Academy of European Law

THE EUROPEAN CONVENTION ON HUMAN RIGHTS

THE UNCRPD & THE LEGAL RIGHTS

OF CITIZENS SUFFERING MENTAL ILL-HEALTH

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Brief

In keeping with my brief, this presentation for European judges on the detention of persons with disabilities, 'with a focus, for example, on conditions for ordering the detention of persons with disabilities, the treatment in detention, relevant EU law, international and domestic case-law.' The slides and case studies are provided separately.

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A – THE EUROPEAN CONVENTION ON HUMAN RIGHTS AND MENTAL HEALTH

INTRODUCTION

The European Convention on Human Rights is an international treaty under which the member states of the Council of Europe promise to secure fundamental civil and political rights, not only to their own citizens but also to everyone within their jurisdiction. The Convention, which was signed on 4 November 1950 in Rome, entered into force in 1953. It is the modern day Magna Carta and one of the most important documents in legal history.

The European Court of Human Rights is an international court which was set up in 1959. It rules on individual or state applications which allege violations of Convention rights. Since 1998 it has sat as a full-time court.

The court has delivered more than 10,000 judgments. These are binding on the countries concerned and have led governments to alter their legislation and administrative practice in a wide range of areas. The case-law makes the Convention a powerful living instrument for meeting new challenges and consolidating the rule of law and democracy in Europe.

This paper summarises the ways in which the Convention applies to people who suffer mental ill-health or who are alleged to be affected by such a condition. The most important case law is summarised. The material is arranged under the following headings:

Sources and acknowledgments

This paper draws heavily on the work and insights of staff of the European Court of Human Rights and the Council of Europe and in particular the following publications and sources to which the reader is referred:

- The HUDOC database.[1]
- *Guide on Article 5 of the Convention: Right to Liberty and Security*, Council of Europe/European Court of Human Rights, 2014.
- *Thematic Report: Health-related issues in the case-law of the European Court of Human Rights*, Council of Europe/European Court of Human Rights, June 2015.
- The following factsheets published by the European Court of Human Rights: *Detention and mental health* (September 2016), *Right to vote* (October 2016), *Elderly people and the ECHR* (October 2016), *Persons with disabilities and the European Convention on Human Rights* (March 2017).

Note on the citation of cases

The form of citation for judgments and decisions published from 1 November 1998 to the end of 2007 follows the following pattern: name of case (in italics), application number, paragraph number (for judgments), abbreviation of the European Court of Human Rights (ECHR), year and number of volume. From the beginning of 2008, there is no volume number (e.g., ECHR 2008, ECHR 2009, etc.).

Any variation from that is added in brackets after the name of the case:

- '(dec.) 'for a decision on admissibility;
- '(preliminary objections)' for a judgment concerning only preliminary objections;
- '(just satisfaction) 'for a judgment concerning only just satisfaction;
- (revision) 'for a judgment concerning revision;
- '(interpretation) 'for a judgment concerning interpretation;
- '(striking out) 'for a judgment striking the case out;
- '(friendly settlement) 'for a judgment concerning a friendly settlement;
- '[GC]' where the judgment or decision has been given by the Grand Chamber of the court.

1 The HUDOC database provides access to the case-law of the court (Grand Chamber, Chamber and Committee judgments and decisions, communicated cases, advisory opinions and legal summaries from the Case-Law Information Note), the European Commission of Human Rights (decisions and reports) and the Committee of Ministers (resolutions).

§2 — ARTICLE 2

Article 2 provides that everyone's right to life shall be protected by law.[2]

> **ARTICLE 2**
>
> **Right to life**
>
> 1. Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.
>
> 2. Deprivation of life shall not be regarded as inflicted in contravention of this Article when it results from the use of force which is no more than absolutely necessary:
>
> (a) in defence of any person from unlawful violence;
>
> (b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;
>
> (c) in action lawfully taken for the purpose of quelling a riot or insurrection.

Under Article 2 state agents are obliged to refrain from acts or omissions of a life-threatening nature or which place the health of individuals at grave risk.[3] Without Convention-compliant justification, they must not use lethal force or force which, while not resulting in death, gives rise to serious injury.

The positive obligation

States also have positive obligations under Article 2 to take appropriate steps to safeguard the lives of those within its jurisdiction.[4] An issue may arise under Article 2 where it is shown that the authorities of a contracting state have put a person's life at risk through the denial of health care which they have undertaken to make available to the population in general.[5]

Such an obligation must be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities, bearing in mind the unpredictability of human conduct and the operational choices which must be made in terms of priorities and resources.[6]

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2 Article 10 of the UNCRPD is also concerned with the right to life: 'States Parties reaffirm that every human being has the inherent right to life and shall take all necessary measures to ensure its effective enjoyment by persons with disabilities on an equal basis with others.' The Convention on the Rights of Persons with Disabilities, United Nations, Treaty Series 2515 (2006).

3 İlhan v Turkey [GC], no. 22277/93, 27 June 2000. In the absence of any indication to the contrary the cited text is a judgment on the merits delivered by a Chamber of the court.

4 Cyprus v Turkey [GC], no. 25781/94, 10 May 2001, §219; LCB v the United Kingdom, judgment of 9 June 1998, Reports 1998-III, p140, §36.

5 Cyprus v Turkey [GC], supra, §219; Nitecki v Poland (dec), no. 65653/01, 21 March 2002; Oyal v Turkey, no. 4864/05, 23 March 2010.

6 Keenan v United Kingdom, no. 27229/95, 3 April 2001, [2001] ECHR 242, §90; Taïs v France, no. 39922/03, 1 June 2006, §97.

Persons in custody are in a vulnerable position and the authorities are under a duty to protect them.[7]

Hospitals and (social) care homes

Article 2 requires states 'to make regulations compelling hospitals … to adopt appropriate measures for the protection of their patients' lives' and to set up an effective independent judicial system 'so that the cause of death of patients in the care of the medical profession, whether in the public or the private sector, can be determined and those responsible made accountable …'[8]

Dodov v Bulgaria (2008)[9] concerned the disappearance from a state-run nursing home for the elderly of a patient called Mrs Stoyanova who was suffering from Alzheimer's disease. Nursing home staff had been instructed not to leave her unattended. However, a nursing orderly left her alone in the home's courtyard and, on returning to fetch her a few minutes later, found that she was no longer there. The area of the nursing home was searched in vain and police were alerted that day. The police interviewed witnesses and seven days later issued a press release. They also subsequently checked patients admitted to psychiatric clinics and leads given by the public. Mrs Stoyanova has never been seen since. Her son, Mr Dodov, alleged a breach of Article 2.

The court held that there had been a violation of Article 2. It was reasonable to assume that Mrs Stoyanova had died. Given the instructions never to leave her unattended, there was a direct link between the failure to supervise her and her disappearance. Despite the availability in Bulgarian law of three avenues of redress – criminal, disciplinary and civil – the authorities had not, in practice, provided the applicant with the means to establish the facts surrounding his mother's disappearance, and to bring to account those people or institutions that had breached their duties. Faced with an arguable case of negligent acts endangering human life, the legal system as a whole had thus failed to provide the adequate and timely response required by the state's procedural obligations under Article 2.[10] There had been no violation of Article 2 with regard to the police's response. Bearing in mind the practical realities of daily police work, the court was not convinced that the police's reaction to the disappearance had been inadequate.

The applicant in ***Watts v. the United Kingdom (2010)***[11] was 106 years of age. She had been living for several years in a care home owned and managed by the city council. The city council decided to close the home for budgetary reasons. The applicant complained that her involuntary transfer to a new residential care home resulted in a risk to her life and her health.

7 Keenan v United Kingdom, no. 27229/95, 3 April 2001, [2001] ECHR 242, §91; Younger v United Kingdom (dec), no. 57420/00, ECHR 2003-I; Trubnikov v Russia, no. 49790/99, 5 July 2005, §68).

8 Calvelli and Ciglio v Italy, judgment (Grand Chamber) of 17 January 2002, §49.

9 Dodov v Bulgaria, no. 59548/00, 17 January 2008.

10 The court also held that the civil proceedings which had lasted ten years had not been concluded within a reasonable time, in violation of Article 6§1.

11 Watts v the United Kingdom (dec), no. 53586/09, 4 May 2010.

The court found that the applicant's complaints were ill-founded and declared the application inadmissible. A poorly managed transfer of elderly care home residents could affect their life expectancy. However, the careful planning and steps taken to minimise any risk to the applicant's life, in the context of the difficult operational choices faced by local authorities, meant that the authorities had met their positive obligations under Article 2.

The case of ***Centre of Legal Resources on behalf of Valentin Câmpeanu v Romania (2014)***[12] concerned a young Roma man suffering from severe mental disabilities and HIV infection who had spent his entire life in state care, having been abandoned at birth and placed in an orphanage. He was then placed in a psychiatric hospital which had no facilities to treat HIV where he died at the age of 18. The conditions were known to be appalling, without adequate staff, medication, heating or food. The Grand Chamber found that there had been a violation of Article 2 in both its substantive and procedural aspects. Mr Câmpeanu had been placed in medical institutions which were not equipped to provide him with adequate care for his condition; he had been transferred from one unit to another without proper diagnosis; and the authorities had failed to ensure his appropriate treatment with anti-retroviral medication. The authorities were aware of the lack of personnel and heating and insufficient food in the psychiatric hospital and had unreasonably put his life in danger. There had been no effective investigation into the circumstances of his death.

Prisons

Prison authorities must discharge their duties in a manner compatible with the rights and freedoms of the individual concerned. There are general measures and precautions which will be available to diminish the opportunities for self-harm, without infringing personal autonomy. Whether any more stringent measures are necessary in respect of a prisoner and whether it is reasonable to apply them will depend on the circumstances of the case.[13] In the case of mentally ill persons, regard must be had to their particular vulnerability.[14]

In ***Keenan v United Kingdom (2001)***,[15] the applicant's son Mark Keenan had committed suicide by hanging while serving a prison sentence at HM Prison Exeter. Mr Keenan had been receiving anti-psychotic medication intermittently from the age of 21. His medical history included symptoms of paranoia, aggression, violence and deliberate self-harm. Mrs Keenan alleged a violation of Article 2. In deciding whether there had been a violation, the court examined whether the authorities knew or ought to have known there was a real and immediate risk of the detainee committing suicide and whether they did all that could be reasonably expected of them, having regard to the nature of the risk. The court found that Mr Keen had not actually been diagnosed as suffering from schizophrenia. On the whole, the authorities responded reasonably to his conduct, placing him in hospital care and under watch when he showed suicidal tendencies. He was subject to daily medical supervision by the prison doctors, who on two occasions had consulted external psychiatrists with knowledge of

12 Center of Legal Resources on behalf of Valentin Câmpeanu v Romania (GC), no. 47848/08, 17 July 2014.

13 Keenan v United Kingdom, no. 27229/95, 3 April 2001, [2001] ECHR 242, §92; Trubnikov v Russia, no. 49790/99, 5 July 2005, §70. A complaint under Article 3 was upheld; see below.

14 Aerts v Belgium, no. 25357/94, 30 July 1998, Reports 1998-V, (1998) 29 EHRR 50, [1998] ECHR 64, §66; Keenan, supra, §111; Rivière v France, no. 33834/03, 11 July 2006, §63.

15 Keenan v United Kingdom, no. 27229/95, 3 April 2001, [2001] ECHR 242.

his case. The prison doctors, who could have required his removal from segregation at any time, found him fit for segregation. On the day of his death there was no reason to alert the authorities that he was in a disturbed state of mind rendering a suicide attempt likely. It was not apparent therefore that the authorities omitted any step which should reasonably have been taken and the Article 2 complaint was not upheld.

In ***Renolde v France (2008)***,[16] the applicant was the sister of Joselito Renolde, who died aged 35 after hanging himself in a cell in Bois-d'Arcy Prison where he was being held in pre-trial detention. Three days after a suicide attempt in prison, he had been given most severe disciplinary penalty possible for an assault, namely 45 days detention in a punishment cell. The court examined whether the authorities knew or ought to have known that he posed a real and immediate risk of suicide and, if so, whether they did all that could reasonably have been expected of them to prevent the risk. The court found that the authorities knew that Mr Renolde was suffering from psychotic disorders capable of causing him to commit acts of self-harm. The risk was real and he required careful monitoring in case of a sudden deterioration. The case could be distinguished from that of *Keenan* because, despite Mr Renolde's suicide attempt and diagnosed mental condition, there was never any discussion of whether he should be admitted to a psychiatric institution. Having regard to the state's obligation to take preventive operational measures to protect an individual whose life is at risk, it might have been expected that state authorities, knowing of such a risk, would take special measures geared to his condition to ensure its compatibility with continued detention. Given that the authorities did not order his admission to a psychiatric institution, they should at the very least have provided him with medical treatment corresponding to the seriousness of his condition. In fact, the evidence indicated that his medication was handed to him twice a week without any supervision of whether he took it. Expert toxicological reports revealed that at the time of his death he had not taken his neuroleptic medication for at least two to three days. This lack of supervision of his daily medication played a part in his death. It was also the case that the imposition of 45 days detention in a punishment cell could not be supported and was likely to have aggravated any existing risk of suicide. In the light of all these considerations, the authorities had failed to comply with their positive obligation to protect Mr Renolde's right to life. There had been a violation of Article 2.

Jasinska v Poland (2010)[17] concerned the suicide of the applicant's grandson while he was serving a prison sentence for theft with aggravating circumstances. The applicant alleged that her grandson was able to steal medicines and kill himself as a result of negligence on the part of the prison authorities. The court held that there had been a violation of Article 2, finding that the Polish authorities had failed to comply with their obligation to protect the prisoner's life. The prison authorities had been informed of the deterioration in his health and should have considered him as a suicide risk, rather than simply renewing his medical prescriptions. There was a clear deficiency in a system that had allowed a first-time prisoner, who was mentally fragile and whose state of health had deteriorated, to gather a lethal dose of drugs without the knowledge of the medical staff responsible for supervising his medicine, and to subsequently commit suicide. The authorities' responsibility was not confined to prescribing medicines. It extended to ensuring that they were properly taken, in particular in the case of mentally disturbed prisoners.

16 Renolde v France, no. 5608/05, 16 October 2008, [2008] ECHR 1085.

17 Jasinska v Poland, no. 28326/05, 1 June 2010.

In ***De Donder and De Clippel v Belgium (2011)***,[18] the applicants' son was convicted and sentenced to a special regime because he was receiving psychiatric treatment. Subsequently, he was transferred to the ordinary section of the prison and even spent several days segregated in a punishment cell. He committed suicide. The court noted that the applicants' son had been detained under the Social Protection Act. This provided that the persons to whom it was applicable were not subject to the rules on ordinary detention but to the rules on compulsory admission, so that they could be given the psychological and medical support their condition required. Furthermore, the decision by the deputy public prosecutor recalling the deceased to prison had specified that he should be admitted to the psychiatric wing. Accordingly, the applicants' son should never have been held in the ordinary section of a prison. By holding him there in breach of domestic law, the authorities had contributed to the risk of him committing suicide. On the facts there had been a violation of the substantive aspect of Article 2. The court could not find any evidence that the state's investigation had not satisfied the requirements of an effective investigation. There was no violation of Article 2 in its procedural aspect.

The case of ***Ketreb v France (2012)***[19] concerned the suicide in prison by hanging of a drug addict. His sisters alleged that the French authorities had failed to take proper steps to protect their brother's life when he was placed in the prison's disciplinary cell. They also complained that the disciplinary measure was unsuitable for a person in his state of mind. The court held that there had been a violation of Article 2, finding that the French authorities had failed in their positive obligation to protect Mr Ketreb's right to life. It must have been clear to both the prison authorities and medical staff that his state was critical and placing him in a disciplinary cell had only made matters worse. That should have led the authorities to anticipate a suicidal frame of mind, which had already been noted during a previous stay in the punishment block some months earlier, and should, for example, have alerted the psychiatric services. Nor had the authorities set in place any special measures, such as appropriate surveillance or regular searches, which might have found the belt he used to commit suicide. There was also a violation of Article 3 (see below).

The case of ***Coselav v Turkey (2012)***[20] concerned a 16-year-old juvenile's suicide in an adult prison. His parents alleged that the Turkish authorities had been responsible for the suicide of their son and that the ensuing investigation into his death had been inadequate. The court held that there had been a violation of Article 2 in relation to both its substantive and procedural limbs. The Turkish authorities had been indifferent to the deceased's grave psychological problems, even threatening him with disciplinary sanctions for previous suicide attempts. They had also been responsible for a deterioration of his state of mind by detaining him in prison with adults without providing any medical or specialist care, thus leading to his suicide. Furthermore, the Turkish authorities had failed to carry out an effective investigation to establish who had been responsible for the applicants' son's death, and how.

In ***Isenc v France (2016)***,[21] the applicant's son had committed suicide 12 days after he was admitted to prison. The applicant alleged a violation of his son's right to life.

18 De Donder and De Clippel v Belgium, no. 8595/06, 6 December 2011.
19 Ketreb v France, no. 38447/09, 19 July 2012.
20 Coselav v Turkey, no. 1413/07, 9 October 2012.
21 Isenc v France, no. 58828/13, 4 February 2016.

The court held that there had been a violation of Article 2. Although provided for in the domestic law, the arrangements for collaboration between the prison and medical services in supervising inmates and preventing suicides had not worked. The court noted that a medical check-up of the deceased when he was admitted was required as a minimum precautionary measure. Although the government submitted that he had received such a medical consultation, it failed to furnish any documentary evidence corroborating this and had not proved that he had been examined by a doctor. In the absence of any proof of an appointment with the prison medical service, the court considered that the authorities had failed to comply with their positive obligation to protect the applicant's son's right to life.

§3 — ARTICLE 3

Article 3 of the Convention provides that, 'No one shall be subjected to torture or to inhuman or degrading treatment or punishment.'[22]

> **ARTICLE 3**
>
> **Prohibition of torture**
>
> No one shall be subjected to torture or to inhuman or degrading treatment or punishment.

Article 3 is cast in absolute terms, without exception or proviso, or the possibility of derogation under Article 15 of the Convention.[23] The court has often stated that it must be regarded as one of the most fundamental provisions of the Convention and as enshrining core values of the democratic societies making up the Council of Europe.

The positive obligation

In general terms, the Convention does not confer a right to a particular standard of medical service or access to medical treatment in any particular country.[24] Nor does it guarantee to any individual a right to receive medical care which if given would exceed the standard level of health care available to the population generally.[25]

The court will, however, have regard to legal and policy materials relating to healthcare which have been adopted within the framework of the Council of Europe. The case law refers to the

22 Article 15 of the UNCRPD (Freedom from torture or cruel, inhuman or degrading treatment or punishment) is in similar terms: '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. 2. States Parties shall take all effective legislative, administrative, judicial or other measures to prevent persons with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhuman or degrading treatment or punishment. The Convention on the Rights of Persons with Disabilities, United Nations, Treaty Series 2515 (2006).

23 Chahal v United Kingdom, no. 22414/93, 15 November 1996, Reports 1996-V, §79, [1996] ECHR 54.

24 Wasilewski v Poland (dec), no. 32734/96, 20 April 1999.

25 Nitecki v Poland (dec), no. 65653/01, 21 March 2002; Kaprykowski v Poland, no. 23052/05, 3 February 2009, [2009] ECHR 198, §75.

recommendations of the Committee of Ministers in the health sector,[26] as well as to conventions such as the Oviedo Convention[27] and the Council of Europe Convention,[28] and the European Social Charter on health-related issues.[29] Such conventions and charters enable the court to assess the margin of appreciation enjoyed by contracting states and to set baseline standards compatible with the human rights of individuals. In effect, therefore, there is no guarantee to high quality healthcare or to a particular treatment but in certain circumstances a minimum standard of healthcare is guaranteed.

Under Article 3, the state may be required to take positive measures to protect the physical and mental health of individuals for whom it assumes special responsibility.

There is a particular need for states to take such measures in the context of psychiatric hospitals, where patients are typically in a position of inferiority and helplessness.[30]

Prison detainees are also in a special situation because of their dependence on the authorities when it comes to their living conditions, including access to medical care. In addition, the fact that they are deprived of their liberty means that any acts and omissions of the authorities are likely to have a greater impact on their psychological well-being. The state must ensure that detainees are held in conditions which are compatible with respect for human dignity. It must also ensure that the manner and method of execution of the measure do not subject them to distress or hardship of an intensity exceeding the unavoidable level of suffering inherent in detention and that, given the practical demands of imprisonment, their health and well-being are adequately secured through requisite medical assistance.[31] Diagnosis and care in detention facilities, including prison and psychiatric hospitals, should be prompt and accurate. Where necessitated by the person's medical condition, supervision should be regular and involve a comprehensive therapeutic strategy aimed at ensuring the detainee's recovery or at least preventing a deterioration of their condition.[32] In order to determine whether these requirements have been met, the court will thoroughly examine, in the light of the particular allegations, whether the authorities have followed the medical advice and recommendations.[33]

The state's positive obligation in relation to ill-treatment inflicted by private individuals

In ***Moldovan v Romania (2005)***,[34] the court said that:

26 Biriuk v Lithuania, no. 23373/03, 25 November 2008, §21.

27 Glass v United Kingdom, no. 61827/00, 9 March 2004, [2004] ECHR 102, (2004) 39 EHRR 15; Vo v France [GC], no. 53924/00, 8 July 2004, §§ 35 and 84.

28 S and Marper v the United Kingdom [GC], nos. 30562/04 and 30566/04, 4 December 2008.

29 Zehnalova and Zehnal v the Czech Republic, no. 38621/97, 14 May 2002; Mółka v Poland (dec), no. 56550/00, 11 April 2006.

30 See e.g. Herczegfalvy v Austria, no. 10533/83, Series A no. 244, [1992] ECHR 58, (1992) 15 EHRR 437 (the 'Herczegfalvy case').

31 Kudła v Poland [GC], no. 30210/96, 26 October 2000, §94.

32 Pitalev v Russia, no. 34393/03, 30 July 2009, §54.

33 Vladimir Vasilyev v Russia, no. 28370/05, 10 January 2012, §59; Center of Legal Resources on behalf of Valentin Câmpeanu v Romania (GC), no. 47848/08, 17 July 2014.

34 Moldovan v Romania, nos. 41138/98 and 64320/01, 12 July 2005, §98.

> 'The obligation of the High Contracting Parties under Article 1 of the Convention to secure to everyone within their jurisdiction the rights and freedoms defined in the Convention, taken together with Article 3, requires States to take measures designed to ensure that individuals within their jurisdiction are not subjected to ill-treatment, including ill-treatment administered by private individuals (see M.C. v. Bulgaria, no. 39272/98, §§149-50, ECHR 2004-...; A. v. the United Kingdom, judgment of 23 September 1998, Reports 1998-VI, p. 2699,§22; Z. and Others v. the United Kingdom [GC], no. 29392/95, §§ 73-75, ECHR 2001-V, and E. and Others v. the United Kingdom, no. 33218/96, 26 November 2002).'

In ***Dordevic v Croatia (2012),***[35] the court said:

> '138. The court reiterates that, as regards the question whether the State could be held responsible, under Article 3, for ill-treatment inflicted on persons by non-State entities, the obligation on the High Contracting Parties under Article 1 of the Convention to secure to everyone within their jurisdiction the rights and freedoms defined in the Convention, taken together with Article 3, requires States to take measures designed to ensure that individuals within their jurisdiction are not subjected to torture or inhuman or degrading treatment or punishment, including such ill-treatment administered by private individuals (see, mutatis mutandis, H.L.R. v. France, 29 April 1997,§40, Reports 1997-III). These measures should provide effective protection, in particular, of children and other vulnerable persons, and include reasonable steps to prevent ill-treatment of which the authorities had or ought to have had knowledge (see, mutatis mutandis, Osman v. the United Kingdom, 28 October 1998, §116, Reports 1998-VIII, and E. and Others v. the United Kingdom, no. 33218/96,§88, 26 November 2002).
>
> 139. Bearing in mind the difficulties in policing modern societies, the unpredictability of human conduct and the operational choices which must be made in terms of priorities and resources, the scope of this positive obligation must, however, be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities. Not every claimed risk of ill-treatment, therefore, can entail for the authorities a Convention requirement to take operational measures to prevent that risk from materialising. For a positive obligation to arise, it must be established that the authorities knew or ought to have known at the time of the existence of a real and immediate risk of ill-treatment of an identified individual from the criminal acts of a third party and that they failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk. Another relevant consideration is the need to ensure that the police exercise their powers to control and prevent crime in a manner which fully respects the due process and other guarantees which legitimately place restraints on the scope of their action to investigate crime and bring offenders to justice, including the guarantees contained in Article 8 of the Convention (see Mubilanzila Mayeka and Kaniki Mitunga v. Belgium, no. 13178/03, §53, ECHR 2006-XI; Members of the Gldani Congregation of Jehovah's Witnesses and Others v. Georgia, no. 71156/01,§96, 3 May 2007; and Milanović, cited above,§84; see also, mutatis mutandis, Osman, cited above,§116).'

35 Dordevic v Croatia, no. 41526/10, 24 July 2012, [2012] ECHR 1640.

The *Dordevic case* involved disabilist hate crime perpetrated by young teenage children against disabled adults. The victims were Dalibor Dordevic and his mother Radmila Dordevic who was his carer. Dalibor was a man with both learning and physical disabilities aged in his mid-30s who suffered a sustained program of abuse and harassment at the hands of children attending a school some 70 metres from his home.

The court considered that this harassment, which on one occasion caused Dalibor physical injuries, when combined with feelings of fear and helplessness, was sufficiently serious to invoke the protection of Article 3. Radmila had not been exposed to violence. Nevertheless, the incidents caused disruption to her daily life and had an adverse effect on her private and family life, and thus Article 8 was applicable.

On the facts, competent state agencies were fully aware of the ongoing harassment of Dalibor but failed to take sufficient steps to ascertain the extent of the problem and to prevent further abuse from taking place. 'No serious attempt was made to assess the true nature of the situation complained of, and to assess the lack of a systematic approach which resulted in the absence of adequate and comprehensive measures.' The lack of any concrete action, the absence of social services involvement or of experts who could have worked with the children were noted, as was the fact that Dalibor had not been provided with counselling. 'Apart from responses to specific incidents, no relevant action of a general nature to combat the underlying problem has been taken by the competent authorities despite their knowledge that the first applicant had been systematically targeted and that future abuse was very likely to follow'. Consequently, although the continuing risk of abuse was real and foreseeable, in breach of Article 3 the state had failed to take all reasonable measures to prevent abuse against Dalibor. Similarly, Croatia had failed to take all adequate and relevant measures to protect the family and private life of Radmila, in breach of Article 8.

Ill-treatment

Ill-treatment must attain a minimum level of severity if it is to fall within the scope of Article 3. The assessment of this minimum level is, in the nature of things, relative: it depends on all the circumstances of the case, such as the duration of the treatment, its physical and mental effects and sometimes the victim's sex, age and state of health.[36]

Although the purpose of such treatment is a factor, in particular whether it was intended to humiliate or debase the victim, the absence of any such purpose does not inevitably lead to a finding that there has been no violation of Article 3.[37]

The distinction between torture and other types of ill-treatment is to be made on the basis of a difference in the intensity of the suffering inflicted. Ill-treatment that is not torture, because it does not have sufficient intensity or purpose, will be classed as 'inhuman or degrading'. As with all Article 3 assessments, the assessment of this minimum is relative.

36 Ireland v United Kingdom, no. 5310/71, 18 January 1978, Series A no. 25, [1978] ECHR 1, (1978), 2 EHRR 25, §162; Kudla v Poland [GC], no. 30210/96, 26 October 2000, §91; Peers v Greece, no. 28524/95, §67.

37 Peers, supra, §74.

'Degrading treatment' is that which arouses in its victims feelings of fear, anguish and inferiority capable of humiliating and debasing them. It has also been described as involving treatment such as would lead to breaking down the physical or moral resistance of the victim[38] or drive them to act against their will or conscience.[39]

Use of seclusion on psychiatric wards/units

Although the segregation or seclusion of a mental health patient or prisoner does not in itself constitute inhuman or degrading treatment, the specific circumstances may mean that such a detention regime is contrary to Article 3.

A v United Kingdom (1980)[40] concerned a complaint that the conditions and circumstances of a patient's seclusion in England's [high-secure] Broadmoor Hospital in 1974 amounted to inhuman and degrading treatment, contrary to Article 3. In particular, the patient alleged that he had been deprived of adequate furnishing and clothing, that the conditions in the room had been insanitary and that it had been inadequately lit and ventilated. A's complaint was declared admissible and a friendly settlement was reached with an *ex gratia* payment to the patient of £500 being made by the Government.

