadustik),* 20 April 2005	
	§§ 10-14 Mental Health Act (MHA) (12 February 1997)	19 June 2002

EU MEMBER STATE	LEGISLATION	LAST SIGNIFICANT AMENDMENT
EL	Article 1687 Civil Code	
	Law 2071/1992 (*regulates involuntary treatment by mental health services*)	
ES	Article 763 Civil Procedure Act (*Ley 1/2000, de 7 de enero, de Enjuiciamiento Civil*), State Official Journal No. 7 of 8 January 2000	Following the decision of the Constitutional Tribunal of 2 December 2010, Dec. 132/2010
	Act of the Autonomy of the Patient Law 41/2002 (14 November 2002)	Under Law 2/2010 of 3 March 2010 and Law 26/2011 Normative Adaptation to the United Nation Convention on the Rights of Persons with Disabilities, 11 August 2011
FI	Section 8 – 20 Mental Health Act, No. 1116/1990	Law 1066/2009 of 11 December 2009
FR	Public Health Code, Articles L.3212-1 to L.3213-11	Law No 2011-803 of 5 July 2011 on the rights and protection of persons under psychiatric care and arrangements for their care (*Loi n° 2011-803 du 5 juillet 2011 relative aux droits et à la protection des personnes faisant l'objet de soins psychiatriques et aux modalités de leur prise en charge)*
HU	Healthcare Act (*1997. évi CLIV. törvény az egészségügyről)* (15 December 1997)	Although it has been amended several times, the provisions concerning involuntary placement and treatment have not changed
IE	Mental Health Act 2001, 1 November 2006	
IT	Article 33-35 Law n. 833/1978 (23 December 1978)	
LT	Law on Mental Health Care/1995, Nr. I-924, (*Psichikos sveikatos priežiūros įstatymas, Žin., 1995, Nr. 53-1290*). Available in EN (without amendments: www3.lrs.lt/pls/inter2/dokpaieska.showdoc_e?p_id=39589)	Law of 5 July 2005
LU	Luxembourg law on hospitalisation without their consent of persons with mental disorders (*relative à l'hospitalisation sans leur consentement de personnes atteintes de troubles mentaux*) (10 December 2009)	
LV	Article 68 Medical Treatment Law (*Ārstniecības likums*) (26 February 1998)	2008

EU MEMBER STATE	LEGISLATION	LAST SIGNIFICANT AMENDMENT
MT	Mental Health Act Chapter 262 of the Laws of Malta (adopted in 1976)	
NL	The 1992 Psychiatric Hospitals (Compulsory Admissions) Act (enforced January 1994)	2008
PL	Law on Protection of Mental Health, (*Ustawa o wychowaniu w trzeźwości i przeciwdziałaniu alkoholizmowi*) Dz. U. 1994 No 111 Item 53519, 19 August 1994	
PT	Article 12 Law on mental health 36/98, 24 July 1998	
RO	Mental Health Law (Law 487/2002), 11 July 2002	
	Law on Patient's Rights No. 46/2002 (*Legea drepturilor pacientului Nr. 46/2002*)	
SE	Compulsory Psychiatric Care Act (SFS: 1991:1128)	2009 (SFS: 2009:809)
SI	Mental Health Act 77/08 (28 July 2008)	
SK	Article 191a-191g Civil Procedure Code (*Zákon 99/1963*) 4 December 1963	1994 by Act no. 46/1994 Coll
	11 6 and 8 Health Care Act (*Zákon 576/2004*) 21 October 2004	Article 6 was amended in 2009 Article 8 was amended in 2011
UK	Mental Health Act 1983 c. 20	Mental Health Act 2007 c. 12
	Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13	2008
	Mental Health (Northern Ireland) Order 1986 No. 595 (N.I. 4)	

Annex 2

Criteria for involuntary placement and involuntary treatment, by EU Member State

EU MEMBER STATE	Mental health problem	Significant risk to oneself or others	Therapeutic purpose	Priority of less restrictive alternative included in the law
AT	✓	✓		✓
BE	✓	✓		✓
BG	✓	✓		
CY	✓	✓		
CZ	✓	✓		
DE	✓	✓		✓
DK	✓	✓	✓	✓
EE	✓	✓		✓
EL	✓	✓	✓	
ES	✓		✓	
FI	✓	✓	✓	✓
FR	✓	✓	✓	✓
HU	✓	✓		✓
IE	✓	✓	✓	
IT	✓		✓	✓
LT	✓	✓		
LU	✓	✓		✓
LV	✓	✓	✓	
MT	✓	✓		✓
NL	✓	✓		✓
PO	✓	✓	✓	✓
PT	✓	✓	✓	✓
RO	✓	✓	✓	✓
SE	✓	✓	✓	✓
SI	✓	✓	✓	✓
SK	✓	✓	✓	
UK	✓	✓	✓	✓

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HELPING TO MAKE FUNDAMENTAL RIGHTS A REALITY FOR EVERYONE IN THE EUROPEAN UNION

Involuntary placement and involuntary treatment of persons with mental health problems affects the most fundamental of rights, including the right to liberty and the right to freedom from torture. Strict safeguards at United Nations and European level attempt to limit undue interference with such rights. The legal approach to this field is evolving rapidly, driven in part by the Convention on the Rights of Persons with Disabilities (CRPD), to which the European Union (EU) and 20 EU Member States have acceded and all Member States have signed. Far more than a repackaging of existing rights, the CRPD represents a sea-change, a move from a charity-based to a rights-based approach characterised by non-discrimination, autonomy and inclusion. This report of the European Union Agency for Fundamental Rights (FRA) analyses the shifting legal panorama and, informed by fieldwork in nine EU Member States on the actual experiences of those involuntarily placed and treated and other stakeholders, points to the need for a renewed discussion of compulsory placement and treatment in the EU.

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