In ***Dhoest v Belgium (1997)***,[41] the custodial mental institution at Tournai was composed of two wings, separated by an administrative unit in the centre. The west wing was designed for the treatment of psychiatric (civil) patients on a voluntary basis or compulsorily and the east wing for the treatment of 'mentally abnormal offenders' confined on the basis of the Act of Social Protection. The applicant complained that his treatment at the custodial mental institution violated Article 3. The Commission noted that it would not normally consider the segregation for security, disciplinary or protective reasons of persons committed to hospital in relation to criminal proceedings as constituting inhuman treatment or punishment. However, in 'making an assessment in a given case, regard must be had to the surrounding circumstances including the particular conditions, the stringency of the measure, its duration, the objective pursued and its effects on the person concerned.' In Mr Dhoest's case:

> '72. The conditions of his detention were also inhuman on account of the fact that he had been segregated from other detainees almost throughout his confinement in Tournai. The cell in which he was detained contained only a bed and a flush toilet and no table or chair. It had only one small window which was situated above eye-level. He had his daily exercise in a courtyard separate from other inmates. His meals were served in his cell and work, if provided at all, had to be carried out in his cell. The only "distraction" offered was a weekly interview with the prison priest. There were no facilities in the form of a common workshop or any recreation in the form of listening to the radio or watching television.

38 Ireland v the United Kingdom, Ireland v United Kingdom, no. 5310/71, 18 January 1978, Series A no. 25, [1978] ECHR 1, (1978), 2 EHRR 25, §167.

39 The Greek Case, nos. 3321-3/67, 1969.

40 A v United Kingdom (dec) (1980) DR 10, 3 EHRR 131.

41 Dhoest v Belgium, no. 10448/83, 14 May 1997, 12 EHRR 135.

> 73. Whereas it is true that, as the Commission had held in the past, the segregation of a prisoner does not in itself constitute inhuman or degrading treatment, specific circumstances might render detention conditions contrary to Article 3 of the Convention. Decisive in this respect was the severity of the measure concerned, its length, its purpose and its effect on the detainee concerned and the availability of a minimum of social contacts.
>
> 74. Isolating him for such a long period of time was a disproportionate sanction to his escapes or attempts to escape. Medical expert opinion had confirmed that he did not constitute a danger to other prisoners.
>
> 75. Finally the applicant's continued detention was also inhuman because he had no prospects of being released, which was against generally recognised principles regarding treatment of long-term prisoners. He It is, however, necessary that those responsible for the patient's seclusion continuously review the arrangements.'

General conditions on psychiatric wards/units

In ***Parascineti v Romania (2012)***,[42] Mr Parascineti was admitted to an endocrinology department where he displayed signs of acute psychosis, as a result of which he was urgently admitted to the psychiatric ward of a municipal hospital. Mr Parascineti complained that conditions on the psychiatric ward during his stay there were appalling. Dozens of patients, some of whom had scabies and lice, were housed in the same room and he had even had to share his bed with one or two other patients. The smell from the toilets, which were at one end of the room, was unbearable and, like the other patients, he was not allowed out into the fresh air. Furthermore, all 70 to 100 patients in the ward were given access to the bathroom at the same time and had to share the only two showers there.

The court reiterated that the state is required to ensure that all persons deprived of their liberty are detained in conditions which are compatible with respect for their human dignity, that the manner and method of the execution of the measure does not subject them to distress or hardship of an intensity exceeding the unavoidable level of suffering inherent in detention and that, given the practical demands of imprisonment or confinement, their health and well-being are adequately secured.

In cases of mental illness, increased vigilance is required in view of the detainees' vulnerability and the risk that this will heighten their sense of inferiority and powerlessness. Mr Parascineti had given a detailed and coherent description of what he had endured, and in particular the overcrowding and the very poor conditions of hygiene. The government had admitted that the conditions in the psychiatric wards the hospital had been inadequate. There were rooms with 20 to 30 beds and sometimes two patients had to share a bed. Hygiene was unsatisfactory, there were not enough specialised staff and patients were likely to catch scabies or become infested with lice. Such conditions, inadequate for any individual deprived of his liberty, were even more so for someone like the applicant who had been diagnosed with mental disorders and who consequently needed specialised treatment as well as a minimum standard of hygiene. There had been a violation of Article 3.

42 Parascineti v Romania [GC] no. 32060/05, 13 March 2012.

Conditions in (social) care homes

In ***Stanev v Bulgaria (2012)***,[43] the Bulgarian courts found Mr Stanev to be partially incapacitated, on the ground that he had been suffering from schizophrenia since 1975 and was unable to manage his own affairs adequately or realise the consequences of his actions. In 2002 he was placed under the partial guardianship of a council officer. Without consulting or informing Mr Stanev, the guardian had him placed in the Pastra social care home for men with psychiatric disorders. Mr Stanev complained about the living conditions in the home.

The court observed that Article 3 prohibits the inhuman and degrading treatment of anyone in the care of the authorities. It was not disputed that the building in which Mr Stanev lived had been renovated in late 2009, resulting in an improvement in his living conditions. Therefore, the complaint would be treated as covering the period between 2002 and 2009. The court found that the food had been insufficient and of poor quality. The residents' diet contained no milk or eggs and only rarely fruit and vegetables. The building was inadequately heated and in winter Mr Stanev had to sleep in his coat. He could shower only once a week in an unhygienic and dilapidated bathroom. The toilets were in an execrable state and, according to the findings of the Council of Europe's Committee for the Prevention of Torture and Degrading Treatment or Punishment (CPT), access to them was dangerous. No therapeutic activities were provided and residents led passive, monotonous lives. The home did not return clothes to the same people after they were washed, which was likely to arouse a feeling of inferiority in the residents. Mr Stanev was exposed to all of these conditions for a considerable period, approximately seven years. Although the CPT had concluded that the living conditions at the relevant time could be said to amount to inhuman and degrading treatment, the Bulgarian government did not act on their undertaking to close down the institution.

The court considered that the lack of financial resources cited by the government was not a relevant argument which justified keeping Mr Stanev in the living conditions described. Taken as a whole, his living conditions for a period of approximately seven years amounted to degrading treatment, in violation of Article 3.

The treatment of persons suffering from mental disorder

The leading case is ***Herczegfalvy v Austria (1992)***[44] which states that as a general rule a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading.

In *Herczegfalvy*, the applicant complained about his medical treatment, in particular that he had been forcibly administered food and neuroleptics, isolated, and attached by handcuffs to a security bed for several weeks.

The Austrian Government argued that the measures were the consequence of the applicant's behaviour. He had refused urgent medical treatment and food which was necessary in view of the deterioration in his physical and mental health.

43 Stanev v Bulgaria [GC], no. 36760/06, 17 January 2012, [2012] ECHR 46.

44 Herczegfalvy v Austria, no. 10533/83, Series A no. 244, [1992] ECHR 58, (1992) 15 EHRR 437.

Similarly, it was his extreme aggressiveness, and his threats and acts of violence against hospital staff, which explained why the staff had used coercive measures, including the intramuscular injection of sedatives and the use of handcuffs and a security bed. These measures had been agreed by his curator, their sole aim had always been therapeutic, and they had been terminated as soon as the patient's state permitted this.

According to the court (at §§82–83):

> '82. The court considers that the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with. While it is for the medical authorities to decide, on the basis of the recognised rules of medical science, on the therapeutic methods to be used, if necessary by force, to preserve the physical and mental health of patients who are entirely incapable of deciding for themselves and for whom they are therefore responsible, such 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.
>
> 83 In this case it is above all the length of time during which the handcuffs and security bed were used which appears worrying. However, the evidence before the court is not sufficient to disprove the Government's argument that, according to the psychiatric principles generally accepted at the time, medical necessity justified the treatment in issue. No violation of Article 3 has thus been shown.'

'Medical necessity' in this context is not limited to life-saving treatment. It can also cover treatment, such as anti-psychotic medication, imposed as part of a therapeutic regime.[45] In addition, the decision as to what therapeutic methods are necessary is principally one for the national medical authorities: those authorities have a certain margin of appreciation in this respect since it is in the first place for them to evaluate the evidence in a particular case.

In ***Buckley v United Kingdom (1997)***,[46] the applicant was the mother of Orville Blackwood, who died in England's [high-secure] Broadmoor Hospital on 28 August 1991, where he was detained under the Mental Health Act 1983. He died after being injected with Modecate 150mg intramuscularly and Sparine 150mg intramuscularly. The drugs were administered without consent. His mother complained that:

1. Her son's death constituted a violation of Article 2 and that his treatment was inhuman or degrading treatment or punishment in violation of Article 3.

2. The Mental Health Act 1983 permitted the treatment, namely the administration of the stated psychiatric drugs in the stated doses, which caused her son's death.

45 See Buckley, infra.

46 Buckley v United Kingdom (dec), European Commission, 26 February 1997, 1997 EHRLR 435.

3. The enforced medical treatment of her son was a violation of the right to respect for private life under Article 8 of the Convention.

4. Her son suffered discrimination contrary to Article 14, on the ground of race and his status as a patient detained in a special hospital under the Mental Health Act 1983.

5. The Mental Health Act 1983, and in particular section 139, which concerns the protection for acts done in pursuance of the said Act, in combination with the law of negligence, resulted in there being no effective remedy before a national authority in breach of Article 13.

Adopting the same numbering, the Commission held that:

1. The circumstances did not disclose any failure, substantive or procedural, to protect the applicant's right to life as required by Article 2 (manifestly ill-founded).

2. None of the circumstances disclosed that Mr Blackwood's treatment was anything other than part of a therapeutic regime. Given that the applicant's own medical expert found no grounds on which to criticise the hospital for negligent treatment, the Commission found no grounds on which to depart from the general rule set out in the *Herczegfalvy* (manifestly ill-founded).

3. The complaint concerning Article 8 was rejected for the same reasons as in (1) and (2) (manifestly ill-founded).

4. There was no evidence of discrimination in respect of Mr Blackwood's treatment, either on grounds of race, or his status as a patient detained in a special hospital under the Mental Health Act 1983 (manifestly ill-founded).

5. Article 13 did not require a remedy under domestic law in respect of any alleged violation of the Convention. It only applied if the individual could be said to have an 'arguable claim' of a violation of the Convention. The application did not disclose any such 'arguable claim' (manifestly ill-founded).

In ***Dvoracek v the Czech Republic (2014)***, [47] Mr Dvoracek was diagnosed with Wilson's disease, a genetic disorder linked associated with neurological and psychological problems. At the time of his diagnosis, he was beginning to suffer speech and motor problems and was afflicted with hebephiliac (a form of paedophilia), as a result of which he was prosecuted on several occasions for offences against minors. On 30 August 2007 the district court ordered him to undergo protective treatment in a hospital instead of the outpatient treatment which another district court had previously ordered. He was given anti-androgen treatment using medication to lower his testosterone level.

47 Dvořáček v the Czech Republic, no. 12927/13, 6 November 2014.

Mr Dvoracek reported that his illness had worsened during his time in hospital, that he had suffered mental problems caused by fear of the hospital, castration, humiliation and loss of dignity, that the medicinal treatment had impeded his sex life with his girlfriend and that he wanted to undergo psychotherapy. After a number of medical examinations, the courts acceded to his request.

The court held that there had been no violation of Article 3 with regard to the applicant's detention in a psychiatric hospital and the medical treatment administered. It noted that anti-androgen treatment had been a therapeutic necessity and that it had not been established that the applicant had been pressured into undergoing it. While there was no reason to cast doubt on the hospital's statements that he had been apprised of the side-effects, a specific form setting out his consent, and informing him of the benefits and side-effects of the treatment and his right to withdraw his original consent at any stage, would have clarified the situation. However, even though such a procedure would have reinforced legal certainty, the failure to use such a form was insufficient for a breach of Article 3. The court could not establish beyond reasonable doubt that the applicant had been subjected to forcible medicinal treatment. The court also held that there been no violation of Article 3 of the Convention concerning the investigation into the applicant's allegations of ill-treatment.

The sentencing of persons with mental ill-health

In ***Drew v United Kingdom (2006)***,[48] it was held that a statutory requirement that courts pass an automatic life sentence for a second serious sexual or violent offence in the absence of exceptional circumstances, even in the case of 'a mentally-disordered offender', did not breach Article 3 or Article 5.

Prisons, prison conditions and medical treatment

Article 3 requires the state to ensure that prisoners are detained in conditions which are compatible with respect for human dignity, that the manner and method of the execution of the measure do not subject them to distress or hardship of an intensity exceeding the unavoidable level of suffering inherent in detention and that, given the practical demands of imprisonment, their health and well-being are adequately secured by, among other things, providing them with the requisite medical assistance.[49]

However, the Convention does not impose a general obligation on state authorities to release detainees on health grounds or to place them in a civil hospital in order to provide particular treatment, even if the person is suffering from an illness that is particularly difficult to treat.[50] However, the detention of a person who is ill may raise issues under Article 3, and a lack of appropriate medical care can amount to inhuman or degrading treatment contrary to that provision:

48 Drew v United Kingdom, no. 35679/03, 7 March 2006, [2006] ECHR 1172.

49 See Hurtado v Switzerland, no. 17549/90, 28 January 1994, Series A no. 280-A, §79; Mouisel, ibid, §40.

50 Mouisel v France, no. 67263/01, 14 November 2002, ECHR 2002-IX, (2002) ECHR 740, §37.

> 'The court has held on many occasions that the detention of a person who is ill may raise issues under Article 3 ... and that the lack of appropriate medical care may amount to treatment contrary to that provision ... In particular, the assessment of whether the particular conditions of detention are incompatible with the standards of Article 3 has, in the case of mentally ill persons, to take into consideration their vulnerability and their inability, in some cases, to complain coherently or at all about how they are being affected by any particular treatment ...
>
> ... [T]here are three particular elements to be considered in relation to the compatibility of an applicant's health with his stay in detention: (a) the medical condition of the prisoner, (b) the adequacy of the medical assistance and care provided in detention, and (c) the advisability of maintaining the detention measure in view of the state of health of an applicant ...'[51]

Detainees with physical disabilities

Where persons with disabilities are detained, the authorities must take care to provide conditions that meet any special needs resulting from the person's disability.[52]

In ***DG v Poland (2013)***,[53] the court found that the conditions of detention of a paraplegic prisoner, who was confined to a wheelchair and suffered from incontinence, were inadequate: he did not have daily access to the shower rooms and could not reach the toilets without help from other inmates.

In contrast, in ***Zarzycki v Poland (2013)***,[54] the court found that the authorities had provided the applicant, a prisoner amputated at both elbows, with the regular and adequate assistance his special needs warranted. In these circumstances, even though his disability made him more vulnerable to the hardships of detention, his treatment had not reached the threshold of severity required to constitute degrading treatment within the meaning of Article 3.

Medical care in prison for persons suffering from mentally illness

Like prisoners with physical disabilities, detainees suffering from mental illness may require special medical care and treatment if their deprivation of liberty is to be compatible with Article 3.

In ***Aerts v Belgium (1998)***,[55] the applicant was arrested in November 1992 for an assault, having attacked his ex-wife with a hammer. He was placed in detention pending trial in the psychiatric wing of a prison. The applicant complained about the conditions of detention. It was accepted that the general conditions in the wing were unsatisfactory. The European Committee for the Prevention of Torture (CPT) had considered that the standard of care given to patients there fell below the minimum acceptable from an ethical and humanitarian point

51 Sławomir Musiał v Poland, no. 28300/06, 20 January 2009, §§87-88.
52 Price v the United Kingdom, no. 33394/96, 10 July 2001.
53 DG v Poland, no. 45705/07, 12 February 2013.
54 Zarzycki v Poland, no. 15351/03, 6 March 2013.
55 Aerts v Belgium, no. 25357/94, 30 July 1998, Reports 1998-V, (1998) 29 EHRR 50, [1998] ECHR 64.

of view. It also considered that prolonging their detention there for lengthy periods carried an undeniable risk of a deterioration of their mental health. In the present case, however, there was no proof of a deterioration in Mr Aerts's mental health, and the living conditions on the psychiatric wing did not seem to have had such serious effects on his mental health as would bring them within the scope of Article 3. It had not been conclusively established that the applicant had suffered treatment that could be classified as inhuman or degrading. There had been no violation of Article 3.

In ***Romanov v Russia (2005)***,[56] the applicant, who suffered from a 'profound dissociative psychopathy', complained about the conditions and length of his detention in the psychiatric ward of a detention facility, where he had been held for over 15 months. The court held that there had been a violation of Article 3. The conditions of detention, in particular the severe overcrowding and its detrimental effect on his well-being, combined with the length of the period during which he had been detained in such conditions, amounted to degrading treatment. They must have undermined his human dignity and aroused in him feelings of humiliation and debasement.

The applicant in ***Khudobin v Russia (2006)***[57] had a history of chronic illnesses which included epilepsy, pancreatitis, hepatitis and 'mental deficiencies'. Doctors had recommended out-patient psychiatric supervision. Although Russian law prohibited any form of entrapment or incitement by police officers, he was arrested for supplying heroin to an undercover police agent and held in custody until the criminal proceedings were discontinued 13 months later. During his trial he underwent three psychiatric examinations which ultimately concluded that he was legally insane at the time of the alleged crime, as a result of which he was discharged from criminal liability. Mr Khudobin complained that he did not receive adequate medical assistance at the relevant detention facility and was subjected to inhuman and degrading treatment. He said that his health sharply deteriorated in detention, where he contracted measles, bronchitis, and repetitive pneumonias and had several epileptic seizures. The court found that the Russian government had violated Article 3 by failing to providing him with adequate medical treatment and subjecting him to inhuman conditions of detention. It accepted the applicant's description of the facts because the government could not refute them, even though the events occurred presumably with the knowledge of the prison authorities. The level of anxiety caused by the lack of medical assistance, compounded by his HIV-positive status, serious mental disorders and physical sufferings, violated Article 3.

In ***Novak v Croatia (2007)***,[58] the applicant complained about a lack of adequate medical treatment for his post-traumatic stress disorder. The court found that the applicant had not provided any documentation to prove that his detention conditions had led to a deterioration of his mental health and dismissed the application.

The applicant in ***Kucheruk v Ukraine (2007)***[59] was suffering from chronic schizophrenia. He complained of ill-treatment while in detention, notably handcuffing in solitary confinement, and of inadequate conditions of detention and medical care. The court held that there had

56 Romanov v Russia, no. 63993/00, 20 October 2005.
57 Khudobin v Russia 59696/00, 26 October 2006, [2006] ECHR 898.
58 Novak v Croatia, no. 8883/04, 14 June 2007.
59 Kucheruk v Ukraine, no. 2570/04, 6 September 2007.

been a violation of Article 3. The handcuffing for seven days of the applicant who was mentally ill without psychiatric justification or medical treatment had to be regarded as inhuman and degrading treatment. Furthermore, his solitary confinement and handcuffing suggested that the authorities had not provided appropriate medical treatment and assistance to him.

The applicant in ***Dybeku v. Albania (2007)***,[60] was suffering from chronic paranoid schizophrenia for which he had treated in psychiatric hospitals for a number of years. Having been sentenced in 2003 to life imprisonment for murder and illegal possession of explosives, he was placed in a normal prison, where he shared cells with inmates who were in good health and where he was treated as an ordinary prisoner. The court held that there had been a violation of Article 3. The fact that the Albanian Government admitted that the applicant had been treated like the other prisoners, notwithstanding his long history of paranoid schizophrenia, showed a failure to comply with the Council of Europe's recommendations on dealing with prisoners with mental illnesses. Under Article 46 (binding force and execution of judgments), the court invited Albania as a matter of urgency to take the necessary measures to secure appropriate conditions of detention, and in particular adequate medical treatment, for prisoners requiring special care on account of their state of health.

In ***Sławomir Musiał v Poland (2009)***,[61] the applicant, who suffered from epilepsy, schizophrenia and other mental disorders, was detained in various remand centres without psychiatric facilities. The court found that the generally poor conditions in which he was held were not appropriate for ordinary prisoners, let alone for someone with a history of mental disorder and in need of specialised treatment, who was more susceptible to a feeling of inferiority and powerlessness. The applicant had been kept in detention centres primarily for healthy people for nearly 3½ years of detention. Doctors had recommended that he receive regular psychiatric supervision but even after his attempted suicide he was not given in-patient care. The authorities' failure during most of the applicant's time in detention to hold him in a suitable psychiatric hospital or a detention facility with a specialised psychiatric ward had unnecessarily exposed him to a risk to his health which must have resulted in stress and anxiety. It also ignored the Council of Europe Committee of Ministers recommendations in respect of prisoners suffering from serious mental-health problems.[62]

Owing to its nature, duration and severity, the treatment to which Mr Musial was subjected qualified as inhuman and degrading, in violation of Article 3. Poland was to secure his transfer to a specialised institution at the earliest possible date which was capable of providing him with the necessary psychiatric treatment and constant medical supervision. Furthermore, in view of the seriousness and structural nature of the problem of overcrowding, and the resultant inadequate living and sanitary conditions in Polish detention facilities, Article 46 would be invoked. Necessary legislative and administrative measures were to be taken rapidly in order to secure appropriate conditions of detention, in particular for prisoners in need of special care because of their state of health.

60 Dybeku v Albania, no. 41153/06, 18 December 2007.

61 Sławomir Musiał v Poland, no. 28300/06, 20 January 2009.

62 Recommendation R (98) 7 of the Committee of Ministers of the Council of Europe to the Member States concerning the ethical and organisational aspects of health care in prison, and Recommendation Rec (2006) 2 of 11 January 2006 on the European Prison Rules.

In ***Kaprykowski v Poland (2009)***,[63] the applicant was suffering from epilepsy marked by frequent (daily) seizures and also from encephalopathy accompanied by dementia. He was classified by social security authorities as a person with a 'first-degree disability making him completely unfit to work'. He alleged that the medical treatment and assistance offered to him during his detention in a remand centre had been inadequate in view of his severe epilepsy and other neurological disorders. The court found that throughout his incarceration several doctors had stressed that he should receive specialised psychiatric and neurological treatment and be under constant medical supervision. Furthermore, the medical experts appointed by the district court considered that the penitentiary system could no longer offer him the treatment he required and recommended that he undergo brain surgery. Consistent with this, when he was being released from the prison hospital, the doctors clearly recommended that he be placed under 24-hour medical supervision. Given the evidence, the court was convinced that Mr Kaprykowski had been in need of constant medical supervision during his time in the remand centre, in the absence of which he faced major health risks. The lack of adequate medical treatment there, and placing him in a position of dependency and inferiority vis-à-vis his healthy cellmates, undermined his dignity and entailed particularly acute hardship. This caused him anxiety and suffering beyond that inevitably associated with any deprivation of liberty. His continued detention without adequate medical treatment and assistance constituted inhuman and degrading treatment, and violated Article 3.

In ***Raffray Taddei v France (2010)***,[64] the applicant suffered from a number of medical conditions, including anorexia and Munchausen's syndrome. She complained about her continuing detention and a failure to provide her with appropriate treatment. In April 2009 a psychiatric expert stated that she required specialised supervision for the treatment of the above conditions. The need for such treatment was confirmed by a psychiatrist assigned to her. The court found that the failure by the national authorities to sufficiently take into account Ms Taddei's need for specialised care in an adapted facility, combined with transfers to prison institutions which appeared not to have the facilities necessary for the proper treatment of her illness, had been capable of causing her a level of distress that exceeded the unavoidable level of suffering inherent in detention. There had been a violation of Article 3.

In ***Cocaign v France (2011)***,[65] the applicant was imprisoned in 2006 for attempted rape committed using a weapon. In January 2007 he killed a fellow-inmate before cutting open his chest and eating part of his lungs. On 17 January 2007, he was condemned to 45 days in a disciplinary cell for this violence' to his deceased cellmate. On 18 January 2007, the prison governor applied to the prefect of the département of Yvelines to have him compulsorily admitted to a psychiatric institution. The prefect acceded to the request, ordering his admission to the Villejuif difficult patients' unit. On 14 February 2007, a hospital doctor concluded that the applicant's condition no longer justified his involuntary placement. The prefect ordered his return to Bois d'Arcy, where he finished serving his disciplinary penalty. On 26 October 2007, a court report by two psychiatrists established that the applicant was legally insane at the time of the murder.

63 Kaprykowski v Poland, no. 23052/05, 3 February 2009, [2009] ECHR 198.

64 Raffray Taddei v France, no. 36435/07, 21 December 2010.

65 Cocaign v France, no. 32010/07, 3 November 2011.

The court noted that the day after the disciplinary penalty had been imposed, the prison Governor had applied for the applicant's compulsory admission to a psychiatric hospital, and an order to that effect had been made four days later. The applicant had spent three weeks in the hospital and the decision to return him to a punishment cell had been taken only after he had been given appropriate treatment. The rest of the disciplinary penalty had been served under medical supervision. It could not be inferred from the applicant's illness alone that his confinement in a punishment cell and the execution of that penalty constituted inhuman and degrading treatment and punishment in breach of Article 3.

In ***G v France (2012)***,[66] the applicant was suffering from a chronic schizophrenia-type illness with evidence of psychosis, hallucinations, delusions and aggressive and addictive behaviour. He was alternately kept in prison and hospital psychiatric wards between 1996 and 2004. On 21 May 2005, he was sent to Toulon-La Farlède prison after causing damage in Chalucet psychiatric hospital, where he had asked to be admitted. As a result, on 30 June 2005 he was sentenced to 12 months imprisonment, of which ten months were suspended. On his arrival in prison he set fire to his mattress. He was placed under psychiatric observation, then made to share a cell with another detainee, who was known to have psychiatric problems. On 16 August 2005 a fire broke out in his cell. Both detainees suffered serious injuries. With burns to 65% of his body, the applicant's cell mate died from his injuries on 6 December the same year. The applicant said that he 'suffered from schizophrenia, heard voices and saw strange things' but that 'everything was better at the moment'; he added that 'I feel freer since the fire in my cell ... everything has become clearer in my head. I can say that everything is calm now'. On 13 November 2008 the Var Assize Court sentenced the applicant to 10 years imprisonment and declared him civilly liable 'for the prejudice suffered by the civil parties'.

Pursuant to Article 3, the applicant argued that his constant moves back and forth between prison and hospital amounted to inhuman and degrading treatment. He explained that when his condition deteriorated to the point where it was no longer compatible with detention he was placed in hospital, and when he recovered his 'stability' he was sent back to prison until his condition deteriorated again. He considered that his return to prison constituted a form of torture. Lastly, he argued that the decision to put him back in normal detention at Les Baumettes was absurd considering his extreme vulnerability *vis-à-vis* the other detainees and the danger to his safety.

The court held that there had been a violation of Article 3. It referred to the Council of Europe Committee of Ministers' Recommendation Rec (2006) on the European Prison Rules. The applicant's continued detention over a four-year period had made it more difficult to provide him with the medical treatment his condition required, and subjected him to hardship exceeding the unavoidable level of suffering inherent in detention. Alternately treating him in prison and a psychiatric institution, and detaining him in prison, clearly impeded the stabilisation of his condition, demonstrating thereby that he had been unfit to be detained from an Article 3 standpoint. The physical conditions of detention in the prison psychiatric unit, where the applicant had been held on several occasions, had been described by the domestic authorities themselves as demeaning and could only have exacerbated his feelings of distress, anxiety and fear.

66 G v France, no. 27244/09, 23 February 2012.

In ***ZH v Hungary (2012)***,[67] ZH had a learning disability. He was also deaf and mute and unable to use sign language or to read or write. He complained that his detention in prison for almost three months constituted inhuman and degrading treatment. The court held that there had been a violation. Given the inevitable feelings of isolation and helplessness that flowed from his disabilities, and ZH's lack of comprehension of his situation and the prison order, he must have suffered anguish and a sense of inferiority, especially as a result of being cut off from the only person (his mother) with whom he could effectively communicate. Although the allegations of molestation by other inmates were not supported by evidence, a person in his position would have faced significant difficulties bringing any such incidents to the wardens' attention, which could have resulted in fear and the feeling of being exposed to abuse.

The applicant in ***Claes v Belgium (2013)***[68] was a man with an intellectual disability who committed a series of sexual assaults. He was held continuously in the psychiatric wing of a prison for many years. Apart from access to the prison psychiatrist or psychologist, no specific treatment or medical supervision was prescribed for him. The court held that there had been a violation of Article 3. The national authorities had not provided him with adequate care and he had been subjected to degrading treatment as a result. His continued detention over a lengthy period in the psychiatric wing without appropriate medical care or any realistic prospect of change constituted particularly acute hardship which caused him distress that went beyond the suffering inevitably associated with detention. Whatever obstacles were created by his own behaviour, they did not release the state from its obligations, given the position of inferiority and powerlessness typical of patients confined in psychiatric hospitals and even more so of those detained in a prison setting. The applicant's situation stemmed in reality from a structural problem: on the one hand the support provided to persons in prison psychiatric wings was inadequate, on the other placing them in facilities outside prison often proved impossible, either because of a shortage of suitable psychiatric hospital beds or because the relevant legislation did not allow mental health authorities to order their placement in external facilities.

In ***Ţicu v Romania (2013)***,[69] the applicant was serving a 20-year sentence for participating in an armed robbery occasioning the victim's death. In childhood he had suffered from an illness which led to considerable delays in his mental and physical development. He complained about the poor conditions of detention in the prisons where he had been serving his sentence, and especially overcrowding and shortcomings in the provision of medical treatment. The court noted that the recommendations of the Committee of Ministers of the Council of Europe to member States[70] advocated that prisoners suffering from serious mental health problems should be kept and cared for in a hospital facility that was adequately equipped and possessed appropriately trained staff. The living conditions in the institutions where the applicant had been held, and continued to be held, were a particular cause for concern. Such conditions would be inadequate for any person deprived of their liberty but especially so for someone like him on account of his mental health problems and need for appropriate medical supervision. There had been a breach of Article 3.

67 ZH v Hungary, no. 28973/11, 8 November 2012.

68 Claes v Belgium, no. 43418/09, 10 January 2013, [2013] ECHR 286.

69 Ţicu v Romania, no. 24575/10, 1 October 2013.

70 Recommendation No. R (98) 7 concerning the ethical and organisational aspects of health care in prison and Recommendation Rec (2006) 2 on the European Prison Rules.

In ***Bamouhammad v Belgium (2015)***,[71] the applicant was suffering from Ganser syndrome (or 'prison psychosis'). He alleged that in prison he had been subjected to inhuman and degrading treatment which affected his mental health. He also complained of a lack of effective remedies. The court found that the level of seriousness required for treatment to be regarded as 'degrading' had been exceeded. The applicant's need for psychological supervision had been emphasised in all medical reports. However, endless transfers had prevented such supervision with the result that his already fragile mental health had not ceased to worsen throughout his detention. The prison authorities had not sufficiently considered his vulnerability or viewed his situation from a humanitarian perspective. There had been a violation of Article 3 (and of Article 13 — right to an effective remedy).

The case of ***Murray v the Netherlands (2016)***[72] concerned a man convicted of murder in 1980 who served his life sentence on the islands of Curaçao and Aruba until being granted a pardon in 2014 due to his deteriorating health. The applicant complained about the imposition of a life sentence without any realistic prospect of release and that he was not provided with a special detention regime for prisoners with psychiatric problems. The court found a violation of Article 3, reiterating that states are under an obligation to provide appropriate medical care to detainees suffering from mental health problems. Mr Murray had been assessed prior to being sentenced as requiring treatment. Subsequently, the domestic court which advised against his release found a close link between the persistence of his risk of reoffending and the lack of treatment. Notwithstanding this, he was never provided with any treatment for his mental condition during the time he was imprisoned, and consequently any request by him for a pardon was in practice incapable of leading to release.

The case of ***WD v Belgium (2016)***[73] concerned the confinement for over 15 years of a mentally-ill man in the psychiatric wing of an ordinary prison without appropriate medical care. Previously, WD had been found not to be criminally responsible for the sex offences with which he was charged. The applicant complained that the institution in which he was held was ill-adapted to the situation of people with mental-health problems. The court found that WD was subjected to degrading treatment by being detained in a prison environment for so long without appropriate treatment and with no prospect of reintegrating into society. This had caused him particularly acute hardship and an intensity of distress which exceeded the unavoidable level of suffering inherent in detention. The court considered that his situation originated in a structural deficiency specific to the Belgian psychiatric detention system. Pursuant to Article 46, the court required the state to reorganise its system for the psychiatric detention of offenders in such a way that the detainees' dignity was respected. In particular, it encouraged the Belgian state to take action to reduce the number of offenders with mental disorders who were detained in prison psychiatric wings without appropriate treatment. The court applied the pilot-judgment procedure to the case, giving the government two years to remedy the general situation and adjourning proceedings in all similar cases for that period.[74]

71 Bamouhammad v Belgium, no. 47687/13, 17 November 2015.

72 Murray v the Netherlands [GC], no. 10511/10, 26 April 2016.

73 WD v Belgium, no. 73548/13, 6 September 2016.

74 The court also found that there had been a violation of Article 5§1. The applicant's detention since 2006 in a facility ill-suited to his condition had broken the link required by Article 5§1(e) between the purpose and the practical conditions of detention. There had also been a violation of Articles 5§4 and 13. The Belgian system in operation at the time had not provided the applicant with an effective remedy in practice in

Prisoners with suicidal tendencies

The applicant in ***Kudla v Poland (2000)***[75] suffered from chronic depression and twice tried to commit suicide. He complained that he was not given adequate psychiatric treatment in detention.

The court found no violation of Article 3. His suicide attempts could not be linked to any discernible shortcoming on the part of the authorities. Furthermore, he had been examined by specialist doctors and frequently received psychiatric assistance. It reiterated that the state must ensure that a detainee's health and well-being are adequately secured by providing them with the requisite medical assistance.

In ***Keenan v United Kingdom (2001)***,[76] Mark Keenan had been receiving intermittent anti-psychotic medication for several years and his medical history included symptoms of paranoia, aggression, violence and deliberate self-harm. His mother alleged th

at he had suffered inhuman and degrading treatment due to the conditions of detention. The court found no violation of Article 2 (see above) but did find that there was a violation of Article 3. The lack of effective monitoring of his condition, and the lack of informed psychiatric input into his assessment and treatment, disclosed significant defects in the medical care provided to a mentally-ill person known to be a suicide risk. The belated imposition on him in those circumstances of a serious disciplinary punishment, which may well have threatened his physical and moral resistance, was incompatible with the standard of treatment required in respect of a mentally-ill person.

In ***Gennadiy Naumenko v Ukraine (2004)***,[77] the applicant had been sentenced to death but this was commuted to life imprisonment. He alleged that he was subjected to inhuman and degrading treatment during his time in prison from 1996 to 2001. In particular, he had wrongfully been forced to take medication.

The court observed that, no matter how disagreeable, therapeutic treatment could not in principle be regarded as contrary to Article 3 if it was persuasively shown to be necessary. From the evidence of the witnesses, the medical file and his own statements it was clear that the applicant was suffering from serious mental disorders and he had twice made attempts on his own life. He had been put on medication to relieve his symptoms. It was highly regrettable that his medical file contained only general statements that made it impossible to determine whether he had consented to the treatment. However, he had not produced sufficient credible evidence to demonstrate that, even without his consent, the authorities had acted wrongfully in making him take the medication. The court had insufficient evidence before it to establish beyond reasonable doubt that he had been forced to take medication in a way that contravened Article 3.

respect of his Convention complaints – in other words, a remedy capable of affording redress for the situation of which he was the victim and preventing the continuation of the alleged violations.

75 Kudla v Poland [GC], no. 30210/96, 26 October 2000.

76 Keenan v United Kingdom, no. 27229/95, 3 April 2001, [2001] ECHR 242.

77 Gennadiy Naumenko v Ukraine, no. 42023/98, 10 February 2004.

In ***Rivière v France (2006)***,[78] the applicant complained about his continued imprisonment in spite of his psychiatric problems. He had been diagnosed with a psychiatric disorder involving suicidal tendencies. The experts in his case had been concerned by aspects of his behaviour, in particular a compulsion towards self-strangulation, which indicated a need for treatment outside the prison. The court held that the applicant's continued detention without appropriate medical supervision amounted to inhuman and degrading treatment. It observed that prisoners with serious mental disorders and suicidal tendencies require special measures geared to their condition regardless of the seriousness of their offence.

The case of ***Renolde v France (2008)***[79] concerned the placement in a disciplinary cell for 45 days and suicide of the applicant's brother who was suffering from acute psychotic disorders capable of resulting in self-harm.

The court found that there had been a violation of Article 2 (see above). The court further held that there had been a violation of Article 3 because of the severity of the disciplinary punishment imposed on him, which was liable to break his physical and moral resistance. He had been suffering from anguish and distress at the time. Indeed, only eight days before his death his condition had so concerned his lawyer that she had immediately asked the investigating judge to order a psychiatric assessment of his fitness for detention in a punishment cell. The disciplinary penalty imposed on him was incompatible with the standard of treatment required in respect of a mentally ill person and constituted inhuman and degrading treatment and punishment.

In ***Güveç v Turkey (2009)***,[80] the applicant, aged 15 at the time, had been tried before an adult court and found guilty of membership of an illegal organisation. He was held for more than 4½ years in pre-trial detention in an adult prison, where he did not receive medical care for his psychological problems and made repeated suicide attempts.

The court held that there had been a violation of Article 3: in the light of his age, the length of his detention with adults and the authorities' failure to provide adequate medical care, or to take steps to prevent his repeated suicide attempts, he had been subjected to inhuman and degrading treatment.

The case of ***Ketreb v France (2012)***[81] concerned the suicide in prison by hanging of a drug addict. His sisters alleged that the French authorities failed to take proper steps to protect their brother's life when he was placed in the prison's disciplinary cell. They also complained that the disciplinary measure applied to their brother was unsuitable for a person in his state of mind.

The court held that there was a violation of Article 2, finding that the authorities had failed in their positive obligation to protect his right to life (see above). There had also been a violation of Article 3: his placement in a disciplinary cell for two weeks was incompatible with the level of treatment required in respect of such a mentally disturbed person.

78 Rivière v France, no. 33834/03, 11 July 2006.
79 Renolde v France, no. 5608/05, 16 October 2008, [2008] ECHR 1085.
80 Güveç v Turkey, no. 70337/01, 20 January 2009.
81 Ketreb v France, no. 38447/09, 19 July 2012.

Detention in police stations

In ***Rupa v Romania (2008)***,[82] the applicant had suffered from psychological disorders since 1990 and was registered by the public authorities as having a second-degree disability. He alleged that twice he had been detained in inhuman and degrading physical conditions at police stations: firstly in January 1998 and later between March and June 1998. The court found that in January he spent the night following his arrest in the police holding room. This was furnished only with metal benches that were manifestly unsuitable for the detention of a person with the applicant's medical problems. He had also not had a medical examination on that occasion. The state of anxiety inevitably caused by such conditions had undoubtedly been exacerbated by the fact that he was guarded by the same police officers who took part in his arrest. As regards his detention from 11 March to 4 June, his behavioural disorders had manifested themselves immediately after he was remanded in custody. These disorders could have endangered his own person. Therefore, the authorities were under an obligation to have him examined by a psychiatrist as soon as possible in order to determine whether his mental condition was compatible with detention, and what therapeutic measures should be taken. Further still, the Romanian government had not shown that the measures of restraint applied during his detention at the police station had been necessary. Subsequently, he was displayed before the court in public with his feet in chains. There had been a violation of Article 3.

In ***MS v the United Kingdom (2012)***,[83] the police were called out in the early hours because the applicant was highly agitated and sitting in a car sounding its horn continuously. He was detained by a police officer under the Mental Health Act 1983 and taken to a police station as a place of safety for a permitted period of up to 72 hours, to enable him to be assessed by a doctor and social worker. The police subsequently found his aunt at his address, seriously injured by him. Unsuccessful efforts were made on the same day to place MS in a psychiatric medium secure unit. He remained in police custody for more than 72 hours, locked up in a cell where he kept shouting, taking off all of his clothes, banging his head on the wall, drinking from the toilet and smearing himself with food and faeces.

MS complained about being kept in police custody during a period of acute mental suffering when it had been clear to all that he was severely mentally ill and required hospital treatment as a matter of urgency. The court stated that there was no doubt that MS's initial detention had been justified and also authorised under English law. The court could not accept his criticism of the clinic's medical personnel or his allegation that his intake of liquid and food had been inadequate. However, the fact remained that he had been in a state of great vulnerability throughout his detention at the police station. As indicated by all the medical professionals who examined him, he had been in dire need of appropriate psychiatric treatment. That situation, which persisted until his transfer to the clinic on the fourth day of his detention, diminished excessively his fundamental human dignity. Throughout that time, he had been entirely under the control of the state and the authorities had been responsible for the treatment he experienced. The maximum 72-hour time limit for his detention had not been respected. Even though there had been no intention to humiliate MS, the conditions he had been required to endure had reached the threshold of degrading treatment.

82 Rupa v Romania, no. 58478/00, 16 December 2008.

83 MS v United Kingdom, no. 24527/08, 3 May 2012, [2012] ECHR 804.

Immigration, deportation and extradition cases

Healthcare needs have been invoked as a shield against expulsion and the court has held that in extreme cases this may engage Article 3. Domestic courts are always under an obligation to carefully assess the alleged risk of ill-treatment in deportation cases.

The applicant in ***Bensaid v United Kingdom (2001)***[84] was an Algerian national who suffered from schizophrenia, as a result of which he had been receiving medical care and support in the UK since 1994. Previously, Mr Bensaid had indefinite leave to remain in the country as the foreign spouse of a UK national but this leave lapsed after he visited Algeria in 1996. Mr Bensaid complained that his proposed expulsion to Algeria placed him at risk of inhuman and degrading treatment contrary to Article 3. He also argued, under Article 8, that his removal would have a severely damaging effect on his private life, in particular his moral and physical integrity. He obtained a psychiatric report stating that he might suffer a relapse of his psychotic illness if he was returned to Algeria and that it was very unlikely that such a relapse would be effectively treated. Although treatment was available, it would require a journey through a dangerous part of the country that the applicant might not be able to undertake. The court found that Mr Bensaid had not met the high threshold necessary to show an Article 3 violation. Although the court accepted the seriousness of his medical condition, and the possibility that his reduced access to treatment and the greater instability in Algeria could increase his risk of relapse, the risk of his condition worsening was largely speculative; he would also face a risk of relapse if he remained in the UK. It was not enough in itself that the treatment available in Algeria was of a lesser quality than that available in the UK.

In ***Aswat v United Kingdom (2013)***,[85] Mr Aswat had been indicted in the United States as a co-conspirator in respect of the establishment of a jihad training camp in Oregon. He was arrested in the UK in 2005 following a request for his extradition by US authorities. Because he suffered from paranoid schizophrenia he was transferred from prison to Broadmoor (high-secure) Hospital in 2008. The last forensic psychiatrist reports in his case, in 2011 and 2012, indicated that while his condition was well-controlled on anti-psychotic medication, and his participation in occupational and vocational activities in the hospital had helped prevent a significant deterioration in his mood, his detention in hospital was required for medical treatment. Such treatment was necessary for his health and safety. Mr Aswat complained that extradition would be incompatible with Article 3. His detention in Broadmoor Hospital in the UK was essential for his personal safety and treatment. If extradited, he could remain in pre-trial detention for a number of years and there was no information as to the conditions of that detention. Furthermore, if convicted in the USA, it was likely that he would be detained in a 'supermax' prison, where he could be isolated in a cell, which was likely to exacerbate his mental illness. The court found that there was a real risk that the applicant's extradition to the USA, a country with which he had no ties, and to a different, potentially more hostile prison environment, would result in a significant deterioration in his mental and physical health. Such extradition would violate Article 3.

84 Bensaid v the United Kingdom, no. 44599/98, 6 February 2001.

85 Aswat v the United Kingdom, no. 17299/12, 16 April 2013.

ARTICLE 5(1)

Article 5§1 provides that everyone has the right to liberty and security of person. No one shall be deprived of their liberty on the ground of unsoundness of mind unless such detention is lawful and in accordance with a procedure prescribed by law.[86]

> **ARTICLE 5**
>
> **Right to liberty and security**
>
> 1. Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:
> …
>
> (a) the lawful detention of a person after conviction by a competent court;
>
> (b) the lawful arrest or detention of a person for non-compliance with the lawful order of a court or in order to secure the fulfilment of any obligation prescribed by law; …
>
> (e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants; ….

Article 5§1(e) refers to several categories of individual: persons spreading infectious diseases, persons of unsound mind, alcoholics, drug addicts and vagrants. There is a link between all of them in that they may be deprived of their liberty either in order to be given medical treatment or because of considerations dictated by social policy, or on both medical and social grounds.[87]

The reason why the Convention allows these individuals to be deprived of their liberty is not only that they may be a danger to public safety but also that their own interests may necessitate their detention.[88]

The term 'a person of unsound mind' does not lend itself to precise definition because psychiatry is an evolving field, both medically and in terms of social attitudes. However, it cannot be taken to permit the detention of someone simply because their views or behaviour deviate from established norms.[89]

Ten commandments

By way of introduction, the Convention and associated case law can be seen as laying down the following commandments:

86 With regard to the security of the person and associated guarantees, see also Article 14 of the UNCRPD. The Convention on the Rights of Persons with Disabilities, United Nations, Treaty Series 2515 (2006).

87 Enhorn v Sweden, no. 56529/00, 25 January 2005, ECHR 2005-I, §43.

88 *Ibid*; Guzzardi v Italy, no. 7367/76, 6 November 1980, Series A no. 39, [1980] ECHR 5, §98.

89 Rakevich v Russia, no. 58973/00, 28 October 2003, §26.

1) Deprivation of liberty requires that the person has been confined in a particular restricted space 'for a not negligible length of time'. This is the 'objective condition'.

2) In addition, a 'subjective condition' must be met. This is that the person has not validly consented to their confinement.

3) A person cannot consent to being confined if they lack capacity to consent to it.

4) The distinction between deprivation of liberty and restriction of liberty is one of degree or intensity, not one of nature or substance.

5) The starting-point is the specific situation of the individual concerned. Account must be taken of a whole range of factors arising in the particular case, such as the type, duration, effects and manner of implementation of the measure in question.

6) Of considerable importance is whether the professionals exercise 'complete and effective control' over the person's his care and movements, so that the individual is 'under continuous supervision and control and is not free to leave.'

7) The state's obligations are engaged if a public authority is directly involved in the detention (it is 'imputable to the state'), but also if the state has breached its positive obligation to protect the individual against interferences by private persons.

8) This is because Article 5(1) imposes a positive obligation on the state to protect the liberty of its citizens. The state is obliged to take measures providing effective protection of vulnerable persons, including reasonable steps to prevent a deprivation of liberty of which the authorities have or ought to have knowledge.

9) It is also essential that the person concerned should have access to a court and the opportunity to be heard in person or, where necessary, through some form of representation. Without this s/he will not have been afforded the fundamental guarantees of procedure applied in matters of deprivation of liberty. In the case of a detention on account of mental illness, special procedural safeguards may prove to be called for in order to protect the interests of persons who, on account of their mental disabilities, are not fully capable of acting for themselves.

10) With regard to persons in need of psychiatric treatment in particular, the state is also under an obligation to secure to its citizens 'their right to physical integrity' under Article 8. Private psychiatric institutions, in particular those where persons are held without a court order, need not only a licence, but also competent state supervision on a regular basis of whether the confinement and medical treatment is justified.

The positive obligation

The right to liberty and security is of the highest importance in a 'democratic society'.[90]

Article 5 is concerned with the physical liberty of the person. Its aim is to ensure that no one is deprived of that liberty in an arbitrary or unjustified manner.[91]

A 'deprivation of liberty' is not confined to the classic case of detention following arrest or conviction. It may take numerous other forms.[92] The fact that a person is not handcuffed, put in a cell or otherwise physically restrained is not a decisive factor in establishing whether or not a deprivation of liberty exists.[93]

Article 5 is applicable in a variety of circumstances, including the placement of individuals in psychiatric or social care institutions[94] and house arrest.[95] Consequently, the court has found that there was a deprivation of liberty in circumstances such as the following:

(a) where an applicant, who had been declared legally incapable and admitted to a psychiatric hospital at his legal representative's request, unsuccessfully attempted to leave the hospital;[96]

(b) where an applicant who initially consented to her admission to a clinic subsequently attempted to escape;[97]

(c) where an applicant was an adult incapable of giving his consent to admission to a psychiatric institution which, nonetheless, he had never attempted to leave.[98]

The court has said that the right to liberty is too important in a democratic society for a person to lose the benefit of Article 5 for the single reason that they may have given themselves up to be taken into detention, especially where the person is legally incapable of consenting to, or disagreeing with, the proposed action.[99]

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90 Medvedyev and Others v France [GC], no. 3394/03, 29 March 2010, ECHR 2010, §76; Ladent v Poland, no. 11036/03, 18 March 2008, §45.

91 McKay v United Kingdom [GC], no. 543/03, 3 October 2006, ECHR 2006-X, §30.

92 Guzzardi v Italy, supra, §95.

93 MA v Cyprus, no. 41872/10, 23 July 2013, §193.

94 See e.g. De Wilde, Ooms and Versyp v Belgium, nos. 2832/66; 2835/66; 2899/66, 18 June 1971, Series A no. 12; Nielsen v Denmark, no. 10929/84, 28 November 1988, Series A no. 144, [1988] ECHR 23, (1988) 11 EHRR 175; HM v Switzerland, no. 39187/98, 26 February 2002, ECHR 2002-II, [2002] ECHR 157, (2002) 38 EHRR 314; HL v United Kingdom, no. 45508/99, 5 October 2004, ECHR 2004-IX, (2004) 40 EHRR 761; Storck v Germany, no. 61603/00, 16 June 2005, ECHR 2005-V, 43 EHRR 96, [2005] ECHR 406; A. and Others v Bulgaria, no. 51776/08, 29 November 2011; Stanev v Bulgaria [GC], no. 36760/06, 17 January 2012, [2012] ECHR 46.

95 Mancini v Italy, no. 44955/98, 2 August 2001, ECHR 2001-IX; Lavents v Latvia, no. 58442/00, 28 November 2002; Nikolova v Bulgaria (no. 2), no. 40896/98, 30 September 2004; Dacosta Silva v Spain, no. 69966/01, 2 November 2006, ECHR 2006-XIII.

96 Shtukaturov v Russia, no. 44009/05, 27 March 2008, 54 EHRR 962.

97 Storck v Germany, no. 61603/00, 16 June 2005, ECHR 2005-V, 43 EHRR 96, [2005] ECHR 406.

98 HL v United Kingdom, no. 45508/99, 5 October 2004, ECHR 2004-IX, (2004) 40 EHRR 761.

99 HL v the United Kingdom, supra, §90; Stanev v Bulgaria [GC], supra, §119; De Wilde, Ooms and Versyp v Belgium, nos. 2832/66; 2835/66; 2899/66, 18 June 1971, Series A no. 12.

Article 5§1 imposes a positive obligation on the state not only to refrain from actively infringing the rights in question, but also to take appropriate steps to protect everyone within its jurisdiction against unlawful interference with those rights.[100]

This duty on the state includes implementing measures which provide for the effective protection of vulnerable persons and taking reasonable steps to prevent any deprivation of liberty of which the authorities have or ought to have knowledge.[101]

The responsibility of a state is engaged if it acquiesces in a person's loss of liberty by private individuals or fails to put an end to the situation.[102]

Deprivation of liberty and restriction of liberty

The case law confirms that Article 5(1) is concerned only with deprivation of liberty and not with restrictions of liberty or movement which do not amount to a deprivation of liberty, which are governed by Article 2 of Protocol 4.[103]

Nor is Article 5 concerned with the conditions of detention. Disciplinary steps imposed within a prison which have effects on conditions of detention cannot be considered as constituting a deprivation of liberty.

Such measures must be regarded in normal circumstances as modifications of the conditions of lawful detention and fall outside the scope of Article 5§1 of the Convention.[104]

In ***Ashingdane v United Kingdom (1985)***,[105] the applicant complained about his prolonged detention in a high secure hospital (Broadmoor Hospital) from October 1978 to October 1980, after he had been declared fit for transfer to an ordinary psychiatric hospital (Oakwood Hospital).

The court reiterated that Article 5(1) is not concerned with mere restrictions on liberty of movement, which are governed by Article 2 of Protocol 4. The distinction between a deprivation and restriction of liberty is one of degree or intensity. In order to determine if the circumstances involve a deprivation, the starting point must be the concrete situation of the individual concerned, and account must be taken of a whole range of criteria, such as the

100 El-Masri v the former Yugoslav Republic of Macedonia [GC], no. 39630/09, 13 December 2012, ECHR 2012, §239.

101 Storck v Germany, supra, §102.

102 Riera Blume and Others v Spain, no. 37680/97, 14 October 1999, ECHR 1999-VII; Rantsev v Cyprus and Russia, no. 25965/04, 7 January 2010, §§319-21; Medova v Russia, no. 25385/04, 15 January 2009, §§123-25.

103 Ashingdane v United Kingdom, no. 8225/78, 28 May 1985, Series A no. 93, (1985) 7 EHRR 528, [1985] ECHR 8; Creangă v Romania [GC], no. 29226/03, 23 February 2012, §92; Engel and Others v Netherlands, nos. 5100/71; 5101/71; 5102/71; 5354/72; 5370/72, 8 June 1976, Series A no. 22, (1976) 1 EHRR 647, §58.

104 Bollan v the United Kingdom (dec), no. 42117/98, 4 May 2000, ECHR 2000-V.

105 Ashingdane v United Kingdom, no. 8225/78, 28 May 1985, Series A no. 93, (1985) 7 EHRR 528, [1985] ECHR 8.

type, duration, effects and manner of implementation of the measure in question.[106] In Mr Ashingdane's case, there were important differences between the regimes at Broadmoor and Oakwood. His transfer to Oakwood had a proximate connection with a possible recovery of liberty because it was a staging post on the road to any eventual discharge into the community. However, since he had remained a detained patient during his subsequent stay at Oakwood,[107] it could not be said that, whilst being kept at Broadmoor pending transfer, he was being maintained in detention although medically and administratively judged fit for a return to liberty.

The Court accepted that there must be some relationship between the permitted ground of for the person's deprivation of liberty relied upon and the place and conditions of detention. The detention of a person as a mental health patient would only be lawful for the purposes of Article 5(1)(e) if effected in a hospital, clinic or other appropriate institution authorised for the purpose. However, subject to that, Article 5(1)(e) is not in principle concerned with the suitability of treatment or the location of the detention.

What is a deprivation of liberty?

Because there must be a deprivation, rather than a mere restriction, of liberty for Article 5 to apply, the first question is always, 'Is this person deprived of their liberty?'

What therefore constitutes a deprivation of liberty? According to the case law, the difference between restrictions on movement serious enough to come within the ambit of a deprivation of liberty under Article 5§1 and mere restrictions of liberty, which are subject to Article 2 of Protocol No. 4, is one of degree or intensity, and not one of nature or substance.[108]

The starting point must be the individual's concrete situation and account must be taken of a whole range of criteria such as the type, duration, effects and manner of implementation of the measure in question.[109]

Relevant objective factors to be considered include the possibility to leave the restricted area, the degree of supervision and control over the person's movements, the extent of isolation and the availability of social contacts.[110]

106 Referring to Engel and Others v Netherlands, nos. 5100/71; 5101/71; 5102/71; 5354/72; 5370/72, 8 June 1976, Series A no. 22, (1976) 1 EHRR 647, §§58-59; Guzzardi v Italy, no. 7367/76, 6 November 1980, Series A no. 39, [1980] ECHR 5, §92.

107 Mr Ashingdane was deprived of his liberty notwithstanding that when eventually transferred to Oakwood he was in an open hospital ward with regular unescorted access to the unsecured hospital grounds, and the possibility of unescorted leave outside the hospital.

108 Ashingdane v United Kingdom, no. 8225/78, 28 May 1985, Series A no. 93, (1985) 7 EHRR 528, [1985] ECHR 8; Guzzardi v Italy,no. 7367/76, 6 November 1980, Series A no. 39, [1980] ECHR 5, §93; Rantsev v Cyprus and Russia, no. 25965/04, 7 January 2010, §314; Stanev v Bulgaria [GC], no. 36760/06, 17 January 2012, [2012] ECHR 46, §115.

109 Guzzardi v Italy,no. 7367/76, 6 November 1980, Series A no. 39, [1980] ECHR 5, §92; Medvedyev and Others v France [GC], no. 3394/03, 29 March 2010, ECHR 2010, §73; Creangă v Romania [GC], no. 29226/03, 23 February 2012, §91.

110 See e.g. Guzzardi v Italy, supra, §95; HM v Switzerland, no. 39187/98, 26 February 2002, ECHR 2002-II, [2002] ECHR 157, (2002) 38 EHRR 314, §45; HL v United Kingdom, no. 45508/99, 5 October 2004, ECHR

Where the overall circumstances indicate a deprivation of liberty within the scope of Article 5§1, the relatively short duration of the person's detention does not prevent there being a deprivation of liberty.[111] For example, an element of coercion in the exercise of police powers of stop and search is indicative of a deprivation of liberty, notwithstanding the short duration of the measure.[112]

The court is not bound by the legal conclusions of the domestic authorities as to whether or not there has been a deprivation of liberty and undertakes an autonomous assessment of the situation.[113]

Two conditions must both be met for a deprivation of liberty to exist: an objective condition and a subjective condition. The objective condition is that the person has been confined in a restricted space (such as a hospital or social care home) for a not negligible length of time. The subjective condition is that they have not validly consented to this confinement.[114]

In relation to the objective condition, in many cases it has been held to be decisive that the individual is under continuous supervision and control and is not free to leave.[115]

The fact that a person *de jure* lacks legal capacity to decide matters for themselves does not dispense with the second condition by rendering irrelevant the question of whether or not they object to their confinement and regime.[116]

2004-IX, (2004) 40 EHRR 761, §91; Storck v Germany, no. 61603/00, 16 June 2005, ECHR 2005-V, 43 EHRR 96, [2005] ECHR 406, §73.

111 Rantsev v Cyprus and Russia, no. 25965/04, 7 January 2010, §317; Iskandarov v Russia, no. 17185/05, 23 September 2010, §140.

112 Krupko and Others v Russia, no. 26587/07, 26 June 2014, §36; Foka v Turkey, no. 28940/95, 24 June 2008, §78; Gillan and Quinton v the United Kingdom, no. 4158/05, ECHR 2010, §57; Shimovolos v Russia, no. 30194/09, 21 June 2011, §50; Brega and Others v Moldova, no. 61485/08, 24 January 2012, §43.

113 HL v United Kingdom, supra, §90; HM v Switzerland, no. 39187/98, 26 February 2002, ECHR 2002-II, [2002] ECHR 157, (2002) 38 EHRR 314, §§30 and 48; Creangă v Romania [GC], supra, §92.

114 Storck v Germany, supra, §74; Stanev v Bulgaria [GC], no. 36760/06, 17 January 2012, [2012] ECHR 46, §117; *mutatis mutandis*, HM v Switzerland, supra, §46;

115 See e.g. HL v United Kingdom, supra, §91; Storck v Germany, supra, §73; DD v Lithuania, no. 13469/06, 14 February 2012, [2012] ECHR 254,§156.

116 Shtukaturov v Russia, no. 44009/05, 27 March 2008, 54 EHRR 962, §§107-09: 109: '§108. The Court notes in this respect that … the applicant lacked *de jure* legal capacity to decide for himself. However, this does not necessarily mean that the applicant was *de facto* unable to understand his situation. …. §109. In sum, even though the applicant was legally incapable of expressing his opinion, the Court in the circumstances is unable to accept the Government's view that the applicant agreed to his continued stay in the hospital. The Court therefore concludes that the applicant was deprived of his liberty by the authorities within the meaning of Article 5§1 …'; DD v Lithuania, supra, §150: '§150 …. Whilst accepting that in certain circumstances, due to severity of his or her incapacity, an individual may be wholly incapable of expressing consent or objection to being confined in an institution for the mentally handicapped or other secure environment, the Court finds that that was not the applicant's case. As transpires from the documents presented to the Court, the applicant subjectively perceived her compulsory admission to the Kėdainiai Home as a deprivation of liberty. Contrary to what the Government suggested, she has never regarded her admission to the facility as consensual and has unequivocally objected to it throughout the entire duration of her stay in the institution ….'

Case law on whether a deprivation of liberty exists

In ***Nielsen v Denmark (1988)***,[117] the mother of the applicant Jon Nielsen, who was then 12 years old, held sole parental rights. She requested his admission to the State Hospital's Child Psychiatric Ward 'since it was clear that he did not want to stay with her'. She acted on the advice of the Social Welfare Committee and Professor Tolstrup, who was responsible for his treatment at the State Hospital, and the recommendation of her family doctor. On 26 September 1983, the applicant was admitted. According to Professor Tolstrup, the procedure followed was the usual one: the holder of parental rights made the request, the family doctor recommended admission and the responsible chief physician of the ward accepted admission. The applicant alleged that his committal to the Child Psychiatric Ward constituted a deprivation of liberty which contravened Article 5. The court held as follows:

'70. There is also no reason to find that the treatment given at the Hospital and the conditions under which it was administered were inappropriate in the circumstances.

> The applicant was in need of medical treatment for his nervous condition and the treatment administered to him was curative, aiming at securing his recovery from his neurosis. This treatment did not involve medication, but consisted of regular talks and environmental therapy ….
>
> The restrictions on the applicant's freedom of movement and contacts with the outside world were not much different from restrictions which might be imposed on a child in an ordinary hospital: it is true that the door of the Ward, like all children's wards in the hospital, was locked, but this was to prevent the children exposing themselves to danger or running around and disturbing other patients; the applicant was allowed to leave the Ward, with permission, to go for instance to the library and he went with other children, accompanied by a member of the staff, to visit playgrounds and museums and for other recreational and educational purposes; he was also able to visit his mother and father regularly and his old school friends and, towards the end of his stay in hospital, he started going to school again; in general, conditions in the Ward were said to be "as similar as possible to a real home" ….
>
> The duration of the applicant's treatment was 5½ months. This may appear to be a rather long time for a boy of 12 years of age, but it did not exceed the average period of therapy at the Ward and, in addition, the restrictions imposed were relaxed as treatment progressed ….
>
> 71. The Commission, in reaching the conclusion that the present case did involve a deprivation of liberty within the meaning of Article 5 … attached particular weight to the fact that the case concerned [the] 'detention in a psychiatric ward of a 12-year-old boy who was not mentally ill and that the applicant, when he disappeared from the hospital, was found and brought back to the hospital by the police' ….

117 Nielsen v Denmark, no. 10929/84, 28 November 1988, Series A no. 144, [1988] ECHR 23, (1988) 11 EHRR 175.

> 72. The Court accepts, with the Government, that the rights of the holder of parental authority cannot be unlimited and that it is incumbent on the State to provide safeguards against abuse. However, it does not follow that the present case falls within the ambit of Article 5 ….
>
> The restrictions imposed on the applicant were not of a nature or degree similar to the cases of deprivation of liberty specified in paragraph 1 of Article 5 (art. 5-1). In particular, he was not detained as a person of unsound mind so as to bring the case within paragraph 1 (e) (art. 5-1-e). Not only was the child not mentally ill within the meaning of the 1938 Act, but the Psychiatric Ward at the Hospital was in fact not used for the treatment of patients under the 1938 Act or of patients otherwise suffering from mental illnesses of a psychotic nature. Indeed, the restrictions to which the applicant was subject were no more than the normal requirements for the care of a child of 12 years of age receiving treatment in hospital. The conditions in which the applicant stayed thus did not, in principle, differ from those obtaining in many hospital wards where children with physical disorders are treated.
>
> Regarding the weight which should be given to the applicant's views as to his hospitalisation, the Court considers that he was still of an age at which it would be normal for a decision to be made by the parent even against the wishes of the child. There is no evidence of bad faith on the part of the mother. Hospitalisation was decided upon by her in accordance with expert medical advice. It must be possible for a child like the applicant to be admitted to hospital at the request of the holder of parental rights, a case which clearly is not covered by paragraph 1 of Article 5 (art. 5-1).
>
> Nor did the intervention of the police, which would have been appropriate for the return of any runaway child of that age even to parental custody, throw a different light on the situation.
>
> 73. The Court concludes that the hospitalisation of the applicant did not amount to a deprivation of liberty within the meaning of Article 5 (art. 5), but was a responsible exercise by his mother of her custodial rights in the interest of the child. Accordingly, Article 5 (art. 5) is not applicable in the case.'

In ***HM v Switzerland (2002)***,[118] the applicant, who was born in 1912, complained of an unlawful deprivation of liberty following her placement in a nursing home on account of neglect. She submitted in this respect that the Convention only cited 'vagrancy', and not neglect, as a ground of detention.

The court held that there had been no violation of Article 5§1. The applicant's placement in the nursing home had not amounted to a deprivation of liberty within the meaning of Article 5§1, but had been a responsible measure taken by the competent authorities in the applicant's interests, in order to provide her with necessary medical care and satisfactory living conditions and standards of hygiene. The applicant was also able to maintain social contact with the outside world while in the home. The court further noted that, after the applicant had moved to the nursing home, she had agreed to stay there.

118 HM v Switzerland, no. 39187/98, 26 February 2002, ECHR 2002-II, [2002] ECHR 157, (2002) 38 EHRR 314.

'44. Turning to the circumstances of the present case, the Court notes that the applicant had had the possibility of staying at home and being cared for by the Lyss Association for Home Visits to the Sick and Housebound, but she and her son had refused to cooperate with the association. Subsequently, the living conditions of the applicant at home deteriorated to such an extent that the competent authorities of the Canton of Berne decided to take action. On 16 December 1996 the Aarberg District Governor visited the applicant at home in order to assess the situation and, finding that she was suffering from serious neglect, decided on 17 December 1996 to place her in the S Nursing Home. On 16 January 1997, after carefully reviewing the circumstances of the case, the Cantonal Appeals Commission of the Canton of Berne concluded that the living conditions and standards of hygiene and of medical care at the applicant's home were unsatisfactory, and that the nursing home concerned, which was in an area which the applicant knew, could provide her with the necessary care.

45. Furthermore, it transpires … that the applicant was not placed in the secure ward of the nursing home … Rather, she had freedom of movement and was able to maintain social contact with the outside world.

46. The Court notes, in addition, the decision of the Cantonal Appeals Commission of 16 January 1997, according to which the applicant was hardly aware of the effects of her stay in the nursing home, which were mainly felt by her son who did not wish to leave his mother. Moreover, the applicant herself was undecided as to which solution she in fact preferred. For example, at the hearing before the Appeals Commission, she stated that she had no reason to be unhappy with the nursing home.

47. Finally, the Court notes that, after moving to the nursing home, the applicant agreed to stay there. As a result, the Aarberg District Government Office had lifted the order for the applicant's placement on 14 January 1998.

48. Bearing these elements in mind, in particular the fact that the Cantonal Appeals Commission had ordered the applicant's placement in the nursing home in her own interests in order to provide her with the necessary medical care and satisfactory living conditions and standards of hygiene, and also taking into consideration the comparable circumstances in *Nielsen* (cited above), the Court concludes that in the circumstances of the present case the applicant's placement in the nursing home did not amount to a deprivation of liberty within the meaning of Article 5§1, but was a responsible measure taken by the competent authorities in the applicant's interests. Accordingly, Article 5§1 is not applicable in the present case.'

In ***HL v the United Kingdom (2004)***,[119] the applicant was autistic and unable to speak, and his level of understanding was limited. In July 1997, while at a day centre, he started harming himself. He was detained in a psychiatric hospital intensive behavioural unit as an 'informal patient', i.e. without any detention order being made under the Mental Health Act 1983. Contact between him and his long-term carers was initially prohibited while he remained in hospital, and then subsequently restricted by the hospital to one visit a week. HL was sedated while in hospital which 'ensured that he remain tractable' and kept under continuous

119 HL v United Kingdom, no. 45508/99, 5 October 2004, ECHR 2004-IX, (2004) 40 EHRR 761.

observation by nursing staff. Those responsible for his care indicated that, if he tried to leave the hospital at all, they would arrange for him to be assessed with a view to his detention under the Mental Health Act 1983.

The applicant alleged that his period of treatment as an informal patient[120] in a psychiatric institution amounted to a deprivation of liberty. Furthermore, this had been unlawful because the procedures available to him for a review of the legality of his detention did not satisfy the requirements of Article 5. The court accepted that HL was deprived of his liberty:

> '91. Turning therefore to the concrete situation as required by the *Ashingdane* judgment, the Court considers the key factor in the present case to be that the health care professionals treating and managing the applicant exercised complete and effective control over his care and movements from the moment he presented acute behavioural problems on 22 July 1997 to the date he was compulsorily detained [under the Mental Health Act 1983] on 29 October 1997.
>
> More particularly, the applicant had been resident with his carers for over three years. On 22 July 1997, following a further incident of violent behaviour and self-harm in his day care centre, the applicant was sedated before being brought to the hospital and subsequently to the IBU [intensive behavioural unit], in the latter case supported by two persons. His responsible medical officer (Dr M) was clear that, had the applicant resisted admission or tried to leave thereafter, she would have prevented him from doing so and would have considered his involuntarily committal under section 3 of the 1983 Act (paragraphs 12, 13 and 41 above): indeed, as soon as the Court of Appeal indicated that his appeal would be allowed, he was compulsorily detained under the 1983 Act. The correspondence between the applicant's carers and Dr M … reflects both the carer's wish to have the applicant immediately released to their care and, equally, the clear intention of Dr M and the other relevant health care professionals to exercise strict control over his assessment, treatment, contacts and, notably, movement and residence: the applicant would only be released from the hospital to the care of Mr and Mrs E as and when those professionals considered it appropriate. While the Government suggested that "there was evidence" that the applicant had not been denied access to his carers, it is clear from the above-noted correspondence that the applicant's contact with his carers was directed and controlled by the hospital, his carers visiting him for the first time after his admission on 2 November 1997.
>
> Accordingly, the concrete situation was that the applicant was under continuous supervision and control and was not free to leave. Any suggestion to the contrary was, in the Court's view, fairly described by Lord Steyn [a House of Lords judge in the earlier UK proceedings] as 'stretching credulity to breaking point' and as a 'fairy tale' (paragraph 46 above) ….
>
> 93. Considerable reliance was placed by the Government on the … *HM v Switzerland* judgment, in which it was held that the placing of an elderly applicant in a foster home, to ensure necessary medical care as well as satisfactory living conditions and hygiene, did not amount to a deprivation of liberty within the meaning of Article 5 of the

120 Subsequently he was detained ('sectioned') under the Mental Health Act 1983.

> Convention. However, each case has to be decided on its own particular 'range of factors' and … there are also distinguishing features. In particular, it was not established that *HM* was legally incapable of expressing a view on her position, she had often stated that she was willing to enter the nursing home and, within weeks of being there, she had agreed to stay. This combined with a regime entirely different to that applied to the present applicant (the foster home was an open institution which allowed freedom of movement and encouraged contacts with the outside world) allows a conclusion that the facts of the *HM* case were not of a 'degree' or 'intensity' sufficiently serious to justify the conclusion that she was detained (see the … *Guzzardi* judgment, at §93).
>
> The Court also finds a conclusion that the present applicant was detained consistent with the above-cited *Nielsen* judgment on which the Government also relied. That case turned on the specific fact that the mother had committed the applicant minor to an institution in the exercise of her parental rights (the *Nielsen* judgment, at §§ 63 and 68), pursuant to which rights she could have removed the applicant from the hospital at any time. [In HL's case] … the fact that the hospital had to rely on the doctrine of necessity and, subsequently, on the involuntary detention provisions of the 1983 Act demonstrates that the hospital did not have legal authority to act on the applicant's behalf in the same way as Mr Nielsen's mother.
>
> 94. The Court therefore concludes that the applicant was 'deprived of his liberty' within the meaning of Article 5§1 of the Convention from 22 July 1997 to 29 October 1997.'

The court also accepted HL's complaint that there had been a violation of Article 5§4 because there were no proper procedural safeguards in place to protect him against an arbitrary deprivation of liberty on general (common law) grounds of necessity.

In ***Storck v Germany (2005)***,[121] the applicant, Waltraud Storck, was a German national who had spent almost 20 years of her life in psychiatric institutions and hospitals. At her father's request, she was placed in a locked ward of a private psychiatric clinic from 29 July 1977 to 5 April 1979 following various family conflicts. Ms Storck was an adult who had not been placed under guardianship and she had never signed a declaration consenting to her placement in the institution. Nor had there had been a judicial decision authorising her detention there.

The applicant repeatedly tried to flee from the clinic and was brought back by force by the police on 4 March 1979. After receiving medical treatment for schizophrenia at the clinic, she developed a post-poliomyelitis syndrome with the result that 'she is now 100% disabled'. From 1980 to 1991/1992 she lost the ability to speak. In 1994, an expert report found that she had never suffered from schizophrenia and also that her behaviour had been caused by conflicts with her family. The applicant brought complaints under Article 5, Article 6§1 and Article 8 of the Convention concerning her placement and medical treatment in the private clinic, her treatment in the university clinic and the fairness of the ensuing proceedings.

121 Storck v Germany, no. 61603/00, 16 June 2005, ECHR 2005-V, 43 EHRR 96, [2005] ECHR 406.

The Court found that the applicant, who had notably tried to flee from the clinic on several occasions, had not agreed to her continued stay there and had therefore been deprived of her liberty within the meaning of Article 5§1.

As there was no court order in place authorising Ms Storck's confinement in the private clinic, her detention had been unlawful and her confinement there breached the right to liberty guaranteed by Article 5§1. No separate issues arose under Article 5§§4 and 5.

The state was responsible for the deprivation of liberty in three respects. Firstly, the authorities became actively involved in her placement in the clinic when the police, by use of force, brought her back to the clinic from which she had fled. Secondly, the national courts, in compensation proceedings brought by the applicant, failed to interpret the civil law provisions relating to her claim in the spirit of Article 5. Thirdly, the state had violated its existing positive obligation to protect Ms Storck against interferences with her liberty carried out by private individuals.

> '73 … it is undisputed that the applicant had been placed in a locked ward of that clinic. She had been under continuous supervision and control of the clinic personnel and had not been free to leave the clinic during her entire stay there of some 20 months. When the applicant had attempted to flee it had been necessary to fetter her in order to secure her stay in the clinic. When she had once succeeded in escaping from there she had to be brought back by the police. She had also not been able to maintain regular social contacts with the outside world. Objectively, she must therefore be considered as having been deprived of her liberty.
>
> 74. However, the notion of deprivation of liberty within the meaning of Article 5§1 does not only comprise the objective element of a person's confinement to a certain limited place for a not negligible length of time. A person can only be considered as being deprived of his or her liberty if, as an additional subjective element, he has not validly consented to the confinement in question (see, *mutatis mutandis*, *H.M. v Switzerland*, cited above, §46). The Court notes that in the present case, it is disputed between the parties whether the applicant had consented to her stay in the clinic.
>
> 75 … the Court observes that the applicant had attained majority at the time of her admission to the clinic and had not been placed under guardianship. Therefore, she had been considered to have the capacity to consent or object to her admission and treatment in hospital. It is undisputed that she had not signed the clinic's admission form prepared on the day of her arrival. It is true that she had presented herself to the clinic, accompanied by her father. However, the right to liberty is too important in a democratic society for a person to lose the benefit of the Convention protection for the single reason that he may have given himself up to be taken into detention (see *De Wilde, Ooms and Versyp v Belgium*, judgment of 18 June 1971, Series A no. 12, p. 36, §65; *H.L. v the United Kingdom*, cited above, §90).
>
> 76. Having regard to the continuation of the applicant's stay in the clinic, the Court considers the key factor in the present case to be that … the applicant, on several occasions, had tried to flee from the clinic. She had to be fettered in order to prevent her from absconding and had to be brought back to the clinic by the police when she

had managed to escape on one occasion. Under these circumstances, the Court is unable to discern any factual basis for the assumption that the applicant — presuming her capacity to consent — had agreed to her continued stay in the clinic. In the alternative, assuming that the applicant had no longer been capable of consenting following her treatment with strong medicaments, she could, in any event, not be considered as having validly agreed to her stay in the clinic.

77. Indeed, a comparison of the facts of this case with those in *HL v the United Kingdom* … cannot but confirm this finding. That case concerned the confinement of an individual who was of age but lacked the capacity to consent in a psychiatric institution which he had never attempted to leave, and in which the Court had found that there had been a deprivation of liberty. In the present case, *a fortiori*, a deprivation of liberty must be found. The applicant's lack of consent must also be regarded as the decisive feature distinguishing the present case from the case of *HM v Switzerland* … In that case, it was held that the placing of an elderly person in a foster home, to ensure necessary medical care, had not amounted to a deprivation of liberty. However, that applicant, who had been legally capable of expressing a view, had been undecided as to whether or not she wanted to stay in the nursing home. The clinic could then draw the conclusion that she did not object.

78. The Court therefore concludes that the applicant had been deprived of her liberty within the meaning of Article 5§1 of the Convention.'

The court reiterated the positive obligation on the state to protect the liberty of its citizens. It also emphasised that *ex post facto* sanctions, in the shape of criminal and civil liability for wrongful detention, do not provide effective protection for people in such a vulnerable position.

In ***Shtukaturov v Russia (2008)***,[122] the applicant was admitted to hospital on 4 November 2005. His admission was requested by his mother as the guardian of a legally incapable person. In terms of domestic law it was therefore a voluntary admission and did not require approval by a court. The applicant claimed that he had been confined in hospital against his will and that his placement in hospital amounted to a deprivation of his liberty. He observed that he was placed in a locked facility. After he attempted to flee the hospital in January 2006, he was tied to his bed and given an increased dose of sedative medication. He was not allowed to communicate with the outside world until he was discharged. Subjectively, he perceived his confinement as a deprivation of liberty, had never regarded his detention as consensual, and unequivocally objected to it throughout his stay. Because the authorities had relied on his status as a legally incapable person, and treated his hospitalization as a voluntary confinement, in contravention of Article 5§4 none of the procedural safeguards usually required in cases of involuntary hospitalisation had applied to him. The court found that the applicant was deprived of his liberty:

'107 ... The applicant was confined in the hospital for several months, he was not free to leave and his contacts with the outside world were seriously restricted ….

122 Shtukaturov v Russia, no. 44009/05, 27 March 2008, 54 EHRR 962.

> 108. The Court notes … that … the applicant lacked *de jure* legal capacity to decide for himself. However, this does not necessarily mean that the applicant was *de facto* unable to understand his situation. First, the applicant's own behaviour at the moment of his confinement proves the contrary. Thus, on several occasions the applicant requested his discharge from hospital, he contacted the hospital administration and a lawyer with a view to obtaining his release, and once he attempted to escape from the hospital (see, *a fortiori*, *Storck v Germany* … where the applicant consented to her stay in the clinic but then attempted to escape). Second … the findings of the domestic courts on the applicant's mental condition were questionable and quite remote in time ….
>
> 109. In sum, even though the applicant was legally incapable of expressing his opinion, the Court in the circumstances is unable to accept the Government's view that the applicant agreed to his continued stay in the hospital. The Court therefore concludes that the applicant was deprived of his liberty by the authorities within the meaning of Article 5§1 of the Convention.
>
> 110. The Court further notes that although the applicant's detention was requested by the applicant's guardian, a private person, it was implemented by a State-run institution — a psychiatric hospital. Therefore, the responsibility of the authorities for the situation complained of was engaged.'

In ***Stanev v Bulgaria (2012)***,[123] the Bulgarian courts found that Mr Stanev was partially incapacitated, on the ground that he had suffered from schizophrenia since 1975 and was unable to manage his own affairs adequately or to realise the consequences of his actions. In 2002 he was placed under the partial guardianship of a council officer. Without consulting or informing him, his guardian had Mr Stanev placed in the Pastra social care home for men with psychiatric disorders, in a remote mountain location. He had lived there ever since and the director of the home subsequently became his guardian.

Mr Stanev was only allowed to leave the institution with the director's permission. On one occasion, when he did not return from a period of organised leave, the director contacted the police who located him. Mr Stanev tried to have his legal capacity restored in November 2004. In 2005 prosecutors refused to bring a case, finding that he could not cope alone and that the institution was the most suitable place for him. This decision relied on a medical report dated 15 June 2005 which stated that there were signs of schizophrenia. An application for judicial review was rejected on the ground that an application could be made by his guardian. Several oral requests to his guardian to apply for his release were refused. Mr Stanev complained that he was deprived of his liberty and therefore was entitled to the protections afforded by Article 5.

The court found that Mr Stanev's placement in the social care home was the result of various steps taken by public authorities and institutions through their officials, from the initial request for his placement there through to its implementation. It was therefore attributable to the Bulgarian authorities.

123 Stanev v Bulgaria [GC], no. 36760/06, 17 January 2012, [2012] ECHR 46.

Mr Stanev was housed in a block which he was able to leave but the time he spent away from the institution and the places he could go were always subject to controls and restrictions. The system of leave of absence and the fact that managers kept his identity papers placed significant restrictions on his personal liberty. Although he was able to undertake certain journeys, he was under constant supervision and was not free to leave the home without permission whenever he wished. In addition, the government had not shown that his state of health put him at immediate risk or required the imposition of any special restrictions to protect him. The duration of the applicant's placement in the home was not specified and so was indefinite; he was listed in the municipal registers as being permanently resident there and indeed was still living there. As he had lived in the home for more than eight years, he must have felt the full adverse effects of the restrictions imposed on him. The court was not convinced that he ever consented to the placement, even tacitly. Although domestic law attached a certain weight to his wishes, and it appeared that he was well aware of his situation, Mr Stanev was not asked for his opinion on his placement in the institution and never explicitly consented to it. At least from 2004 onwards, he explicitly expressed his desire to leave the institution, both to psychiatrists and through applications to the authorities to have his legal capacity restored. Taking into consideration the authorities involvement in the decision to place him in the institution, the rules on leave of absence, the duration of the placement and his lack of consent, this was a deprivation of liberty and Article 5§1 was applicable.

Furthermore, this deprivation of liberty was unlawful and there had therefore been a violation of Article 5§1. There were deficiencies in the assessment of whether he still suffered from a disorder warranting his confinement, and indeed no provision was made for such an assessment under the relevant legislation. The lack of a recent medical assessment alone would have been sufficient to conclude that his placement in the home was unlawful. In addition, it had not been established that he posed a danger to himself or to others. Further still, the decision by his guardian to place him in an institution for people with psychiatric disorders without obtaining his prior consent was invalid under Bulgarian law and therefore his deprivation of liberty was unlawful for the purposes of Article 5.

> '115. The Court reiterates that the difference between deprivation of liberty and restrictions on liberty of movement … is merely one of degree or intensity, and not one of nature or substance. Although the process of classification into one or other of these categories sometimes proves to be no easy task in that some borderline cases are a matter of pure opinion, the Court cannot avoid making the selection upon which the applicability or inapplicability of Article 5 depends (see *Guzzardi v Italy*, 6 November 1980, §§ 92-93, Series A no. 39) ....
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> 120 … The State is therefore obliged to take measures providing effective protection of vulnerable persons, including reasonable steps to prevent a deprivation of liberty of which the authorities have or ought to have knowledge (see *Storck*, cited above, §102). Thus, having regard to the particular circumstances of the cases before it, the Court has held that the national authorities' responsibility was engaged as a result of detention in a psychiatric hospital at the request of the applicant's guardian (see *Shtukaturov*, cited above) and detention in a private clinic (see *Storck*, cited above) ….

121. The Court observes at the outset that it is unnecessary in the present case to determine whether, in general terms, any placement of a legally incapacitated person in a social care institution constitutes a "deprivation of liberty" within the meaning of Article 5§1.[124] In some cases, the placement is initiated by families who are also involved in the guardianship arrangements and is based on civil-law agreements signed with an appropriate social care institution. Accordingly, any restrictions on liberty in such cases are the result of actions by private individuals and the authorities' role is limited to supervision. The Court is not called upon in the present case to rule on the obligations that may arise under the Convention for the authorities in such situations.[125]

122. It observes that there are special circumstances in the present case. No members of the applicant's family were involved in his guardianship arrangements, and the duties of guardian were assigned to a State official (Ms RP), who negotiated and signed the placement agreement … without any contact with the applicant, whom she had in fact never met. The placement agreement was implemented in a State-run institution by social services, which likewise did not interview the applicant … The applicant was never consulted about his guardian's choices, even though he could have expressed a valid opinion and his consent was necessary in accordance with the Persons and Family Act 1949 … That being so, he was not transferred to the Pastra social care home at his request or on the basis of a voluntary private-law agreement on admission to an institution to receive social assistance and protection. The Court considers that the restrictions complained of by the applicant are the result of various steps taken by public authorities and institutions through their officials … and not of acts or initiatives by private individuals. [That] … set[s] the present case apart from *Nielsen* … in which the applicant's mother committed her son, a minor, to a psychiatric institution in good faith … [in] the exercise of exclusive custodial rights over a child who was not capable of expressing a valid opinion.

123. The applicant's placement in the social care home can therefore be said to have been attributable to the national authorities. It remains to be determined whether the restrictions resulting from that measure amounted to a "deprivation of liberty" within the meaning of Article 5.

124. With regard to the objective aspect, the Court observes that the applicant was housed in a block which he was able to leave, but emphasises that the question whether the building was locked is not decisive (see *Ashingdane*, cited above, §42). While it is true that the applicant was able to go to the nearest village, he needed express permission to do so … Moreover, the time he spent away from the home and the places where he could go were always subject to controls and restrictions.

125 ... such leave of absence was entirely at the discretion of the home's management, who kept the applicant's identity papers and administered his finances, including transport costs ….

124 A critical observation because it can be seen that this vital question remains open.

125 Likewise, a critical observation because it can be seen that this vital question also remains open.

126. The Court considers that this system of leave of absence and the fact that the management kept the applicant's identity papers placed significant restrictions on his personal liberty.

127. Moreover, it is not disputed that when the applicant did not return from leave of absence in 2006, the home's management asked the Ruse police to search for and return him … since his authorised period of leave had expired, the staff returned him to the home without regard for his wishes.

128 …. the factors outlined above lead the Court to consider that, contrary to what the Government maintained, he was under constant supervision and was not free to leave the home without permission whenever he wished. With reference to the *Dodov* case … the applicant's mother [in that case] suffered from Alzheimer's disease and … as a result, her memory and other mental capacities had progressively deteriorated, to the extent that the nursing home staff had been instructed not to leave her unattended. In the present case, however, the Government have not shown that the applicant's state of health was such as to put him at immediate risk, or to require the imposition of any special restrictions to protect his life and limb ….

130. As to the subjective aspect of the measure … the applicant was not asked to give his opinion on his placement in the home and never explicitly consented to it … The Court observes in this connection that there are situations where the wishes of a person with impaired mental faculties may validly be replaced by those of another person acting in the context of a protective measure and that it is sometimes difficult to ascertain the true wishes or preferences of the person concerned. However, the Court has already held that the fact that a person lacks legal capacity does not necessarily mean that he is unable to comprehend his situation (see *Shtukaturov …* §108). In the present case … it appears that he was well aware of his situation … the applicant explicitly expressed his desire to leave the Pastra social care home ….

131. These factors set the present case apart from *HM v Switzerland …* in which the Court found that there had been no deprivation of liberty as the applicant had been placed in a nursing home purely in her own interests and, after her arrival there, had agreed to stay. In that connection the Government have not shown that in the present case, on arrival at the Pastra social care home or at any later date, the applicant agreed to stay there. That being so, the Court is not convinced that the applicant consented to the placement or accepted it tacitly at a later stage and throughout his stay.

132. Having regard to the particular circumstances of the present case, especially the involvement of the authorities in the decision to place the applicant in the home and its implementation, the rules on leave of absence, the duration of the placement and the applicant's lack of consent, the Court concludes that the situation under examination amounts to a deprivation of liberty within the meaning of Article 5§1 …'

In ***DD v Lithuania (2012)***,[126] the applicant had suffered from mental disorder since the age of 16 when she discovered she was adopted. More than 20 hospital admissions had resulted in various diagnoses, the most recent being episodic paranoid schizophrenia. Her adoptive father was granted a declaration that DD was legally incapacitated and a legal guardian was appointed. Her first guardian was her psychotherapist and friend, who later resigned and was replaced with DD's adoptive father.

In 2004, on the initiative of her adoptive father and without her consent, DD was placed in a social care home where she remained at the time of the hearing. In 2007, the director of the home became her guardian. As an incapacitated person, DD was not given the opportunity to participate in this or any other guardianship proceedings.

DD contended that her involuntary admission to the home amounted to a 'deprivation of liberty'. The government argued that the care home was providing social services, not compulsory psychiatric treatment, and that the restrictions on DD were necessary because of the severity of her mental illness, were in her interests and were no more than the normal requirements associated with the responsibilities of a social care institution taking care of inhabitants suffering mental health problems.

Finding that there was a deprivation of liberty, the court distinguished the *Nielsen* and *HM* cases:

> '146… the key factor in determining whether Article 5§1 applies to the applicant's situation is that the Kedainiai Home's management has exercised complete and effective control by medication and supervision over her assessment, treatment, care, residence and movement from 2 August 2004, when she was admitted to that institution, to this day (ibid.,§91). As transpires from the rules of the Kedainiai Home, a patient therein is not free to leave the institution without the management's permission. In particular, … on at least one occasion the applicant left the institution without informing its management, only to be brought back by the police … Moreover, the director of the Kedainiai Home has full control over whom the applicant may see and from whom she may receive telephone calls … Accordingly, the specific situation in the present case is that the applicant is under continuous supervision and control and is not free to leave (see *Storck v Germany*, no. 61603/00, §73, ECHR 2005-V). Any suggestion to the contrary would be stretching credulity to breaking point.
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> 147. Considerable reliance was placed by the Government on the court's judgment in [HM v Switzerland] … in which it was held that the placing of an elderly applicant in a foster home in order to ensure necessary medical care as well as satisfactory living conditions and hygiene did not amount to a deprivation of liberty within the meaning of Article 5 of the Convention. However, each case has to be decided on its own particular "range of factors" and, while there may be similarities between the present case and HM, there are also distinguishing features. In particular, it was not established that HM was legally incapable of expressing a view on her position. She had often stated that she was willing to enter the nursing home and, within weeks of being there, she had agreed to stay, in plain contrast to the applicant in the instant case. Further, a

126 DD v Lithuania, no. 13469/06, 14 February 2012, [2012] ECHR 254.

number of safeguards — including judicial scrutiny — were in place in order to ensure that the placement in the nursing home was justified under domestic and international law. This led to the conclusion that the facts in HM were not of a "degree" or "intensity" sufficiently serious to justify a finding that H.M. was detained (see *Guzzardi*, cited above, §93). By contrast, in the present case the applicant was admitted to the institution upon the request of her guardian without any involvement of the courts.

148. As to the facts in *Nielsen*, the other case relied on by the Government, the applicant in that case was a child, hospitalised for a strictly limited period of time of only five and a half months, on his mother's request and for therapeutic purposes. The applicant in the present case is a functional adult who has already spent more than seven years in the Kėdainiai Home, with negligible prospects of leaving it. Furthermore, in contrast to this case, the therapy in *Nielsen* consisted of regular talks and environmental therapy and did not involve medication. Lastly, as the court found in *Nielsen*, the assistance rendered by the authorities when deciding to hospitalise the applicant was "of a limited and subsidiary nature" (§63), whereas in the instant case the authorities contributed substantially to the applicant's admission to and continued residence in the… Home.

149. Assessing further, the court draws attention to the incident of 25 January 2005, when the applicant was restrained by the Kedainiai Home staff. Although the applicant was placed in a secure ward, given drugs and tied down for a period of only fifteen to thirty minutes, the court notes the particularly serious nature of the measure of restraint and observes that where the facts indicate a deprivation of liberty within the meaning of Article 5§1, the relatively short duration of the detention does not affect this conclusion …

150. The court next turns to the "subjective" element … the applicant subjectively perceived her compulsory admission to the Kedainiai Home as a deprivation of liberty. Contrary to what the Government suggested, she has never regarded her admission to the facility as consensual and has unequivocally objected to it throughout the entire duration of her stay in the institution. On a number of occasions the applicant requested her discharge … She even twice attempted to escape … In sum, even though the applicant had been deprived of her legal capacity, she was still able to express an opinion on her situation, and in the present circumstances the court finds that the applicant had never agreed to her continued residence at the Kedainiai Home.

151. Lastly, the court notes that although the applicant's admission was requested by the applicant's guardian, a private individual, it was implemented by a State-run institution – the Kedainiai Home. Therefore, the responsibility of the authorities for the situation complained of was engaged …'

Having found that there was a deprivation of liberty, the court decided that it was lawful to confine DD to the care home because she satisfied the *Winterwerp* criteria (see below) and no alternative measures were appropriate.[127]

127 Whether a person of unsound mind is detained in a psychiatric hospital or a community facility, *Stanev* and *DD* confirm that *Winterwerp* should be applied.

The issue of deprivations of liberty in supported living placements and a person's own home was considered by the UK Supreme Court in what is known as the ***Cheshire West Case (2014)***.[128] The court reiterated the standard test set out in cases such as *HL, Storck* and *Stanev* and also that a deprivation of liberty imputable to the state may occur in a setting such as one's own home or a supported living environment. The judgment lacked intellectual rigour, however, and did little to clarify the grey areas. Consequently, its implementation nationally has been fairly subjective.

When is a deprivation of liberty on the ground of unsoundness of mind 'lawful'

If an individual is deprived of his liberty on the ground of unsoundness of mind, the next question is whether their deprivation of liberty is lawful? Does it comply with or contravene the Article 5 requirements? The leading case is ***Winterwerp v The Netherlands***.[129] In that case, the court set down four conditions that must be satisfied for a person's detention on the basis of unsoundness of mind to be lawful under Article 5§1(e):[130]

1. **The deprivation of liberty must be lawful.**

   Lawfulness presupposes conformity with domestic law and the Convention.

   As regards the conformity with the domestic law, the term 'lawful' covers procedural as well as substantive rules.

   Domestic law must be in conformity with the Convention, including the general principles expressed or implied by it.[131] The general implied principles to which the Article 5§1 case law refers are the principle of the rule of law and, connected to this, the principles of legal certainty, proportionality and protection from arbitrariness, which is the very aim of Article 5.[132] A deprivation of liberty may be lawful in terms of domestic law but still arbitrary and contrary to the Convention.[133]

   As concerns the principle of legal certainty, the Convention requires that the law is sufficiently clear and precise. It is essential that the conditions for a deprivation of liberty under domestic law are clearly defined and that the law foreseeable in its application, so that so that a person may know to a degree that is reasonable in the circumstances the consequences which a given action may entail, if need be by taking appropriate advice.[134]

128 P v Cheshire West and Chester Council and P and Q v Surrey County Council [2014] UKSC 19.

129 Winterwerp v Netherlands, no 6301/73, 24 October 1979, Series A no. 33, 2 EHRR 387.

130 See Winterwerp v Netherlands, supra, §39. The four conditions were confirmed in Stanev v Bulgaria [GC], no. 36760/06, 17 January 2012, [2012] ECHR 46, §145; DD v Lithuania, no. 13469/06, 14 February 2012, [2012] ECHR 254,§156; Kallweit v Germany, no. 17792/07, 13 January 2011, §45; Shtukaturov v Russia, no. 44009/05, 27 March 2008, 54 EHRR 962, §114; Varbanov v Bulgaria, no. 31365/96, ECHR 2000-X, §45.

131 Plesó v Hungary, no. 41242/08, 2 October 2012, §59.

132 Simons v Belgium (dec), no. 71407/10, 28 August 2012, §32.

133 Creangă v Romania, supra, §84; A and Others v the United Kingdom [GC], no. 3455/05, 19 February 2009, §164.

134 See e.g. Del Río Prada v Spain [GC], no. 42750/09, 21 October 2013, ECHR 2013, §125; Creangă v Romania [GC], no. 29226/03, 23 February 2012, §120; Medvedyev and Others v France [GC], no. 3394/03, 29 March 2010, ECHR 2010, §80.

The essential objective of Article 5 is to prevent citizens from being deprived of their liberty abritrarily.[135] No detention that is arbitrary can ever be regarded as 'lawful'. If there are no procedural rules, no criteria, no statement of purpose, no time limits or treatment, and no requirement for continuing clinical assessment, then there is nothing in the law to protect the individual against the arbitrary deprivation of liberty.

Arbitrariness may arise where there has been an element of bad faith or deception on the part of the authorities; where the order to detain and the detention do not genuinely conform to the purpose of the restrictions permitted by the relevant sub-paragraph of Article 5§1; where there is no connection between the ground relied on and the place and conditions of detention; and where there is no proportionality between the ground of detention relied on and the detention in question.[136] The speed with which the domestic courts replace a detention order which has expired or has been found to be defective is a further relevant element in assessing whether a person's detention must be considered arbitrary.[137] The absence or lack of reasoning in detention orders is another element taken into account by the court when assessing lawfulness under Article 5§1.[138]

In terms of the principle of proportionality, the authorities should consider less intrusive measures than detention.[139]

As regards the relationship between the ground relied upon and the place and conditions of detention, in principle the detention of a person as a mental health patient will only be lawful for the purposes of Article 5(1)(e) if effected in a hospital, clinic, or other appropriate institution authorised for the detention of such persons.[140] However, where the circumstances justify it, a person may be placed temporarily in an establishment not specifically designed for the detention of mental

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135 See e.g. Witold Litwa v Poland, no. 26629/95, 4 April 2000, ECHR 2000-III, §78.

136 See James, Wells and Lee v the United Kingdom, nos. 25119/09, 57715/09 and 57877/09, 18 September 2012, §§191-95; Saadi v the United Kingdom [GC], no. 13229/03, 29 January 2008, §§68-74.

137 Mooren v Germany [GC], no. 11364/03, 9 July 2009, §80. Thus, in the context of sub-paragraph (c), the court considered that a period of less than one month between the expiry of the initial detention order and the issue of a fresh, reasoned detention order following a remittal of the case from the appeal court to a lower court did not render the applicant's detention arbitrary: Minjat v Switzerland, no. 38223/97, 28 October 2003, §§46 and 48. In contrast, a period of more than a year following a remittal from a court of appeal to a court of lower instance, in which the applicant remained in a state of uncertainty as to the grounds for his detention on remand, combined with the lack of a time-limit for the lower court to re-examine his detention, was found to render the applicant's detention arbitrary: Khudoyorov v Russia, no. 6847/02, 8 November 2005, ECHR 2005-X (extracts), §§ 136-37.

138 The absence of any grounds given by the judicial authorities in their decisions authorising detention for a prolonged period of time may be incompatible with the principle of protection from arbitrariness enshrined in Article 5§1: Stašaitis v Lithuania, no. 47679/99, 21 March 2002, §§66-67. Likewise, a decision which is extremely laconic and makes no reference to any legal provision which would permit detention will fail to provide sufficient protection from arbitrariness: Khudoyorov v Russia, supra, §157. What is required is a detention order based on concrete grounds and setting a specific time-limit: Meloni v Switzerland, no. 61697/00, 10 April 2008, §53.

139 Ambruszkiewicz v Poland, no. 38797/03, 4 May 2006, §32.

140 LB v Belgium, no. 22831/08, 2 October 2012, §93; Ashingdane v United Kingdom, no. 8225/78, 28 May 1985, Series A no. 93, (1985) 7 EHRR 528, [1985] ECHR 8, §44; OH v Germany, no. 4646/08, 24 November 2011, §79.

health patients before being transferred to the appropriate institution, provided that the waiting period is not excessively long.[141]

2. **Except in emergency cases, the individual concerned must be reliably shown to be of 'unsound mind', that is to say, a true mental disorder must be established before a competent authority on the basis of objective medical expertise.**

   The very nature of what has to be established before the competent national authority — a true mental disorder — calls for objective medical expertise. Except in an emergency, no deprivation of liberty of a citizen considered to be of unsound mind is in conformity with Article 5§1 (e) if it has been ordered without seeking the opinion of a medical expert.[142] A mental condition must be of a certain gravity in order to be considered as a 'true' mental disorder.[143] The relevant time at which a person must be reliably established to be of unsound mind is the date of adoption of the measure depriving that person of their liberty as a result of that condition.[144]

3. **The mental disorder must be of a kind or degree warranting compulsory confinement.**

   In deciding whether an individual should be detained as a person 'of unsound mind', the national authorities have a certain discretion because it is in the first place for the national authorities to evaluate the evidence adduced before them in a particular case.[145] The detention of a mentally disordered person may be necessary not only where the person needs therapy, medication or other clinical treatment to cure or alleviate their condition, but also where the person needs control and supervision to prevent them from, for example, causing harm to themselves or others.[146]

141 Pankiewicz v Poland, no. 34151/04, 12 February 2008, §§44-45; Morsink v Netherlands, no. 48865/99, 11 May 2004, §§67-69; Brand v Netherlands, no. 49902/99, 11 May 2004, §§64-66. With regard to Article 5§1(e), the case law provides that it should not be interpreted as only allowing the detention of 'alcoholics' in the limited sense of persons in a clinical state of 'alcoholism', because nothing in the text of this provision prevents that measure from being applied by the State to an individual abusing alcohol, in order to limit the harm caused by alcohol to himself and the public, or to prevent dangerous behaviour after drinking: Kharin v Russia, no. 37345/03, 3 February 2011, §34. Therefore, persons whose conduct and behaviour under the influence of alcohol pose a threat to public order or themselves can be taken into custody for the protection of the public or their own interests, such as their health or personal safety: Hilda Hafsteinsdóttir v Iceland, no. 40905/98, 8 June 2004, Witold Litwa v Poland, no. 26629/95, 4 April 2000, ECHR 2000-III, §42. However, this does not mean however that Article 5§1(e) permits the detention of an individual merely because of his alcohol intake: Witold Litwa v Poland, supra, §§ 61-62.

142 Ruiz Rivera v Switzerland, no. 8300/06, 18 February 2014, §59; SR v Netherlands (dec), no. 13837/07, 18 September 2012, §31.

143 Glien v Germany, no. 7345/12, 28 November 2013, §85.

144 OH v Germany, no. 4646/08, 24 November 2011, §78.

145 Plesó v Hungary, no. 41242/08, 2 October 2012, §61; HL v United Kingdom, no. 45508/99, 5 October 2004, ECHR 2004-IX, (2004) 40 EHRR 761, §98.

146 Hutchison Reid v United Kingdom, no. 50272/99, 20 February 2003, ECHR 2003-IV, [2003] ECHR 94, (2003) 37 EHRR 211, §52.

4. The validity of continued confinement depends upon the persistence of such a disorder.

When the medical evidence points to recovery, the authorities may need some time to consider whether to terminate an applicant's confinement.[147] However, the continuation of a deprivation of liberty for purely administrative reasons is not justified.[148]

In ***X v United Kingdom (1981)***,[149] a patient who was subject to special restrictions because of a risk of serious harm to others complained that it had been unlawful for the Home Secretary to recall him to Broadmoor (high-secure) Hospital without any doctor having certified first that he was of unsound mind. This argument was rejected by the court. The court noted that the Home Secretary's power of recall was concerned,

> 'with the recall, perhaps in circumstances when some danger is apprehended, of patients whose discharge from hospital has been restricted for the protection of the public ... The *Winterwerp judgment* expressly identified "emergency cases" as constituting an exception to the principle that the individual concerned should not be deprived of his liberty unless he has been reliably shown to be of "unsound mind"; nor could it be inferred from the *Winterwerp judgment* that the "objective medical expertise" must in all conceivable cases be obtained before rather than after confinement of a person on the ground of unsoundness of mind. Clearly, where a provision of domestic law was designed ... to authorise the emergency confinement of persons capable of presenting a danger to others, it would be impracticable to require thorough medical examination prior to any arrest or detention. A wide discretion must in the nature of things be enjoyed by the national authority empowered to order such emergency confinements.'

The court found that the statutory conditions governing a recall to hospital were not incompatible with the meaning under the Convention of the expression 'the lawful detention of persons of unsound mind'. In circumstances such as X's, the interests of the protection of the public prevailed over the individual's right to liberty to the extent of justifying an emergency confinement in the absence of the usual guarantees. However, following the use for a short period of such an emergency measure, the patient's further detention in hospital had to satisfy the minimum conditions described in *Winterwerp.*

In the ***Luberti Case (1984)***,[150] the court accepted that terminating the confinement of an individual whom a court has previously found to be of unsound mind and to present a danger to society is a matter that concerns, as well as that individual, the community in which he will live if released. Having regard to that fact, and the very serious nature of the offence committed by the applicant when mentally ill, the responsible authority was entitled to proceed with caution and needed some time to consider whether to terminate his confinement, even if the medical evidence pointed to his recovery.

147 Luberti v Italy, no. 9019/80, 23 February 1984, Series A no. 75, [1984] ECHR 3, [1984] ECHR 3, §28.
148 RL and M-JD v France, no. 44568/98, 19 May 2004, §129.
149 X v United Kingdom, no. 7215/75, 5 November 1981, [1981] ECHR 6, (1982) 4 EHRR 188.
150 Luberti v Italy, no. 9019/80, 23 February 1984, Series A no. 75, [1984] ECHR 3, [1984] ECHR 3, §28.

As with *X v United Kingdom (1981)*, the applicant in ***Kay v United Kingdom (1994)***[151] complained about his recall to Broadmoor Hospital without a prior medical assessment, in his case on the expiration of a lengthy prison sentence. The Commission noted that his recall was in accordance with the procedures prescribed by domestic law. Furthermore, the Home Secretary was entitled to be concerned about the protection of the public in the light of the applicant's history of psychopathy, and his serious criminal record involving extreme violence towards girls and women. However, this historical background did not mean that one could dispense with the need to obtain up-to-date medical evidence about the applicant's mental health before ordering his recall. The most recent tribunal decision in 1986 had found that there was no evidence the applicant was then suffering from a psychopathic disorder and the weight of medical evidence at the time of recall was in his favour. It had not been impossible to have him assessed in prison, and the existence of a dissenting report from a Broadmoor doctor who had not interviewed him could not outweigh the tribunal's finding, nor provide a sufficient scientific basis for his continued compulsory confinement in hospital nearly three years later. Consequently, when the Home Secretary decided to recall the applicant to Broadmoor certain minimum conditions of lawfulness were not respected. In particular, there was no up-to-date objective medical expertise showing that the applicant suffered from a true mental disorder, or that his previous psychopathic disorder persisted. In the absence of any emergency, there were no particular circumstances to justify the omission. Accordingly, the applicant's recall and return to Broadmoor could not be qualified as the lawful detention of a person of unsound mind for the purposes of Article 5(1)(e).

In ***Johnson v United Kingdom (1997)***,[152] the applicant's detention in Rampton [high secure] Hospital was reviewed by a tribunal on 15 June 1989. The tribunal accepted the medical evidence that he was not then suffering from mental illness, stating that the episode of mental illness from which he formerly suffered has come to an end. It ordered his conditional rather than absolute discharge, because he required rehabilitation under medical supervision in a hostel environment, and a recurrence of his mental illness requiring recall to hospital could not be excluded. This discharge was deferred until arrangements could be made for his suitable accommodation. Considerable efforts to secure a hostel were unsuccessful. Eventually, on 12 January 1993, a tribunal ordered his absolute discharge. The applicant complained that his detention between 15 June 1989 and 12 January 1993 violated Article 5(1). More particularly, the tribunal in 1989 should have ordered his immediate and unconditional discharge, since he had made a full recovery from the episode of mental illness specified in the hospital order imposed by the court.

The court observed that it does not automatically follow from a finding by an expert authority that the mental disorder which justified confinement no longer persists that therefore the patient must be immediately and unconditionally released into the community. Such a rigid approach would place an unacceptable degree of constraint on the responsible authority's exercise of judgment when determining whether the interests of the patient and the community will be best served by such a course of action. In the field of mental illness, the assessment as to whether the disappearance of symptoms is confirmation of complete recovery is not an exact science. Whether or not recovery from the episode of illness which justified the confinement is complete and definitive, or merely apparent, cannot always be

151 Kay v United Kingdom, no. 17821/91, 1 March 1994, [1994] ECHR 51.

152 Johnson v United Kingdom, no. 22520/93, 24 October 1997, (1997) 27 EHRR 296, [1997] ECHR 88.

measured with absolute certainty. It is the patient's behaviour outside the confines of the psychiatric institution which will be conclusive of this. Therefore, a responsible authority is entitled to exercise a measure of discretion in deciding whether it is appropriate to order immediate and absolute discharge in a case as this. It is, however, of paramount importance that appropriate safeguards are in place which ensure that any deferral of discharge is consonant with the purpose of Article 5(1)(e) and, in particular, that discharge is not unreasonably delayed.

Although the tribunal was entitled to conclude that it was premature to order Mr Johnson's absolute and immediate discharge from hospital, it lacked the power to guarantee that he would be relocated to a suitable hostel within a reasonable time. The onus was on the authorities to secure a hostel willing to admit him. In between reviews, Mr Johnson could not petition the tribunal to have the terms of the residence condition reconsidered; nor was the tribunal empowered to monitor the progress made in the search for a hostel outside the annual reviews, and to amend the deferred conditional discharge order in the light of the difficulties encountered by the authorities. The imposition of the hostel residence condition in 1989 by the tribunal therefore led to the indefinite deferral of the applicant' release from hospital. Having regard to this situation, and the lack of adequate safeguards, including provision for judicial review to ensure that his release would not be unreasonably delayed, his continued confinement after 15 June 1989 could not be justified under Article 5(1)(e).

In ***Roux v United Kingdom (1996)***,[153] the applicant was subject to special restrictions because of a risk of serious harm to others. He complained that it had been unlawful for the Home Secretary to recall him to Broadmoor [high-secure] Hospital because of a concern that he was beginning to repeat the pattern of behaviour evident before the commission of his two offences against prostitutes. Mr Roux complained that his recall contravened Article 5 because he had not failed to comply with or breached any condition of the tribunal order discharging him and no breach of an obligation prescribed by law. Furthermore, no court had determined the state of his mental health at the time of his recall. The Government submitted that the Home Secretary's power of recall was not limited by the conditions attached to release and there could be occasions where recall was appropriate even though no conditions had been breached. Conversely, some breaches of the conditions of discharge from hospital would not warrant recall to hospital. In the event, a friendly settlement was reached, whereby the Government agreed to pay £2,000 to the applicant together with the agreed costs.

In ***Aerts v Belgium (1998)***,[154] national legislation provided only for the detention of a mentally ill person in a prison as a provisional measure, pending a designation by the relevant mental health board as to the institution where the person was to be detained. The applicant maintained that his detention for seven months in the psychiatric wing of Lantin Prison, pending transfer to the Paifve Social Protection Centre (his designated place of detention), breached Article 5. The prison psychiatric wing was not an appropriate institution for the treatment of the mentally ill and the treatment he received there had done him harm. The court reiterated that there must be some relationship between the ground of permitted deprivation of liberty relied on and the place and conditions of detention. In principle, the detention of a person as a mental health patient will only be lawful for the purposes of Article

153 Roux v United Kingdom, no. 25601/94, 4 September 1996.

154 Aerts v Belgium, no. 25357/94, 30 July 1998, Reports 1998-V, (1998) 29 EHRR 50, [1998] ECHR 64.

5(1)(e) if effected in a hospital, clinic or other appropriate institution. Lantin psychiatric wing could not be regarded as an institution appropriate for the detention of persons of unsound mind. Indeed, on 2 August 1993, the Mental Health Board had expressed the view that the situation was harmful to the applicant, who was not receiving the treatment required by the condition that had given rise to his detention. The proper relationship between the aim of the detention and the location and conditions in which it took place was therefore deficient, and there had been a breach of Article 5.

In ***Halilovic v Bosnia and Herzegovina (2009)***,[155] the appellant's detention for four years and five months was pursuant to an administrative decision, as opposed to a decision of the competent civil court, as required by the amended domestic legislation and so breached Article 5(1). Compensation of €22,500 was awarded.

In ***X v Finland (2012)***,[156] *the court* found that while there had been no problem with the applicant's initial involuntary confinement in a mental institution, the safeguards against arbitrariness as regards the need for her continued confinement had been inadequate. In particular, there had been no independent psychiatric opinion, as the two doctors who had decided to prolong her stay were from the hospital where she was confined. In addition, the applicant had no standing under domestic law to seek a review of the need for her continued confinement, as a review could only take place at the initiative of the domestic authorities. In addition to the breach of Article 5, the court also found a violation of the applicant's right to respect for her private life under Article 8 because of the forced administration of medication during her confinement.

ARTICLE 5(2)

Article 5(2) provides that everyone who is arrested must be informed promptly of the reasons for their arrest and of any charge against them.

> **ARTICLE 5**
>
> **Right to liberty and security**
>
> 2. Everyone who is arrested shall be informed promptly, in a language which he understands, of the reasons for his arrest and of any charge against him.

The remaining paragraphs of Article 5 set out the Convention rights of persons who are 'deprived of their liberty' within the meaning of Article 5(1).

The underlying purpose of Article 5§2 is that a person who is arrested must be told why they are being deprived of their liberty. This is an integral part of the scheme of protection afforded by Article 5. It enables the person, if they wish, to apply to a court to challenge the grounds and reasons given and the lawfulness of their detention. This is the right conferred by Article

155 Halilovic v Bosnia and Herzegovina, no. 23968/05, 24 November 2009, [2009] ECHR 1933.
156 X v Finland, no. 34806/04, 3 July 2012.

5§4,[157] and a person in such a situation cannot make effective use of it unless they are promptly and adequately informed of the reasons for the deprivation of liberty.[158]

The words in Article 5§2 must be interpreted 'autonomously', that is in accordance with the aim and purpose of Article 5 which is to protect everyone from arbitrary deprivations of liberty. The term 'arrest' extends beyond the realm of the criminal law to persons deprived of their liberty in other situations, for example on the ground of unsoundness of mind, and the words 'any charge' must be interpreted accordingly.[159]

The wording clearly indicates that the duty on states is to furnish specific information to the individual or their representative.[160] The detained person must be told the essential legal and factual grounds for their detention in simple non-technical language that they can understand.[161]

The reasons do not have to be set out in the text of the decision which authorises the person's detention; nor do they have to be in writing or in any special form.[162] Whether the content of the information conveyed is sufficient must be assessed in each case according to its special features.[163] However, a bare indication of the legal basis for the arrest or detention, taken on its own, is insufficient for the purposes of Article 5§2.[164]

If the relevant person is incapable of receiving the information, the relevant details must be given to the individuals who represent their interests, such as their lawyer or guardian.[165] More particularly, if the mental condition of a person with an intellectual disability is not given due consideration in the process, it cannot be said that they were provided with the requisite information enabling them to make effective and intelligent use of the right ensured by Article 5§4, unless a lawyer or another authorised person was informed in their stead.[166]

In ***X v the United Kingdom (1981)***,[167] the court emphasised that the need for the applicant to be apprised of the reasons for his recall followed from Article 5§4; a person entitled to take proceedings to have the lawfulness of their detention speedily decided cannot make effective

157 Fox, Campbell and Hartley v the United Kingdom, no. 12244/86, 30 August 1990, Series A no. 182, 13 EHRR 157, [1990] ECHR 18, §40; Čonka v Belgium, no. 51564/99, 5 February 2002, ECHR 2002-I, [2002] ECHR 14, §50.

158 Van der Leer v the Netherlands, no. 11509/85, 21 February 1990, Series A no. 170-A, [1990] ECHR 3, 12 EHRR 567, §28; Shamayev and Others v Georgia and Russia, no. 36378/02, 12 April 2005, ECHR 2005-III, §413.

159 Van der Leer v the Netherlands, supra, §§ 27-28; X v United Kingdom, no. 7215/75, 5 November 1981, [1981] ECHR 6, (1982) 4 EHRR 188, §66.

160 Saadi v the United Kingdom [GC], no. 13229/03, 29 January 2008, §53.

161 See e.g. Bordovskiy v Russia, no. 49491/99, 8 February 2005, §56; Nowak v Ukraine, no. 60846/10, 31 March 2011, §63; Gasiņš v Latvia, no. 69458/01, 19 April 2011, §53.

162 X v Germany, Commission decision of 13 December 1978, DR 16; Kane v Cyprus (dec), no. 33655/06, 13 September 2011.

163 Fox, Campbell and Hartley v the United Kingdom, supra, §40.

164 Ibid, §41; Murray v the Netherlands [GC], no. 10511/10, 26 April 2016, §76; Kortesis v Greece, no. 60593/10, 12 June 2012, §§61-62.

165 ZH v Hungary, no. 28973/11, 8 November 2012, §§42-43.

166 ZH v Hungary, supra, §41.

167 X v United Kingdom, no. 7215/75, 5 November 1981, [1981] ECHR 6, (1982) 4 EHRR 188.

use of that right unless they are promptly and adequately informed of the facts, and the legal authority relied on, to deprive them of their liberty.'

In ***Van der Leer v The Netherlands (1990)***,[168] the court held that the word 'arrest' in Article 5(2) embraces deprivation of liberty on the ground of unsoundness of mind:

> '28. … Paragraph 4 (art. 5-4) does not make any distinction as between persons deprived of their liberty on the basis of whether they have been arrested or detained. There are therefore no grounds for excluding the latter from the scope of paragraph 2 (art. 5-2).
>
> 29. Having found that Article 5§2 (art. 5-2) is applicable, the Court must determine whether it has been complied with in this case.
>
> 30. The applicant was in hospital to receive treatment as a "voluntary" patient. It was not until 28 November 1983 that she learned, when she was placed in isolation, that she was no longer free to leave when she wished because of an order made ten days previously … The Government did not contest this.
>
> 31. It therefore appears that neither the manner in which she was informed of the measures depriving her of her liberty, nor the time it took to communicate this information to her, corresponded to the requirements of Article 5§2 (art. 5-2). In fact it was all the more important to bring the measures in question to her attention since she was already in a psychiatric hospital prior to the Cantonal Court judge's decision, which did not change her situation in factual terms.'

ARTICLE 5(4)

Article 5§4 provides that everyone who is deprived of their liberty by arrest or detention is entitled to take proceedings by which the lawfulness of their detention shall be decided speedily by a court and their release ordered if the detention is not lawful.'[169]

> **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.

168 Van der Leer v the Netherlands, no. 11509/85, 21 February 1990, Series A no. 170-A, [1990] ECHR 3, 12 EHRR 567.

169 As concerns access to justice, see also Article 13 of the UNCRPD. The Convention on the Rights of Persons with Disabilities, United Nations, Treaty Series 2515 (2006).

Article 5§4 is the *habeas corpus* provision of the Convention. It provides detained persons with the right to seek a judicial review of their detention[170] and this extends to both the procedural and substantive justifications of the deprivation of liberty.[171]

Furthermore, the notion of 'lawfulness' in Article 5§4 has the same meaning as in Article 5§1. Consequently, the detained person is entitled to a review of the 'lawfulness' of their detention not just in terms of the requirements of domestic law but also the Convention, the general principles embodied therein and the aim of the restrictions permitted by Article 5§1.[172]

The remedy of habeas corpus does not enable a judicial determination as wide as this because where the terms of a statute afford the executive a discretion, whether wide or narrow, the review exercisable by the courts in habeas corpus proceedings bears solely on the conformity of the exercise of that discretion with the empowering statute.[173]

The Article 5§1(e) criteria for 'lawful detention' necessitates that the review guaranteed by Article 5§4 in relation to the continuing detention of a mental health patient should be made by reference to their contemporaneous state of health, including their dangerousness, as evidenced by up-to-date medical assessments, and not by reference to past events at the time of the initial decision to detain.[174]

A person of unsound mind who is compulsorily confined in a psychiatric institution for a lengthy period is entitled to take proceedings 'at reasonable intervals' to put in issue the lawfulness of their detention.[175] A system of periodic review in which the initiative lies solely with the authorities is insufficient on its own.[176]

The forms of judicial review which satisfy the requirements of Article 5§4 may vary from one domain to another and will depend on the type of deprivation of liberty in issue.[177]

Where the European Court of Human Rights court has found no breach of the requirements of Article 5§1, this does not release the court from carrying out a review of compliance with Article 5§4. The two paragraphs are separate provisions. Observance of the former does not necessarily entail observance of the latter.[178]

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170 Mooren v Germany [GC], no. 11364/03, 9 July 2009, §106; Rakevich v Russia, no. 58973/00, 28 October 2003, §43.

171 Idalov v Russia [GC], no. 5826/03, 22 May 2012, §161; Reinprecht v Austria, no. 67175/01, 12 April 2006, ECHR 2005-XII, (2007) 44 EHRR 39, IHRL 3254, §31.

172 Suso Musa v Malta, no. 42337/12, 23 July 2013, §50.

173 See X v United Kingdom, no. 7215/75, 5 November 1981, [1981] ECHR 6, (1982) 4 EHRR 188.

174 See X v United Kingdom, supra.

174 Juncal v United Kingdom (dec), no. 32357/09, 17 September 2013, §30; Ruiz Rivera v Switzerland, no. 8300/06, 18 February 2014, §60.

175 Ibid, §77.

176 X v Finland, no. 34806/04, 3 July 2012, §170; no. 24086/03, 17 December 2013, §82.

177 MH v United Kingdom, no. 11577/06, 22 October 2013, §75.

178 Douiyeb v Netherlands [GC], no. 31464/96, 4 August 1999, §57; Kolompar v Belgium, no. 11613/85, 24 September 1992, Series A no. 235-C, 16 EHRR 197, §45.

It is not always necessary that an Article 5§4 procedure is attended by the same guarantees as are required under Article 6 for criminal or civil litigation but it must have a judicial character and provide guarantees appropriate to the type of deprivation of liberty.[179]

The 'court' to which the detained person has access does not have to be a court of law of the classical kind integrated within the standard judicial machinery of the country.[180] However, it must be a body of 'judicial character' offering certain procedural guarantees appropriate to the kind of deprivation of liberty in question.[181] To satisfy the requirements of the Convention the review must comply with both the substantial and procedural rules of national legislation and be conducted in conformity with the aim of Article 5, which is to protect the individual against arbitrariness.[182] The 'court' must be independent both of the executive and of the parties to the case,[183] and have the power to order release if it finds that the detention is unlawful. A mere power of recommendation is insufficient.[184]

A 'speedy' decision

Article 5§4 also proclaims the right to a speedy judicial decision concerning the lawfulness of detention and the ordering of its termination if it is unlawful.[185]

The term 'speedily' cannot be defined in the abstract. As with the 'reasonable time' requirements of Article 5§3 and Article 6§1, whether the decision has been made 'speedily' must be determined in the light of the circumstances of the particular case.[186]

The notion of 'speedily' (*à bref délai*) indicates a lesser urgency than that of 'promptly' (*aussitôt*) in Article 5§3.[187] However, where a decision to detain a person has been taken by a non-judicial authority rather than a court, the standard of 'speediness' of judicial review under Article 5§4 comes closer to the standard of 'promptness' under Article 5§3.[188] The relevant starting point is the date when the application for release was made/the proceedings were instituted. The relevant period comes to an end with the final determination of the legality of the applicant's detention, including any appeal.[189]

179 A and Others v United Kingdom [GC], no. 3455/05, 19 February 2009, §203; Idalov v Russia [GC], no. 5826/03, 22 May 2012, §161.

180 Weeks v United Kingdom, no. 9787/82, 2 March 1987, Series A no. 114, (1988) 10 EHRR 293, §61.

181 See e.g. De Wilde, Ooms and Versyp v Belgium, nos. 2832/66; 2835/66; 2899/66, 18 June 1971, Series A no. 12, §§76 and 78.

182 Koendjbiharie v Netherlands, no. 11487/85, 25 October 1990, Series A no. 185-B, [1990] ECHR 28, (1991) 13 EHRR 820, §27.

183 Stephens v Malta (no. 1), no. 11956/07, 21 April 2009, §95.

184 Benjamin and Wilson v United Kingdom, no. 28212/95, 26 September 2002, §§33-34.

185 Ibid, §154; Baranowski v Poland, no. 28358/95, 28 March 2000 ECHR 2000-III, §68.

186 RMD v Switzerland, no. 19800/92, 26 September 1997, §42; Rehbock v Slovenia, no. 29462/95, 28 November 2000, ECHR 2000-XII, §84.

187 E v Norway, no. 11701/85, 29 August 1990, Series A no. 181-A, (1994) 17 EHRR 30, §64; Brogan and Others v United Kingdom, nos. 11234/84 and 11209/84, 29 November 1988, Series A no. 145-B, (1988) 11 EHRR 117, §59.

188 Shcherbina v Russia, no. 41970/11, 26 June 2014, §§65-70, where a delay of sixteen days in the judicial review of the applicant's detention order issued by the prosecutor was found to be excessive.

189 Sanchez-Reisse v Switzerland, no. 9862/82, 21 October 1986, Series A no. 107, [1986] ECHR 12, (1986) 9 EHRR 71, §54; E. v Norway, §64.

Where the judicial determination involves complicated issues — such as the detained person's medical condition — this may be taken into account when considering how long is 'reasonable' under Article 5§4. However, even in complicated cases, there are factors which require the authorities to carry out a particularly speedy review, including the presumption of innocence in the case of pre-trial detention.[190]

If the length of time before a decision is taken is *prima facie* incompatible with the notion of speediness, the court will look to the state to explain the reason for the delay.[191]

In assessing the speedy character required by Article 5§4, factors such as the diligence shown by the authorities, any delay caused by the detained person and any other factors causing delay that do not engage the state's responsibility may be taken into consideration.[192]

Neither an excessive workload nor a vacation period can justify a period of inactivity on the part of the judicial authorities.[193]

In the case of ***Barclay-Maguire v United Kingdom (1983)***,[194] the Commission declared admissible an application which alleged that a delay of 18 weeks between the making of a tribunal application and its determination contravened Article 5(4). The government, seeking a settlement from the Commission, suggested 13 weeks as a reasonable target time. It subsequently failed to meet this target. A number of patients subsequently sought judicial review in relation to delayed hearings but judgment was avoided by offering them an earlier date, necessarily at the expense of other patients.[195]

In ***Koendjbiharie v Netherlands (1990)***,[196] the relevant period was held to have began on 17 May 1984 when the application to extend the patient's confinement was filed with the Court of Appeal. The decision was received more than four months later. Such a lapse of time was not compatible with the notion of speediness. The court, accordingly, found a failure to comply with the requirement of 'speediness' laid down in Article 5(4).

In ***Kay v United Kingdom (1994)***,[197] the Commission referred to the court's case law that periods of eight weeks to five months in mental health determinations were difficult to reconcile with the notion of 'speedily' in Article 5(4) of the Convention.[198]

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190 Frasik v Poland, no. 22933/02, 5 January 2010, §63; Jablonski v Poland, no. 33492/96, 21 December 2000, §§91-93.

191 Koendjbiharie v Netherlands, no. 11487/85, 25 October 1990, Series A no. 185-B, [1990] ECHR 28, (1991) 13 EHRR 820, §29.

192 Mooren v Germany [GC], no. 11364/03, 9 July 2009, §106; Kolompar v Belgium, no. 11613/85, 24 September 1992, Series A no. 235-C, 16 EHRR 197, §42.

193 E v Norway, no. 11701/85, 29 August 1990, Series A no. 181-A, (1994) 17 EHRR 30, §66; Bezicheri v Italy, no. 11400/85, 25 October 1989, Series A no. 164, (1990) 12 EHRR 210, [1989] ECHR 19, §25.

194 Barclay-Maguire v United Kingdom (dec), no. 9117/80, 9 December 1983.

195 See e.g. the judicial review applications in R. v Mental Health Review Tribunal, ex p. Hudson (unreported, 1986) and R. v Mental Health Review Tribunal, ex p. Mitchell (unreported, 1985).

196 Koendjbiharie v Netherlands, no. 11487/85, 25 October 1990, Series A no. 185-B, [1990] ECHR 28, (1991) 13 EHRR 820.

197 Kay v United Kingdom, no. 17821/91, 1 March 1994, [1994] ECHR 51.

198 E v Norway, no. 11701/85, 29 August 1990, Series A no. 181-A, (1994) 17 EHRR 30, §64; Van der Leer v the Netherlands, supra, §§ 27-28; X v United Kingdom, no. 7215/75, 5 November 1981, [1981] ECHR 6, (1982) 4 EHRR 188, §§32–36.

It was not contested by the government that mental health review tribunals frequently took up to six months to determine cases like the applicant's. In Kay's case, the determination took just over two years and the first hearing date proposed by the tribunal was nearly five months after referral. In the Commission's view, the system itself was inherently too slow. The tribunal proceedings were not conducted 'speedily' within the meaning of Article 5(4).

In ***Pauline Lines v United Kingdom (1997)***,[199] the applicant was subject to special restrictions because of a risk of serious harm to others. She was readmitted to hospital on 27 July 1993. On 7 December 1993, the Home Secretary referred her case to a tribunal which then heard the matter on 23 February 1994. The patient complained about the length of time it took for her to have a review following admission, contrary to Article 5(4). The Commission unanimously declared her complaint to be admissible. In the event, a friendly settlement was reached, whereby the government paid the applicant's representatives £3591.75, of which £2000 represented compensation and the remainder costs.

In ***RSC v United Kingdom (1997)***,[200] the applicant was subject to special restrictions because of a risk of serious harm to others. He was recalled to Broadmoor [high-secure] Hospital on 16 November 1994. On 22 November 1994, the Home Secretary referred his case to a tribunal, which adjourned the initial hearing on 20 September 1995 and did not determine his detention until 25 March 1996. The applicant alleged a violation of Article 5(4), *inter alia* on the ground that the tribunal did not decide the matter 'speedily'. A friendly settlement was reached. The government agreed to pay the applicant £2,000 compensation, together with £2,800 costs. It also undertook to amend the tribunal rules, so that when a conditionally discharged patient was recalled there must be a tribunal hearing within two months from the date on which the case was referred to the tribunal (which must be within a month of recall).

Periodic reviews

The detention of persons on the ground of unsoundness of mind constitutes a special category with its own specific problems. In particular, the reasons initially warranting confinement may cease to exist. The very nature of the deprivation of liberty 'would appear to require a review of lawfulness to be available at reasonable intervals. By virtue of Article 5(4), a person of unsound mind compulsorily confined in a psychiatric institution for an indefinite or lengthy period is thus in principle entitled, at any rate where there is no automatic periodic review of a judicial character, to take proceedings at reasonable intervals before a court to put in issue the lawfulness ... of his detention, whether that detention was ordered by a civil or criminal court or by some other authority.'[201]

Whereas one year per instance may be a rough rule of thumb in Article 6§1 cases, Article 5§4 concerns issues of liberty which require particular expedition.[202] Where an individual's personal liberty is at stake, the court has very strict standards concerning the state's compliance with the requirement of speedy review of the lawfulness of detention.

199 Pauline Lines v United Kingdom, European Commission, no. 2451/94, 17 January 1997.

200 RSC v United Kingdom, European Commission, no. 27560/95, 28 May 1997.

201 X v United Kingdom, no. 7215/75, 5 November 1981, [1981] ECHR 6, (1982) 4 EHRR 188, §52, referring to Winterwerp v Netherlands, no 6301/73, 24 October 1979, Series A no. 33, 2 EHRR, §§ 57 and 60.

202 Panchenko v Russia, §117.

The applicant in ***Turnbridge v United Kingdom (1990)***[203] was detained in Broadmoor [high-secure] Hospital. He complained that an annual review of the lawfulness of his detention by a tribunal was insufficient. The Commission found nothing to suggest that the period of a year which the applicant must respect before reapplying to a tribunal for his discharge was an unreasonable interval in the circumstances. Inadmissible.

Legal assistance

In the ***Megyeri Case (1992)***,[204] the applicant's confinement was grounded on a finding in criminal proceedings that he was not responsible for his acts because he was suffering from a schizophrenic psychosis with signs of paranoia. Sometime later, in July 1986, the Aachen Regional Court had before it expert evidence stating that his condition had deteriorated, he was unwilling to undergo treatment and he had shown a distinct propensity towards aggressive behaviour and violence. Before the Commission, Mr Megyeri submitted that the failure to appoint a lawyer to assist him in the 1986 regional court proceedings concerning his possible release violated Article 5(4). The court found it was doubtful 'to say the least' whether, acting on his own, he was able to marshal and present adequately points in his favour on the relevant issues, involving as they did matters of medical knowledge and expertise. It was even more doubtful whether, on his own, he was in a position to address adequately the legal issue arising: would his continued confinement be proportionate to the aim pursued (the protection of the public). There had been a breach of Article 5(4).

The court stated that the principles enshrined within Article 5(4) included the following:

1. A person of unsound mind who is compulsorily confined in a psychiatric institution for an indefinite or lengthy period is in principle entitled, at any rate where there is no automatic periodic review of a judicial character, to take proceedings 'at reasonable intervals' before a court to put in issue the 'lawfulness' of their detention (see, *inter alia*, *X v United Kingdom*, no. 7215/75, 5 November 1981, [1981] ECHR 6, (1982) 4 EHRR 188, §52).

2. Article 5(4) requires that the procedure followed must have a judicial character and give to the individual concerned guarantees appropriate to the kind of deprivation of liberty in question. In order to determine whether a proceeding provides adequate guarantees, regard must be had to the particular nature of the circumstances in which such proceeding takes place (see *Wassink v Netherlands*, no. 12535/86, 27 September 1990, Series A no. 185-A, [1990] ECHR 22, [1990] ECHR 22, §30).

3. The judicial proceedings referred to in Article 5(4) need not always be attended by the same guarantees as those required by Article 6(1) for civil or criminal litigation. None the less, it is essential that the person concerned should have access to a court and the opportunity to be heard either in person or, where necessary, through some form of representation. Special procedural safeguards

203 Turnbridge v United Kingdom (dec), European Commission, no. 16397/90, 17 May 1990.
204 Megyeri v Germany, no. 13770/88, 12 May 1992, (1993) 15 EHRR 584, [1992] ECHR 49.

may prove called for in order to protect the interests of persons who, on account of their mental disabilities, are not fully capable of acting for themselves (see *Winterwerp v Netherlands*, no 6301/73, 24 October 1979, Series A no. 33, 2 EHRR 387, §60).

4. Article 5(4) does not require that persons committed to care under the head of 'unsound mind' should themselves take the initiative in obtaining legal representation before having recourse to a court (see *Winterwerp v Netherlands*, supra, §66).

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

Case law

The applicant in ***R v United Kingdom (1986)***[205] was detained in Broadmoor [high-secure] Hospital, subject to special restrictions because of a risk of serious harm to others. On 23 March 1984, he appeared before a mental health review tribunal. The tribunal found that it could not evaluate the degree to which he presented a risk to the public without evidence of unescorted leave and accordingly he was not discharged. The applicant complained of a violation of Article 5(4), in that the Mental Health Act 1983 failed to give the tribunal sufficient power to meet the reasonable needs of a 'court' within the meaning of Article 5(4). It was not sufficient that the tribunal be able to discharge, conditionally or unconditionally; it must also have ancillary powers, such as the ability to grant brief trial leave of absence. Furthermore, it was difficult to reconcile the exclusive power of the Home Secretary to authorise even one day's escorted leave with the tribunal's power to give an absolute discharge, because the power to grant brief trial leave was clearly less drastic than a power to order an absolute discharge.

According to the Commission, 'In the present case the Mental Health Review Tribunal had jurisdiction to decide on the substantive lawfulness of the applicant's detention and it had the power (indeed the duty) to release the applicant if the conditions for continued detention were not satisfied. In this respect the present Mental Health Review Tribunal is different from that considered by the Court in the case of *X v United Kingdom'* (§1). Article 5(4) 'does not require any control of detention beyond that of "the lawfulness of his detention" and in the present case the Mental Health Review Tribunal was able to make such a review. It follows that this part of the application is manifestly ill-founded' (§1).

205 R v United Kingdom (dec), European Commission, no. 12039/86, 18 July 1986.

In ***Stanev v Bulgaria (2012)***,[206] the court found that Mr Stanev was deprived of his liberty (see above). The court then considered his complaint under Article 5§4. The court observed that the Bulgarian Government had not provided any domestic remedy capable of giving him a direct opportunity to challenge the lawfulness of his placement in the institution and the continued implementation of that measure. The validity of the placement agreement could only have been challenged on the ground of lack of consent on his guardian's initiative. The Bulgarian courts were not involved at any time or in any way in the placement and the domestic legislation did not provide for automatic periodic judicial review of placements in homes for people with mental disorders. Because his placement in the institution was not recognised as a deprivation of liberty in Bulgarian law, there were no national legal remedies available to challenge its lawfulness. Therefore, there had been a violation of Article 5§4.

In ***DD v Lithuania (2012)***,[207] the court found that DD was deprived of her liberty in the social care home where she was confined (see above). The court then considered her right to a review of her deprivation of liberty. The court noted that Article 5§4 requires that the procedure followed has a judicial character and gives to the individual guarantees appropriate to the kind of deprivation of liberty in question. It is essential that the person has access to a court and the opportunity to be heard in person or, where necessary, through some form of representation. Special procedural safeguards may be called for to protect the interests of those who, because of their mental disabilities, are not fully capable of acting for themselves. That last principle was all the truer when, as here, the placement was carried out without any involvement on the part of the courts. The form of judicial review may vary from one domain to another and depend on the type of the deprivation liberty at issue. However:

> '165… It appears that, in situations such as the applicant's, Lithuanian law does not provide for automatic judicial review of the lawfulness of admitting a person to and keeping him in an institution like the Kedainiai Home. In addition, a review cannot be initiated by the person concerned if that person has been deprived of his legal capacity. In sum, the applicant was prevented from independently pursuing any legal remedy of a judicial character to challenge her continued involuntary institutionalisation.
>
> 166. The Government claimed that the applicant could have initiated legal proceedings through her guardians. However, that remedy was not directly accessible to her: the applicant fully depended on her legal guardian, her adoptive father, who had requested her placement in the Kedainiai Home in the first place. The court also observes that the applicant's current legal guardian is the Kedainiai Home – the same social care institution which is responsible for her treatment and, furthermore, the same institution which the applicant had complained against on many occasions, including in court proceedings. In this context the court considers that where a person capable of expressing a view, despite having been deprived of legal capacity, is deprived of his liberty at the request of his guardian, he must be accorded an opportunity of contesting that confinement before a court, with separate legal representation…

206 Stanev v Bulgaria [GC], no. 36760/06, 17 January 2012, [2012] ECHR 46.

207 DD v Lithuania, no. 13469/06, 14 February 2012, [2012] ECHR 254.

167. In the light of the above, the court … holds that there has also been a violation of Article 5§4 of the Convention.'

ARTICLE 6

Article 6(1) provides that in the determination of their civil rights and obligations everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law.[208]

ARTICLE 6

Right to a fair trial

1. In the determination of his civil rights and obligations or of any criminal charge against him, everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law. Judgment shall be pronounced publicly but the press and public may be excluded from all or part of the trial in the interests of morals, public order or national security in a democratic society, where the interests of juveniles or the protection of the private life of the parties so require, or to the extent strictly necessary in the opinion of the court in special circumstances where publicity would prejudice the interests of justice.

Proceedings to divest individuals of their legal capacity

In **Shtukaturov v Russia (2008)**,[209] the applicant had a history of mental illness and was officially declared disabled in 2003. Following a request filed by his mother, the Russian courts declared him legally incapable in December 2004. His mother was subsequently appointed as his guardian and, in November 2005, she admitted him to a psychiatric hospital. The applicant alleged that he had been deprived of his legal capacity without his knowledge.

The court held that there had been a violation of Article 6 in relation to the proceedings depriving the applicant of his legal capacity. The applicant, who appeared to have been a relatively autonomous person despite his illness, had not been given any opportunity to participate in the proceedings concerning his legal capacity. Given the consequences of those proceedings for his personal autonomy and indeed liberty, his attendance had been indispensable not only to give him the opportunity to present his case, but also to allow the judge to form an opinion on his mental capacity. Therefore, the decision in December 2004, based as it was purely on documentary evidence, had been unreasonable and in breach of the principle of adversarial proceedings enshrined in Article 6§1.

208 As concerns access to justice, see also Article 13 of the UNCRPD. The Convention on the Rights of Persons with Disabilities, United Nations, Treaty Series 2515 (2006).

209 Shtukaturov v Russia, no. 44009/05, 27 March 2008, 54 EHRR 962.

The case of ***X and Y v Croatia (2011)***[210] concerned proceedings brought by social services to divest a mother and daughter of their legal capacity. The first applicant, who was born in 1923, was bedridden and suspected to be suffering from dementia. She was divested of her legal capacity in August 2008. She alleged that the proceedings had been unfair because she had not been notified of them and thus had not been heard by a judge or been able to give evidence. The court held that there had been a violation of Article 6§1, finding that the first applicant had been deprived of adequate procedural safeguards in proceedings which resulted in a decision adversely affecting her private life. As regards the reasons adduced by the domestic court for its decision, the court observed that in order to ensure proper care for the ill and elderly the state authorities had at their disposal much less intrusive measures than divesting them of legal capacity.

In ***Stanev v Bulgaria (2012)***,[211] the court found that Mr Stanev was deprived of his liberty and that there had been a violation of his rights under Article 5§4 (see above). The court then proceeded to consider whether Article 6 had also been breached. The court noted that, under Bulgarian law, no legal distinction was made between those partially and fully deprived of legal capacity. The measure in question was indefinite and Mr Stanev was unable to apply for the restoration of his legal capacity other than through his guardian or one of the people listed in legislation. Nor was there any automatic periodic review of whether the grounds for placing a person under guardianship remained valid. Although the right of access to the courts was not absolute and restrictions on a person's procedural rights might be justified, even in cases where the person had been only partially deprived of legal capacity, the right to ask a court to review a declaration of incapacity was a fundamental procedural right for the protection of those who had been partially deprived of legal capacity. It followed that in principle such people should have direct access to the courts.

The court observed that, according to a recent study, 18 out of 20 national European legal systems allowed direct access to the courts for any partially incapacitated person who wished to have their status reviewed. In 17 countries such access was even open to those declared fully incapable. There was therefore a European trend towards granting legally incapacitated people direct access to the courts to seek a restoration of their legal capacity. The court stressed the growing importance which international instruments for the protection of people with mental disorders attached to granting them as much legal autonomy as possible. Article 6§1 should be interpreted therefore as guaranteeing in principle that anyone in Mr Stanev's position must have direct access to a court to seek restoration of their legal capacity. As direct access of this kind was not guaranteed with a sufficient degree of certainty by the relevant Bulgarian legislation, there had been a violation of Article 6§1.

The case of ***Nataliya Mikhaylenko v Ukraine (2013)***[212] concerned the applicant's lack of access to court for the purpose of seeking a restoration of her legal capacity. In 2007, the applicant was deprived of her legal capacity on the ground that she was suffering from a serious mental illness. Gradually, her mental health improved. In 2009, her guardian applied for her legal capacity to be restored but the application was dismissed without being considered on its merits owing to the guardian's repeated failure to appear in court. In 2010

210 X and Y v Croatia, no. 5193/09, 3 November 2011.

211 Stanev v Bulgaria [GC], no. 36760/06, 17 January 2012, [2012] ECHR 46.

212 Nataliya Mikhaylenko v Ukraine, no. 49069/11, 30 May 2013, [2013] ECHR 484.

the applicant herself lodged an application for her legal capacity to be restored. However, both it and her subsequent appeals were dismissed on the ground that the Code of Civil Procedure did not provide her with a right to lodge such an application. Under domestic legislation it was for the applicant's guardian or the guardianship authority to raise the issue of the restoration of her legal capacity before a court.

The court observed that the applicant had had no procedural status in capacity proceedings and could not influence them. By virtue of clear and foreseeable rules of domestic law, she could not personally apply to a court for restoration of her legal capacity. Furthermore, the Code did not provide that a declaration of legal incapacity was subject to automatic judicial review even though the duration of the measure in her case was not limited in time. Lastly, it had not been shown that the domestic authorities had effectively supervised the applicant's situation, including the performance of the guardian's duties, or taken the requisite steps to protect her interests. Restrictions on the procedural rights of persons deprived of their legal capacity could be justified to protect their own or others' interests or for the proper administration of justice. However, the approach pursued by the domestic law in this case was not in line with the general trend at European level. The absence of any judicial review, which had seriously affected many aspects of the applicant's life, could not be justified by the legitimate aims underpinning the limitations on access to a court by incapacitated persons. The situation in which she had been placed amounted to a denial of justice as regards the possibility of securing a review of her legal capacity. Article 6(1) had been violated.

Other case law

In ***Mocie v France (2003)***,[213] the applicant had applied to the competent national courts, seeking mainly an increase in his military invalidity pension. The first set of proceedings, which commenced in 1988, was still pending when the European Court of Human Rights delivered its judgment almost 15 years later; a second set of proceedings had lasted for almost eight years.

The court held that there had been a violation of Article 6§1 on account of the length of the proceedings in question. It noted that the invalidity pension had made up the bulk of the applicant's income. The proceedings had in substance been aimed at boosting the applicant's pension in the light of his deteriorating health. They were therefore of particular importance to him and called for particular diligence on the part of the authorities.

The case of ***Farcaş v Romania (2010)***[214] involved applicant who had suffered from progressive muscular dystrophy since the age of 10. He complained that one effect of his physical disability was that it was impossible for him to access certain buildings, in particular those of the courts that had jurisdiction over disputes concerning his civil rights. Because the entrance to the local court building was not specially adapted, he could not enter the court or seek assistance from the bar association, and had been unable to challenge the termination of his contract.

213 Mocie v France, no. 46096/99, 8 April 2003.

214 Farcaş v Romania (dec), no. 32596/04, 14 September 2010.

The court declared the application to be manifestly ill-founded and inadmissible, even when viewed in conjunction with Article 14 (prohibition of discrimination). On the facts, it found that neither Mr Farcas's right of access to a court nor his right of individual petition had been hindered by insurmountable obstacles which prevented him from bringing proceedings, lodging an application or communicating with the court. He could have brought proceedings before the courts or administrative authorities by post, if necessary through an intermediary. The local post-office was accessible and, in any event, access to it was not indispensible for posting letters. The assistance of a lawyer was not necessary to bring the proceedings in question, and the applicant could always have contacted the bar association by letter or fax, or made a request to the court for free legal assistance. No appearance of discriminatory treatment against the applicant had been noted.

The case of ***Blokhin v Russia (2016)*** concerned the detention for 30 days in a temporary detention centre for juvenile offenders of a 12-year old boy suffering from a mental and neuro-behavioural disorder. The applicant maintained that the proceedings against him had been unfair for two reasons. He had been questioned by the police in the absence of his guardian, a legal counsel or a teacher and he had not been given the opportunity to cross-examine the two witnesses against him. The Grand Chamber held that there had been a violation of Article 6§§1 and 3. The applicant's defence rights had been violated because he had been questioned by the police without legal assistance. Furthermore, the statements of two witnesses whom he was unable to question had served as a basis for his placement in temporary detention. When their liberty was at stake, it was essential that adequate procedural safeguards were in place to protect the best interests and well-being of a child. Children with disabilities might moreover require additional safeguards to ensure that they were sufficiently protected. There had also been violations of Article 3 (inhuman or degrading treatment) and Article 5§1 (right to liberty and security).

ARTICLE 8

Article 8 provides that everyone has the right to respect for their private and family life, home and correspondence. There must be no interference by a public authority with the exercise of this right except such as is in accordance with the law, is necessary in a democratic society and is for one of the purposes expressly permitted by Article 8.[215]

> **ARTICLE 8**
>
> **Right to respect for private and family life**
>
> 1. Everyone has the right to respect for his private and family life, his home and his correspondence.

215 See also Article 22 (Respect for privacy) of the UNCRPD: '1. No person with disabilities, regardless of place of residence or living arrangements, shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence or other types of communication or to unlawful attacks on his or her honour and reputation. Persons with disabilities have the right to the protection of the law against such interference or attacks. 2. States Parties shall protect the privacy of personal, health and rehabilitation information of persons with disabilities on an equal basis with others. The Convention on the Rights of Persons with Disabilities, United Nations, Treaty Series 2515 (2006).

> 2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

The Court has on a number of occasions ruled that 'private life' is a broad term not susceptible to exhaustive definition.[216] However, Article 8 'secures to the individual a sphere within which he or she can freely pursue the development and fulfilment of his or her personality'.[217] It protects the moral and physical integrity of the individual, including the right to live privately away from unwanted attention.[218]

The right to respect for one's private life guaranteed by Article 8 has been prominent in relation to issues of health, treatment and care. The court has interpreted the right to such respect as including the right to protection of one's physical, moral and psychological integrity, as well as the right to choose and exercise one's personal autonomy; for example, to refuse medical treatment or to request a particular form of medical treatment.[219] The imposition of treatment against a person's will gives rise to an interference with their right to respect for their private life and their right to physical integrity.

While Article 8 contains no explicit procedural requirements, 'the decision-making process involved in measures of interference must be fair and such as to ensure due respect of the interests safeguarded by Article 8'.[220] The extent of the state's margin of appreciation turns partly on the quality of the decision-making process. If the procedure was seriously deficient in some respect, the conclusions of the domestic authorities are more open to criticism.[221]

The issue of proportionality (the interference must be 'necessary in a democratic society') is a consistent theme the case law. When considering whether an interference is proportionate, the burden lies on the state to justify its action. The 'proportionality' test entails assessing whether a measure is necessary for the achievement of the legitimate aim and, if so, whether it fairly balances the rights of the individual with those of the whole community.

More particularly, under Article 8 the authorities must strike a fair balance between the interests of a person of unsound mind and the other legitimate interests concerned. As a rule, in complicated matters such as issues concerning mental capacity the authorities enjoy a wide margin of appreciation. National authorities have the benefit of direct contact with the persons concerned and therefore are particularly well placed to determine such issues. The court's task is rather to review under the Convention the decisions taken by the national authorities in the exercise of their powers.[222]

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216 Peck v United Kingdom, no. 44647/98, 28 January 2003, (2003) 36 EHRR 41, [2003] ECHR 44, §57.

217 Sidabras v Lithuania, nos. 55480/00 and 59330/00, 27 July 2004, (2006) 42 EHRR 6, §43; Brüggeman v Germany, no. 6959/75, 12 July 1977, (1981) 3 EHRR 244, §55.

218 X and Y v Netherlands, no. 8978/80, 26 March 1985, (1985) 8 EHRR 235, [1985] ECHR 4, §§22–27.

219 Glass v United Kingdom, no. 61827/00, 9 March 2004, [2004] ECHR 102, (2004) 39 EHRR 15, §§74-83; Tysiąc v Poland, no. 5410/03, 20 March 2007, [2007] ECHR 219, (2007) 45 EHRR 42.

220 Shtukaturov v Russia, supra, §89; Görgülü v Germany, no. 74969/01, 26 February 2004, §52.

221 Shtukaturov v Russia, supra, §89; Sahin v Germany, no. 30943/96, 11 October 2001, §§46 et seq.

222 Shtukaturov v Russia, supra, §87; *mutatis mutandis*, Bronda v Italy, no. 22430/93, 9 June 1998, Reports 1998-IV, §59.

Notwithstanding this observation, the margin of appreciation varies in accordance with the nature of the issues and the importance of the interests at stake. A stricter scrutiny is called for in respect of very serious limitations in the sphere of private life.[223]

The positive obligation

Article 8 gives rise to both negative and positive obligations. States are under a positive obligation to secure the right to effective respect for physical and psychological integrity.[224] This obligation may require the state to take measures to provide effective and accessible protection of the right to respect for private life,[225] through both a regulatory framework of adjudicatory and enforcement machinery and the implementation, where appropriate, of specific measures.[226]

Medical treatment

The issue of free and informed consent to medical treatment has been a feature of the case law under Article 8.

In ***Grare v France (1983)***,[227] a voluntary in-patient complained his treatment with antipsychotic drugs resulted in unpleasant side-effects that violated Article 8. It was held that, even if the treatment regime constituted an invasion of his private life, it justified in the interests of his health and public order.

In ***Acmanne v Belgium (1983)***,[228] compulsory tuberculosis screening was held not to breach Article 8 although it interfered with the individual's private life.

In ***TV v Finland (1994)***,[229] the court ruled inadmissible a claim by an HIV-positive prisoner that his Article 8 rights were breached because guards were present during his medical review at an outside clinic and because staff involved in his treatment had allegedly disclosed his HIV status to others.

It was held that although access by prison and medical staff to information regarding the applicant's HIV status constituted an interference with his Article 8(1) rights, this could be justified under Article 8(2). His medical notes were marked to alert staff to his blood-borne disease and the access to this information was lawful, necessary to protect the rights and freedoms of others and proportionate.

223 Shtukaturov v Russia, supra, §88; Elsholz v Germany [GC], no. 25735/94, ECHR 2000-VIII, §49.

224 Sentges v Netherlands (dec), no. 27677/02, 8 July 2003; Pentiacova and Others v Moldova (dec) no. 14462/03, 4 January 2005; Nitecki v Poland (dec), no. 65653/01, 21 March 2002.

225 Airey v Ireland, no. 6289/73, 11 September 1979, (1979) 2 EHRR 305, [1979] ECHR 3, §33; McGinley and Egan v United Kingdom, nos. 10/1997/794/995-996, 9 June 1998, [1998] ECHR 51, §101; Roche v United Kingdom, no. 32555/96, 19 October 2005, [2008] ECHR 926, (2006) 42 EHRR 30, §162.

226 Tysiąc v Poland, supra, §110.

227 Grare v France, no. 18835/91, 2 December 1992, 15 EHRR CD 100.

228 Acmanne v Belgium, no. 10435/83, 40 DR 251.

229 TV v Finland (dec), no. 21780/93, 2 March 1994.

The case of ***Passannante v Italy (1998)***[230] concerned a five-month delay for a neurological appointment in the state system, whereas a private appointment was available in four days. Pursuant to the positive obligation, it was held that excessive delay on the part of a public health service to provide a medical service to which a patient was entitled can raise an issue under article 8, if the delay has or is likely to have a serious impact on the patient's health. However, on the facts this duty did not arise because no damage to health was evidenced.

The case of ***Glass v United Kingdom (2004)***[231] concerned the administration of drugs to a severely disabled child (the second applicant) despite the opposition of his mother (the first applicant). Believing that the child had entered a terminal phase and, with a view to relieving his pain, the doctors administered diamorphine against the mother's wishes. Furthermore, a 'do not resuscitate' notice was added to the child's file without consulting the mother. During this time disputes broke out in the hospital involving family members and the doctors. The child survived the crisis and was able to be discharged home. The applicants argued that UK law and practice had failed to guarantee respect for the child's physical and moral integrity.

The court held that the decision of the authorities to override the mother's objections to the proposed treatment in the absence of authorisation by a court resulted in a breach of Article 8. The decision to impose treatment in defiance of her objections interfered with the child's right to respect for his private life, and in particular his right to physical integrity. This interference was in accordance with the law and the action taken by the hospital staff had pursued a legitimate aim. However, as to the necessity of the interference, it had not been explained to the court's satisfaction why the hospital had not sought the intervention of the courts in the initial stages to overcome the deadlock. The onus to take such an initiative and defuse the situation in anticipation of a further emergency was on the hospital. Instead, the doctors used the limited time available to try to impose their views on the mother.

Correspondence of patients

In ***Herczegfalvy v Austria (1992)***,[232] the applicant complained that the hospital authorities had violated Article 8 by administering food by force, imposing treatment he complained of and refusing to send on his correspondence. The complaint was directed in particular at the psychiatric hospital's practice of sending all of his letters to the curator for him to select which ones to pass on. The court noted that this interference constituted a breach of Article 8 unless it was 'in accordance with the law', pursued a legitimate aim or aims under paragraph 2, and was 'necessary in a democratic society' for achieving such aims. The expression 'in accordance with the law' required that the impugned measure had a basis in national law; but it also referred to the quality of the law in question, requiring that it was accessible to the person, who must be able to foresee its consequences for him, and compatible with the rule of law. Compatibility with the rule of law implied that there must be a measure of protection in national law against arbitrary interferences with the rights safeguarded by Article 8(1). If a law conferred a discretion on a public authority, it must indicate the scope of that discretion, although the degree of precision required would depend on the particular subject matter.

230 Passannante v Italy (dec), no. 32647/ 96, 1 July 1998, 26 EHRR CD153.

231 Glass v United Kingdom, no. 61827/00, 9 March 2004, [2004] ECHR 102, (2004) 39 EHRR 15.

232 Herczegfalvy v Austria, no. 10533/83, Series A no. 244, [1992] ECHR 58, (1992) 15 EHRR 437 (the 'Herczegfalvy case').

Although the Austrian government had argued that the impugned decisions were based directly on section 51 of the Hospitals Law, and articles in the Civil Code, these very vaguely worded provisions did not specify the scope or conditions of exercise of the discretionary power. Such specifications appeared all the more necessary in the field of detention in psychiatric institutions because the persons concerned were frequently at the mercy of the medical authorities. Their correspondence might be their only contact with the outside world. In the absence of any detail at all as to the kind of restrictions permitted or their purpose, duration and extent or the arrangements for their review, the provisions did not offer the minimum degree of protection against arbitrariness required by the rule of law in a democratic society, and there had been a violation of Article 8.

Information and Confidentiality

In ***Panteleyenko v Ukraine (2006)***,[233] the applicant complained about the disclosure at a court hearing of confidential information about his mental state and psychiatric treatment. The court found that obtaining from a psychiatric hospital confidential information concerning the applicant's mental state and treatment, and disclosing it at a public hearing, amounted to an interference with his right to respect for his private life. The court noted that the information was incapable of affecting the outcome of the litigation; the first-instance court's request for information was 'redundant' because the information was not 'important for an inquiry, pre-trial investigation or trial'.

In ***Szuluk v United Kingdom (2009)***,[234] the court dealt for the first time with the issue of medical confidentiality in prison. A prisoner who had undergone brain surgery discovered that his correspondence with the specialist supervising his hospital treatment had been monitored by a prison medical officer. The court found a violation of his right to respect for his correspondence under Article 8.

Changes of mentor, guardian or similar person in authority

In ***JT v United Kingdom (2000)***,[235] the applicant was detained in hospital for treatment under the Mental Health Act 1983. Her statutory 'nearest relative', who exercised important powers under the Act, was her mother. There was no mechanism in the Act which enabled JT to apply for the 'nearest relative' to be replaced. Her mother had persistently taken her stepfather's side and he had (allegedly) sexually abused her, which she said was responsible to a significant extent for her psychiatric difficulties. She complained that because her mother was her nearest relative in law, she was entitled to receive, and then discuss with him, information for tribunal reviews, which violated her right to respect for her private life. The Commission held that the absence of any possibility to apply to a court to change her nearest relative interfered with JT's rights under Article 8(1) and was disproportionate to the aims pursued. There had been a violation. Following that finding, the applicant's case was struck out after a friendly settlement under which the government undertook to seek to amend the legislation.

233 Panteleyenko v Ukraine, no. 11901/02, 29 June 2006.

234 Szuluk v United Kingdom, no. 36936/05, 2 June 2009, [2009] ECHR 845.

235 JT v United Kingdom, no. 26494/95, 30 March 2000, [2000] ECHR 132; [2000] ECHR 133.

The case of ***A-MV v Finland (2017)***[236] concerned an intellectually disabled man's complaint about the Finnish courts' refusal to replace his court-appointed mentor, which had the effect that he had been prevented from deciding where, and with whom, he would like to live. His court-appointed mentor had decided that it was not in his best interests to move from his home town in the south to live in a remote village in the far north with his former foster parents. His request to replace the mentor was refused in the domestic proceedings.

The court held that there had been no violation of Article 8. The Finnish courts' decision to refuse to replace the mentor was justified. It was reached following a concrete and careful consideration of the applicant's situation. It had taken into account his inability to understand what was at stake if he moved, namely that it would involve a radical change in his living conditions. Such a decision, taken in the context of protecting his health and well-being, had therefore not been disproportionate. Moreover, the applicant had been involved at all stages of the proceedings and his rights, will and preferences had been taken into account by competent, independent and impartial domestic courts. Nor had there been any violation of Article 2 (freedom of movement) of Protocol No. 4 to the Convention.

Disproportionate deprivation of decision-making legal capacity

In ***Shtukaturov v Russia***,[237] the applicant had a history of mental illness and was officially declared disabled in 2003. Following a request filed by his mother, the Russian courts declared him legally incapable on 28 December 2004. This decision deprived him of his capacity to act independently in almost all areas of life: he was no longer able to buy or sell any property on his own, to work, to travel, to choose his place of residence, to join associations or to marry. Even his liberty could henceforth be limited without his consent and without any judicial supervision. His mother was appointed as his guardian and, in November 2005, she admitted him to a psychiatric hospital. The applicant alleged, *inter alia*, that the interference with his private life was disproportionate and so contravened Article 8.

The court held that there had been a violation of Article 8 as a result of the applicant being fully deprived of his legal capacity. The principles for the legal protection of incapable adults set down by the Council of Europe's Committee of Ministers[238] recommended that legislation should provide a 'tailor-made' response to each individual case. However, Russian legislation distinguished only between full capacity and full incapacity and made no allowances for borderline situations.

The interference with the applicant's private life had resulted in him becoming fully dependent on his official guardian in almost all areas of his life for an indefinite period when this was disproportionate to the government's legitimate aim of protecting his interests and health of others.

236 A-MV v Finland, no. 53251/13, 23 March 2017.

237 Shtukaturov v Russia, no. 44009/05, 27 March 2008, 54 EHRR 962.

238 Recommendation no. R (99) 4 of 23 February 1999. 'Although these principles have no force of law for this Court, they may define a common European standard in this area', at §95.

Furthermore, his participation in the decision-making process had been 'reduced to zero'. The court was particularly struck by the fact that the only hearing on the merits in his case lasted ten minutes. In such circumstances it could not be said that the judge had 'had the benefit of direct contact with the persons concerned', which normally would call for judicial restraint on the part of the European Court of Human Rights. Given the seriousness of the interference complained of, the court proceedings were perfunctory at best and the reasoning inadequate:

> '94 … the existence of a mental disorder, even a serious one, cannot be the sole reason to justify full incapacitation. By analogy with the cases concerning deprivation of liberty, in order to justify full incapacitation the mental disorder must be "of a kind or degree" warranting such a measure — see, mutatis mutandis, *Winterwerp*, cited above, §40.'

In the applicant's case, the questions to the doctors formulated by the judge did not concern 'the kind and degree' of his mental illness, and the medical report did not analyse the degree of his incapacity in sufficient detail, nor explain what kind of actions he was unable to understand and control.

Having examined the decision-making process and the reasoning behind the domestic decisions, the court concluded that the interference with the applicant's private life was disproportionate to the legitimate aim pursued. There had therefore been a breach of Article 8 'on account of the applicant's full incapacitation (§96).'

In ***Ivinović v Croatia (2014)***, [239] the applicant, who was born in 1946, had suffered from cerebral palsy and used a wheelchair since early childhood. The case concerned proceedings, brought by a social welfare centre, in which she had been partly divested of her legal capacity. The court held that there had been a violation of Article 8, finding that the Croatian courts, in depriving partially the applicant of her legal capacity, did not follow a procedure which could be said to be in conformity with the guarantees under Article 8.

In ***AN v Lithuania (2016)***,[240] the applicant had a history of mental illness. He complained that he had been deprived of his legal capacity without his participation or knowledge and that, as an incapacitated person, he had then been unable to request the restoration of his legal capacity. The court held that there had been a violation of Article 8, finding that the interference with the applicant's right to respect for his private life had been disproportionate to the legitimate aim pursued. The district court had had no opportunity to examine the applicant in person and essentially had relied in its decision on the testimony of his mother and the psychiatric report. While the court did not doubt the competence of the medical expert or the seriousness of the applicant's illness, it stressed that the existence of a mental disorder, even a serious one, could not be the sole reason to justify full incapacitation. The court also held that there had been a violation of Article 6§1 (right to a fair trial), finding that the regulatory framework for depriving people of their legal capacity had not provided the necessary safeguards. The applicant had been deprived of a clear, practical and effective opportunity to have access to court in connection with the incapacitation proceedings.

239 Ivinović v Croatia, no. 13006/13, 18 September 2014.

240 AN v Lithuania, no. 17280/08, 31 May 2016.

Lack of legal representation of a disabled child

The case of ***AMM v Romania (2012)***[241] concerned proceedings to establish the paternity of a 10-year old minor AMM who was born outside marriage and had a number of disabilities. He had been registered on his birth certificate as having a father of unknown identity. His putative father Z did not attend the domestic court hearing or co-operate with forensic tests. Before the domestic court, the applicant was first represented by his mother and subsequently, since his mother suffered from a serious disability which resulted in her being placed under the care of the social welfare authorities, by his maternal grandmother. The court held that there had been a violation of Article 8. The domestic courts did not strike a fair balance between the child's right to have his interests safeguarded in the proceedings and the right of his putative father not to undergo a paternity test or take part in the proceedings. As concerned the issue of whether the Romanian State had acted in breach of its positive obligation under Article 8, the guardianship office had not taken part in the proceedings as it was required to do. Nor had the applicant or his mother had been represented by a lawyer at any point in the proceedings. The Court pointed out that it had previously held that consideration must be given to the vulnerability of certain individuals and their inability in some cases to plead their case coherently or, indeed, at all. Having regard to the child's best interests, it had been up to the authorities to act on his behalf in order to compensate for the difficulties facing his mother, so as to avoid him being without protection.

Strip-searches

In ***Wainwright v United Kingdom (2006)***,[242] Mr Patrick O'Neill (the first applicant's son and the second applicant's half-brother) was arrested on suspicion of murder and detained on remand at HM Prison Armley. Following a report by a senior prison officer raising suspicions that he was involved in the supply and use of drugs within prison, the prison governor ordered that all of his visitors be strip-searched before visits. A complaint was made that this contravened Article 8. The court held that due to their manner the strip searches of the applicants did breach Article 8 but did not reach the minimum level of severity prohibited by Article 3.

Other case law

In ***X and Y v the Netherlands (1985)***,[243] a girl with an intellectual disability (the second applicant) lived in a home for children with mental disabilities. On the day after her sixteenth birthday (which was the age of consent for sexual intercourse in the Netherlands) she was raped in the home by a relative of the person in charge. She was traumatised by the experience but deemed unfit to sign an official complaint given her low mental age. Her father (the first applicant) signed in her place but proceedings were not brought against the perpetrator because the girl had to make the complaint herself. The domestic courts recognised that there was a gap in the law.

241 AMM v Romania, no. 2151/10, 14 February 2012.

242 Wainwright v United Kingdom, no. 12350/04, 26 September 2006, [2006] ECHR 807.

243 X and Y v Netherlands, no. 8978/80, 26 March 1985, (1985) 8 EHRR 235, [1985] ECHR 4.

The court recalled that the object of Article 8 is essentially that of protecting the individual against arbitrary interference by public authorities. However, it does not merely compel the state to abstain from such interference. In addition to this primarily negative undertaking, there may be positive obligations inherent in an effective respect for private or family life. In the present case, the protection afforded by the civil law in a case of wrongdoing of the kind inflicted on the second applicant was insufficient. This was a case where fundamental values and essential aspects of private life were at stake. Effective deterrence was indispensable in this area and could be achieved only by criminal-law provisions. Observing that the Dutch Criminal Code had not provided her with practical and effective protection, the court concluded that the second applicant had been the victim of a violation of Article 8.

In ***Kutzner v Germany (2002)***,[244] the applicants, husband and wife, and their two daughters had lived since the children's birth with the first applicant's parents and an unmarried brother in an old farmhouse. The applicants had attended a special school for people with learning difficulties. Owing to their late physical and, more particularly, mental development, the girls were examined on a number of occasions by doctors. On the advice of one of the doctors and their own application, the girls had received educational assistance and support from a very early age. The applicants complained that the subsequent withdrawal of their parental authority and the placing of their daughters with foster families, mainly on the ground that they lacked the intellectual capacity to bring up their children, breached their right to respect for their family life. The court held that there had been a violation of Article 8. The authorities may have had legitimate concerns about the late development of the children, as noted by the social services departments concerned and psychologists. However, the placement order and its implementation had been unsatisfactory. Although the reasons relied on by the administrative and judicial authorities had been relevant, they had been insufficient to justify such a serious interference in the applicants' family life. Notwithstanding a margin of appreciation, the interference had not been proportionate to the legitimate aims pursued.

In ***AK and L v Croatia (2013)***,[245] the first applicant was the mother of the second applicant, who was born in 2008. Soon after his birth, the second applicant was placed with a foster family in another town on the grounds that his mother had no income and lived in a dilapidated property without heating. The first applicant had consented to this. Her complaint was that she had not been represented in the subsequent court proceedings which resulted in a decision divesting her of her parental rights, on the ground that she had a mild mental disability, and that her son had been put up for adoption without her knowledge, consent or participation in the adoption proceedings. The court held that there had been a violation of Article 8. Despite it being a requirement of domestic law, and the authorities' findings that the first applicant suffered from a mild mental disability, she had not been represented by a lawyer in the proceedings divesting her of parental rights. In addition, by not informing her of the adoption proceedings, the national authorities had deprived her of the opportunity to seek a restoration of her parental rights before the ties between her and her son had been finally severed by his adoption. The first applicant had thus been prevented from enjoying her right guaranteed by domestic law and had not been sufficiently involved in the decision-making process.

244 Kutzner v Germany, no. 46544/99, 26 February 2002, (2002) 35 EHRR 653; [2002] ECHR 160.
245 AK and L v Croatia, no. 37956/11, 8 January 2013, [2013] ECHR 290.

In ***Kocherov and Sergeyeva v Russia (2016)***,[246] the first applicant, who had a mild intellectual disability, lived in a care home between 1983 and 2012. In 2007, he and another resident of the care home had a daughter, the second applicant. A week after her birth the child was placed in public care where, with the first applicant's consent, she remained for several years. In 2012, the first applicant was discharged from the care home and expressed an intention to take the second applicant into his care. However, the domestic courts restricted his parental authority over the child. The second applicant remained in public care although the first applicant was allowed to maintain regular contact with her. In 2013, he managed to have the restriction of his parental authority lifted and the second applicant went to live with him. The applicants complained that, as a result of the restriction of the first applicant's parental authority, their reunification had been postponed for a year.

The court held that there had been a violation of Article 8. The reasons relied on by the Russian courts to restrict the first applicant's parental authority had been insufficient to justify the interference with the applicants' family life, and therefore been disproportionate to the legitimate aim pursued. As to the first applicant's mental disability, it appeared from a report submitted to the domestic authorities that his state of health allowed him fully to exercise his parental authority. However, the domestic court had disregarded this evidence. The question whether the mother posed a danger to the child was directly relevant when it came to striking a balance between the child's interests and those of her father. However, the domestic courts had based their fears for the second applicant's safety on a mere reference to the fact that she lacked legal capacity, without demonstrating that her behaviour had or might put the second applicant at risk. Their reference to the mother's legal status was thus not a sufficient ground for restricting the first applicant's parental authority.

In ***Dmitriy Ryabov v Russia (2013)***,[247] the applicant complained about having only restricted access to his son following his son's placement in the care of maternal grandparents soon after being born. The applicant and his wife both suffered from schizophrenia and he alleged that court decisions to restrict his parental rights on the ground he was a danger to his son had not been convincing. Any contact that had been granted to him had been illusory because it had to take place with the consent of his son's guardian, the maternal grandmother, who was hostile to him having any contact. The court held that there had not been a violation of Article 8. The interference with the applicant's parental rights constituted an interference with his right to respect for his family life. However, it had been in accordance with the law, pursued the legitimate aim of protecting the health and morals and rights and freedoms of the child, and had been necessary in a democratic society, within the meaning of Article 8.

ARTICLE 12

Men and women of marriageable age have the right to marry and to found a family, according to the national laws governing the exercise of this right.[248]

246 Kocherov and Sergeyeva v Russia, no. 16899/13, 29 March 2016, [2016] ECHR 312.

247 Dmitriy Ryabov v Russia, no. 33774/08, 1 August 2013, [2013] ECHR 771.

248 Article 23 (Respect for home and the family) of the UNCRPD requires State parties to ensure that the right of all persons with disabilities who are of marriageable age to marry and to found a family on the basis of

ARTICLE 12

Right to marry

Men and women of marriageable age have the right to marry and to found a family, according to the national laws governing the exercise of this right.

The right contained in Article 12 is closely related to Article 8 which secures a right to respect for one's private and family life, home and correspondence.

In ***Lashin v Russia (2013)***,[249] the applicant suffered from schizophrenia and had been legally incapacitated since 2000. In 2002 he and his fiancée applied to the competent authority in order to register their marriage. However, they were unable to do so because the Russian Family Code prohibited persons who were legally incapacitated due to mental disorder from getting married. Having already found a violation of Article 8 on account of the maintenance of the applicant's status as an incapacitated person and his inability to have it reviewed, the court considered that there was no need for a separate examination under Article 12. The applicant's inability to marry was one of many legal consequences of his incapacity status.

Pending application

Delecolle v France[250] is a pending application which was communicated to the French Government on 18 September 2015. The applicant, who was born in 1937, complains that he is unable to marry, and criticises the fact he must obtain authorisation from a supervisor or the guardianship judge in order to marry. The court gave notice of the application to the French Government and put questions to the parties under Article 12 of the Convention.

ARTICLE 14

Article 14 prohibits discrimination based on 'any status', such as mental ill-health.

ARTICLE 14

Prohibition of discrimination

The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.

free and full consent of the intending spouses is recognized. The Convention on the Rights of Persons with Disabilities, United Nations, Treaty Series 2515 (2006).

249 Lashin v Russia, no. 33117/02, 22 January 2013, [2013] ECHR 282.

250 Delecolle v France, no. 37646/13.

The right under Article 14 not to be discriminated against on account of one's physical or mental condition has also been examined by the court, which has expressly acknowledged health as being one of the protected grounds which can be relied on in non-discrimination cases.[251] Relevant case law has been referred to above in the course of summarising the case law concerning persons suffering from mental ill-health.

RIGHT TO VOTE (ARTICLE 3 OF PROTOCOL NO. 1)

States undertake to hold elections which ensure the free expression of the opinion of 'the people'.

> **ARTICLE 3**
>
> **Right to free elections**
>
> The High Contracting Parties undertake to hold free elections at reasonable intervals by secret ballot, under conditions which will ensure the free expression of the opinion of the people in the choice of the legislature.

Having been diagnosed with a psychiatric condition in 1991, the applicant in ***Alajos Kiss v Hungary (2010)***[252] was placed under partial guardianship in May 2005 on the basis of the civil code. In February 2006, he realised that he had been omitted from the electoral register drawn up for upcoming legislative elections. His complaint to the electoral office was to no avail. He further complained to the district court which in March 2006 dismissed his case, observing that under the Hungarian Constitution persons placed under guardianship did not have the right to vote. When legislative elections took place in April 2006, the applicant could not participate. He submitted that his disenfranchisement, imposed on him because he was under partial guardianship for a psychiatric condition, constituted an unjustified deprivation of his right to vote that was not susceptible to any remedy.

The court held that there had been a violation of Article 3 of Protocol No. 1. The indiscriminate removal of voting rights without an individualised judicial evaluation, solely on the grounds of mental disability necessitating partial guardianship, could not be considered compatible with the legitimate grounds for restricting the right to vote. Mentally disabled people were at risk of legislative stereotyping and the state had to have very weighty reasons when restricting fundamental rights to such particularly vulnerable groups in society without an individualised evaluation of their capacities and needs. The applicant had lost his right to vote as a result of the imposition of an automatic, blanket restriction.

251 Kiyutin v Russia, no. 2700/10, 10 March 2011; IB v Greece, no. 552/10, 3 October 2013.

252 Alajos Kiss v Hungary, no. 38832/06, 20 May 2010, [2010] ECHR 692.

The case of ***Gajcsi v Hungary (2014)***[253] concerned an applicant who suffered from a psycho-social disability. In 2000 a district court placed the applicant under partial guardianship and as an automatic consequence his name was deleted from the electoral register. In 2008 his legal capacity was restored in all areas in health care matters but his electoral rights were not restored. This meant that he was unable to vote in the general elections in Hungary in 2010.

Referring to its decision in *Alajos Kiss v Hungary*, the court held that there had been a violation of Article 3 of Protocol No. 1.

ARTICLE 2 OF PROTOCOL No 4 (FREEDOM OF MOVEMENT)

Everyone has the right to liberty of movement and freedom to choose his residence. There shall be no restrictions on the exercise of these rights other than such as are in accordance with law, necessary in a democratic society and for one of the expressly permitted purposes.

> **ARTICLE 2**
>
> **Freedom of movement**
>
> 1. Everyone lawfully within the territory of a State shall, within that territory, have the right to liberty of movement and freedom to choose his residence.
>
> 2. Everyone shall be free to leave any country, including his own.
>
> 3. No restrictions shall be placed on the exercise of these rights other than such as are in accordance with law and are necessary in a democratic society in the interests of national security or public safety, for the maintenance of ordre public, for the prevention of crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.
>
> 4. The rights set forth in paragraph 1 may also be subject, in particular areas, to restrictions imposed in accordance with law and justified by the public interest in a democratic society.

Somewhat surprisingly, Article 2 of Protocol No. 4 seems only rarely to have been invoked in respect of restrictions on liberty which fall short of being a deprivation of liberty for the purposes of Article 5. The answer may be that such restrictions, interfering as they do with a person's private life, are dealt with under Article 8.

Article 2 of Protocol No. 4 was relied on by the applicant in the case of ***MV v Finland (2017)***,[254] where it was dealt with fairly summarily. His application was effectively disposed of under Article 8:

253 Gajcsi v Hungary, no. 62924/10, 23 September 2014.
254 A-MV v Finland, no. 53251/13, 23 March 2017.

'94. In support of his complaint, the applicant also invoked the provisions of Article 2 of Protocol No. 4 to the Convention. In view of the content of that Article as cited above, in particular the fact that paragraph 3 of the Article is closely aligned with paragraph 2 of Article 8, and taking into account the conclusions reached under Article 8 of the Convention above, the Court does not consider that an examination of the applicant's complaint can lead to different findings when reviewed under Article 2 of Protocol No. 4. There has therefore been no violation of that Article, either.'

B – UNCRPD

The text of the Convention on the Rights of Persons with Disabilities was adopted by the United Nations General Assembly on 13 December 2006. It opened for signature on 30 March 2007. Following ratification by the twentieth party, it came into force on 3 May 2008. As of April 2017, the Convention has 160 signatories and 173 parties. The European Union ratified it on 23 December 2010 to the extent that responsibilities of the member states were transferred to it.

By Article 1, the purpose of the 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'.

'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.'[255]

DEFINITIONS

"Discrimination on the basis of disability" means 'any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable accommodation.'[256]

ARTICLE 12

> **Article 12**
>
> **Equal recognition before the law**
>
> 1. States Parties reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law.
>
> 2. States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.
>
> 3. States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.

255 The Convention on the Rights of Persons with Disabilities, United Nations, Treaty Series 2515 (2006), Article 1. Referred to in the footnotes which follow as 'The UNCRPD'. This 'definition' is to be found in Article 1 rather than as a definition in 'Article 2: Definitions'.

256 The UNCRPD, Article 2.

> 4. States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests.
>
> 5. Subject to the provisions of this article, States Parties shall take all appropriate and effective measures to ensure the equal right of persons with disabilities to own or inherit property, to control their own financial affairs and to have equal access to bank loans, mortgages and other forms of financial credit, and shall ensure that persons with disabilities are not arbitrarily deprived of their property.

There is arguably some ambiguity as to the precise meaning of Article 12 and presumably that is because it embodies a compromise of different opinions expressed during the drafting and adoption process.

On the one hand, the article requires states to 'recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life' and 'to take all appropriate and effective measures to ensure the equal right of persons with disabilities to own or inherit property, to control their own financial affairs and to have equal access to bank loans, mortgages and other forms of financial credit …'

On the other hand, the article provides that all measures that relate to the exercise of legal capacity must provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law; and that such safeguards shall ensure that legal capacity measures 'respect' the rights, will and preferences of the person, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body'. Such safeguards must be proportional to the degree to which such measures affect the person's rights and interests' and states 'ensure that persons with disabilities are not arbitrarily deprived of their property'.

The inclusion of the requirements, conditions and caveats stipulated in the preceding paragraph make no sense whatsoever unless the interventions referred to are permitted by the Convention subject to the appropriate safeguards. Necessarily once such an intervention takes place, the person affected at that point no longer 'enjoys legal capacity on an equal basis with others in all aspects of life'.

The intention may be that Article 12 is to be understood in the same way as Article 8 of the European Convention on Human Rights, in that there is a general statement of rights followed by a statement of the circumstances in which those rights may be qualified and the safeguards and limits attaching to any interference. If so, Article 12 can be understood in the following way:

1. Persons with disabilities shall not by virtue of the fact that they have a disability (whether physical, mental, intellectual or sensory) be denied 'the right to recognition everywhere as persons before the law' or prevented from enjoying 'legal capacity on an equal basis with others in all aspects of life'. States shall 'take appropriate measures to provide access by such persons to the support they may require in exercising their legal capacity' and shall ensure that persons with disabilities may own or inherit property, control their own financial affairs and have equal access to bank loans, mortgages and other forms of financial credit.

2. States shall also ensure that all measures that concern the exercise of legal capacity by a person with a mental or other disability:

   - incorporate appropriate and effective safeguards which are consistent with international human rights and proportional to the degree to which such measures affect the person's rights and interests;
   - protect them from abuse;
   - respect their rights, will and preferences;
   - are free of conflict of interest and undue influence;
   - are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body; and
   - do not arbitrarily deprive the person of their property.

Such a formulation incorporates the fundamental principles set down in Article 12 without ignoring the clearly enumerated conditions and reservations which can only be there for a purpose.

It also acknowledges the reality that some people are so disabled that they cannot exercise certain legal rights even with support. Take for example the person in the final sad stages of dementia, confined to bed and so cognitively impaired as to be unable to form the idea of swallowing let alone mobilising, or the person in a persistent vegetative state following a road traffic accident.

It seems unlikely that more than this is intended given that the UNCRPD recognises the need for some interference with liberty in this and other articles.[257] The counterpart of autonomy is accountability for acts autonomously done. The reality is that not all adults are able to assume this burden of legal responsibility. If, in a desire to maximise the autonomy and dignity of a person with a significant learning disability we hold that they are able to enter into a binding contract which they are unable to understand even with full support, with that goes all the potentially disastrous consequences of then being liable for breaches of an ununderstood contract.

257 See e.g. Article 14 below (Liberty and Security of the Person).

Likewise, if we hold that a person who cannot understand the litigation is able to litigate they will be personally liable to pay the often substantial costs of misconceived litigation. In other situations the fact that the individual is held in all cases to have legal capacity may render them liable to pay damages and/or to imprisonment for injuring someone when mentally unwell, bound by gifts made in a manic phase or as a result of delusional beliefs, and so on. We cannot do without capacity laws which define a person's ability to make legally-binding decisions and either to be held legally accountable to others for their acts and omissions or to be released from such liability.

In ***A-MV v Finland (2017)***,[258] the court rejected a central tenet of the interpretation of Article 12 of the UNCRPR, namely that the will and preferences of an individual should always be determinative of any decision taken in their name. The case concerned an intellectually disabled man's complaint about the Finnish courts' refusal to replace his court-appointed mentor, meaning that he had been prevented from deciding where and with whom he would like to live (see above).

A-MV's application was supported by the Mental Disability Advocacy Centre which argued that 'states were required to ensure that the will and preferences of persons with disabilities were respected at all times and could not be overridden or ignored by paternalistic "best interests" decision-making … The starting point, based on the current international standards, was that the will and preferences of a person with disabilities should take precedence over other considerations when it came to decisions affecting that person … There was a clear move from a "best-interests" model to a "supported decision-making" approach.'

The court accepted that AM-V's right to private life under Article 8 was interfered with by the fact that the domestic courts had refused to change his mentor. The question was whether the interference was justified. The court identified the critical legal contention advanced by the applicant as being that 'there was a measure in place under which the mentor was required not to abide by the applicant's wishes and instead to give precedence to his best interests, if and where the applicant was deemed unable to understand the significance of a specific matter'. The court reminded itself that, in order to determine the proportionality of a general measure, it had primarily to assess the legislative choices underlying it, and further reminded itself of the margin of appreciation left to national authorities. The court noted that under Finnish law the appointment of a mentor does not entail a deprivation or restriction of the legal capacity of the person for whom the mentor is designated:

> 'The powers of the mentor to represent the ward cover the latter's property and financial affairs to the extent set out in the appointing court's order, but these powers do not exclude the ward's capacity to act for him- or herself. If, like in the present case, the court has specifically ordered that the mentor's function shall also cover matters pertaining to the ward's person, the mentor is competent to represent the ward in such a matter only where the latter is unable to understand its significance […]. In a context such as the present one, the interference with the applicant's freedom to choose where and with whom to live that resulted from the appointment and retention of a mentor for him was therefore solely contingent on the determination that the applicant was unable to understand the significance of that particular issue. This determination in turn depended

258 A-MV v Finland, no. 53251/13, 23 March 2017

> on the assessment of the applicant's intellectual capacity in conjunction with and in relation to all the aspects of that specific issue. The Court also notes that Finland, having recently ratified the UNCRPD, has done so while expressly considering that there was no need or cause to amend the current legislation in these respects.'

Reminding itself of the review nature of its jurisdiction, the court saw no reason to call into question the factual findings of the domestic courts:

> 'In the light of the above mentioned findings, the Court is satisfied that the impugned decision was taken in the context of a mentor arrangement that had been based on, and tailored to, the specific individual circumstances of the applicant, and that the impugned decision was reached on the basis of a concrete and careful consideration of all the relevant aspects of the particular situation. In essence, the decision was not based on a qualification of the applicant as a person with a disability. Instead, the decision was based on the finding that, in this particular case, the disability was of a kind that, in terms of its effects on the applicant's cognitive skills, rendered the applicant unable to adequately understand the significance and the implications of the specific decision he wished to take, and that therefore, the applicant's well-being and interests required that the mentor arrangement be maintained.'

The Court was mindful of the need for domestic authorities to reach, in each particular case, a balance between the respect for the dignity and self-determination of the individual and the need to protect them and safeguard their interests, especially under circumstances where their individual qualities or situation placed them in a particularly vulnerable position. The Court considered that a proper balance was struck in the AM-V's case: there were effective safeguards in the domestic proceedings to prevent abuse, as required by the standards of international human rights law which ensured that the applicant's rights, will and preferences were taken into account. The applicant was involved at all stages of the proceedings: he was heard in person and he could put forward his wishes. The interference was proportional and tailored to his circumstances and was subject to review by competent, independent and impartial domestic courts. The measure taken was also consonant with the legitimate aim of protecting his health, in a broader sense of his well-being.

For these reasons, the court considered that, in the light of the findings of the domestic courts, the impugned decision was based on relevant and sufficient reasons and the refusal to make changes in the mentor arrangements concerning the applicant was not disproportionate to the legitimate aim pursued. There had been no violation of Article 8.[259]

Best interests approaches

Properly interpreted, a 'best interests' approach is not dismissive of the significance of the individual's autonomy, wishes, feelings, beliefs and values.

259 This summary of the facts is taken from one prepared by Alex Ruck-Keene, an English barrister at 39 Essex Street Chambers who is an authority on the UNCRPD.

There is much less difference than has commonly been supposed between a properly applied person-centred 'best interests' approach and a supported decision model. For example, one of the principles of the English and Welsh Mental Capacity Act 2005 is that 'a person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success'.[260] That therefore requires providing the person with the support they require to make their own decision before reaching any decision on evidence that they lack the capacity to decide the matter in issue.[261] If the person cannot make their own decision, the fact that any decision made on their behalf must be made in their 'best interests' simply imposes a person-centred requirement that it is their best interests, not anyone else's, which is determinative. Furthermore, the fact that the individual's past and present wishes, feelings, beliefs and values must be considered[262] and given due weight tells us that this is not a sterile objective test of best interests. It is not a case of trying to determine what some hypothetical objective or rational person would decide in this situation when presented with these choices. Nor are we seeking to do nothing more sophisticated than impose on the individual an objective and rational analysis based on professional expertise of what they ought sensibly to do in that situation. The person's wishes and feelings are always the starting point and very often the end point. The decision or outcome will often be that which accords with their wishes because any risks must be significant to outweigh the benefit for them of autonomy and self-determination. After all, why would any person wish another person to receive care or treatment otherwise than in accordance with their wishes if they can be cared for adequately in accordance with their wishes? The law requires objective analysis of a subject not an object. The incapacitated person is the subject. Therefore, it is their welfare in the context of their wishes, feelings, beliefs and values that is important. This is the principle of beneficence which asserts an obligation to help others further *their* important and legitimate interests, not one's own.

It is also the case that, properly interpreted, the objective and subjective importance of individual liberty is a crucial factor in all 'best-interests' decision-making. The enduring impression left after spending many years visiting psychiatric wards is not one of fear or dangerousness, but of suffering and an often disarming kindness on the part of those who have lost their liberty. Although compelled to submit to the will of others, and forced to accept medication which, if mentally beneficial, often produces severe physical discomfort, most patients remain dignified and courteous, and retain the compassion to respond to the plight of others in a similarly unfortunate situation.

Equally remarkable is their striving to be free members of society after many years outside society, even when many other higher faculties are profoundly impaired. A hospital is not a prison but for the individual concerned both involve detention and a complete loss of that right most important to them, so that Byron's words — 'Eternal spirit of the chainless Mind ! / Brightest in dungeons, Liberty ! thou art' — are often an apt description of the individual's predicament.

260 Mental Capacity Act 2005, s.1.

261 This requirement is equivalent to what other jurisdictions may refer to as 'co-decision-making' ('You wouldn't have capacity on your own to make the decision') or a decision-making representative scheme ('You don't have capacity on your own to make that decision and don't have a co decision-maker').

262 Ibid, s4.

Shared and co-decision making

There has been considerable support in recent years for shared decision-making and co-decision making schemes. The difficulty intellectually is that a person is either able with support to make their own decision or is not able. If the person is able to do so then they should be entitled in law to make their own decision, rather than having to share this right with another person. If they wish to relieve themselves of some of the burden of decision-making they can appoint an attorney to act on their behalf and in accordance with such conditions and restrictions as they wish to insert in the power of attorney document. It is not a matter for the state. If the person is not able with support to make their own decision then masking this with a co-decision-making agreement is dubious. Having just found that they are unable to make their own decision even if properly and fully supported, the corollary can only be that it is the co-decision maker or shared decision-maker who is making the decisions for them on a best interests basis.

The Victorian Law Reform Commission's *Guardianship: Final Report*[263] sets out some of the relevant considerations. The Commission itself supported the introduction of co-decision-making. In its view, co-decision making is qualitatively different to substitute decision-making because the person with impaired decision-making ability continues to have legal responsibility for decisions about their own affairs, even though those decisions require the agreement of another person. However, there were a number of 'challenges'. In particular, the co-decision maker might be in a position to exert significant influence over a person with impaired decision-making ability. That created the potential for abuse. In circumstances where a person's decision-making ability fluctuated considerably, it might also be difficult for co-decision makers to determine whether a decision had been jointly made or was really a substitute decision. The Mental Health Legal Centre indicated that while they initially supported the proposal for co-decision makers, negative consumer feedback and concerns about the potential for abuse had changed their view. Victoria Legal Aid expressed concern that a co-decision-making arrangement had the potential to be an 'uneven partnership', where the co-decision maker may heavily influence the person with a disability to agree with a decision that the co-decision maker thinks is appropriate. The Federation of Community Legal Centres shared Victoria Legal Aid's concerns, arguing that 'the co-decision making model … seems likely to increase complexity without much associated benefit'.

ARTICLE 13

> **Article 13**
>
> **Access to justice**
>
> 1. States Parties shall ensure effective access to justice for persons with disabilities on an equal basis with others, including through the provision of procedural and age-appropriate accommodations, in order to facilitate their effective role as direct and indirect participants, including as witnesses, in all legal proceedings, including at investigative and other preliminary stages.

263 *Guardianship: Final Report*, Victorian Law Reform Commission, 2012.

> 2. In order to help to ensure effective access to justice for persons with disabilities, States Parties shall promote appropriate training for those working in the field of administration of justice, including police and prison staff.

This is an important statement of principle and one which, if properly implemented by states, would have enormous benefits both in terms of the rights of people suffering from significant mental ill-health and the fair administration of justice.

Of critical significance is the availability of state-funded legal aid for persons in court proceedings which involve a deprivation or restriction of their liberty or which impact on the exercise by them of a citizen's usual legal rights. The European Court of Human Rights has bit-by-bit extended the requirement for legal representation in Article 5 and Article 8 proceedings without yet laying down the unequivocal principle that representation is required by the Convention.

The relevant factors which affect access to justice in this field of law include:

- The simplicity of the legislative scheme. Laws should be a last resort; impose minimum powers, duties and rights; be unambiguous, just, as short as possible, in plain language, provide a mechanism for enforcing duties and a remedy when powers are exceeded.
- The professional and judicial culture.
- The appointment of specialist mental health judges with experience in the field rather than generic judges.
- The existence of a specialist panel of lawyers to assist applicants.
- The formality of proceedings and the volume and complexity of rules, procedures and forms.
- The availability of publicly-funded legal aid and representation.
- The level of resources (judicial, court space, local authority and health services support in relation to providing court reports and less restrictive alternatives).
- The existence of a system of periodic automatic referral of cases which does not rely on the individual making an application.
- The forensic model (one, two or three person courts or tribunals; the use of assessors; inquisitorial or adversarial).
- The location of hearings (conventional court, tribunal sitting locally, the person's own home).
- Court fee levels.
- Public and press access, publicity, reporting.
- Training.

— The delegation of powers to civil servants.

ARTICLE 14 (LIBERTY AND SECURITY OF PERSON)

> **Article 14**
>
> **Liberty and security of 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.
>
> 2. States Parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of the present Convention, including by provision of reasonable accommodation.

The CRPD states that a 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.'[264]

According to 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.' 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.'[265]

264 *Involuntary placement and involuntary treatment of persons with mental health problems*, FRA – European Union Agency for Fundamental Rights, Luxembourg: Publications Office of the European Union, 2012, p.15.

265 *Involuntary placement and involuntary treatment of persons with mental health problems*, FRA – European Union Agency for Fundamental Rights, Luxembourg: Publications Office of the European Union, 2012, p.16.

OTHER ARTICLES

The remaining articles contain a number of significant rights, some of which overlap with Article 8 of the European Convention but many of which go further and impact on the considerable economic and social disadvantage experienced by people with disabilities:

Article 17 (Protecting the integrity of the person) provides that, **'**Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others.' This is relevant to interventions such as community treatment orders, medication and other treatment without consent, access to one's home and searches.

Article 19 (Living independently and being included in the community) requires states to 'recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and [to] take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community'. States must ensure that 'Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement.' They must 'have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community'. This will be relevant to people with a disability who are subject to a guardian or mentor with power to determine their place of residence. It will also be relevant to individuals who are required to live in a particular community setting because of their disability, e.g. supported living for a person with Alzheimer's disease or an intellectual disability.

Article 22 (Respect for privacy) provides that, '1. No person with disabilities, regardless of place of residence or living arrangements, shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence or other types of communication or to unlawful attacks on his or her honour and reputation. Persons with disabilities have the right to the protection of the law against such interference or attacks. 2. States Parties shall protect the privacy of personal, health and rehabilitation information of persons with disabilities on an equal basis with others. This Article has a considerable overlap with Article 8 of the ECHR.

Article 23 (Respect for home and the family) states that, **'**1.States Parties shall take effective and appropriate measures to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships, on an equal basis with others. Inter alia, State parties must ensure that the right of all persons with disabilities who are of marriageable age to marry and to found a family on the basis of free and full consent of the intending spouses is recognized. This article overlaps with Articles 8 and 12.

Article 24 (Education) recognizes the right of persons with disabilities to education and the necessity for persons with disabilities to develop their personality, talents and creativity to their fullest potential. States must enable persons with disabilities to learn life and social development skills to facilitate their full and equal participation in education and as members of the community.

Article 25 (Health) provides 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 must provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, and also such health services as are needed specifically because of their disabilities.

Article 26 (Habilitation and rehabilitation) requires States Parties to take effective and appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life. To that end, States Parties must organize, strengthen and extend comprehensive habilitation and rehabilitation services and programmes, particularly in the areas of health, employment, education and social services.

Article 27 (Work and employment) provides that States Parties must protect the rights of persons with disabilities, on an equal basis with others, to just and favourable conditions of work, including equal opportunities and equal remuneration for work of equal value, safe and healthy working conditions, including protection from harassment, and the redress of grievances.

Article 28 (Adequate standard of living and social protection) recognizes the right of persons with disabilities to an adequate standard of living for themselves and their families, including adequate food, clothing and housing, and to the continuous improvement of living conditions. State Parties must take appropriate steps to safeguard and promote the realization of this right without discrimination on the basis of disability.

Article 29 (Participation in political and public life) requires that States Parties guarantee to persons with disabilities political rights and the opportunity to enjoy them on an equal basis with others.

Article 30 (Participation in cultural life, recreation leisure and sport) recognises the right of persons with disabilities to take part on an equal basis with others in cultural life. State Parties must take all appropriate measures to ensure that persons with disabilities enjoy access to cultural materials in accessible formats.

OTHER CONVENTIONS, DECLARATIONS AND RECOMMENDATIONS

Over the years a number of other conventions and international documents have been published, including the following:[266]

European Recommendations

- Recommendation No R (99) 4 of 23 February 1999 of the Committee of Ministers of the Member States of the Council of Europe On Principles Concerning the Legal Protection of Incapable Adults
- Recommendation No. R (98) 7 concerning the ethical and organisational aspects of health care in prison;
- Recommendation Rec (2006) 2 on the European Prison Rules.

Recommendation No R (99) 4 on Principles re the Legal Protection of Incapable Adults

The recommendation was adopted by the Committee of Ministers on 23 February 1999. The Committee recommended that the governments of member states take or reinforce, in their legislation and practice, all measures considered necessary with a view to the implementation of the principles set out in the Recommendation. The recommendation is set out in full here because it is surprisingly difficult to download a copy:

PRINCIPLES

Part I — Scope of application

1. The following principles apply to the protection of adults who, by reason of an impairment or insufficiency of their personal faculties, are incapable of making, in an autonomous way, decisions concerning any or all of their personal or economic affairs, or understanding, expressing or acting upon such decisions, and who consequently cannot protect their interests.

2. The incapacity may be due to a mental disability, a disease or a similar reason.

3. The principles apply to measures of protection or other legal arrangements enabling such adults to benefit from representation or assistance in relation to those affairs.

4. In these principles "adult" means a person who is treated as being of full age under the applicable law on capacity in civil matters.

266 Some of the language and terms used would today be considered inappropriate but the relevant provisions are summarised as published.

5. In these principles "intervention in the health field" means any act performed professionally on a person for reasons of health. It includes, in particular, interventions for the purposes of preventive care, diagnosis, treatment, rehabilitation or research.

Part II — Governing principles

Principle 1 — Respect for human rights

In relation to the protection of incapable adults the fundamental principle, underlying all the other principles, is respect for the dignity of each person as a human being. The laws, procedures and practices relating to the protection of incapable adults shall be based on respect for their human rights and fundamental freedoms, taking into account any qualifications on those rights contained in the relevant international legal instruments.

Principle 2 — Flexibility in legal response

1. The measures of protection and other legal arrangements available for the protection of the personal and economic interests of incapable adults should be sufficient, in scope or flexibility, to enable a suitable legal response to be made to different degrees of incapacity and various situations.

2. Appropriate measures of protection or other legal arrangements should be available.

3. The law should provide for simple and inexpensive measures of protection or other legal arrangements.

4. The range of measures of protection should include, in appropriate cases, those which do not restrict the legal capacity of the person concerned.

5. The range of measures of protection should include those which are limited to one specific act without requiring the appointment of a representative or a representative with continuing powers.

6. Consideration should be given to the inclusion of measures under which the appointed person acts jointly with the adult concerned, and of measures involving the appointment of more than one representative.

7. Consideration should be given to the need to provide for, and regulate, legal arrangements which a person who is still capable can take to provide for any subsequent incapacity.

8. Consideration should be given to the need to provide expressly that certain decisions, particularly those of a minor or routine nature relating to health or personal welfare, may be taken for an incapable adult by those deriving their powers from the law rather than from a judicial or administrative measure.

Principle 3 — Maximum preservation of capacity

1. The legislative framework should, so far as possible, recognise that different degrees of incapacity may exist and that incapacity may vary from time to time. Accordingly, a measure of protection should not result automatically in a complete removal of legal capacity. However, a restriction of legal capacity should be possible where it is shown to be necessary for the protection of the person concerned.

2. In particular, a measure of protection should not automatically deprive the person concerned of the right to vote, or to make a will, or to consent or refuse consent to any intervention in the health field, or to make other decisions of a personal character at any time when his or her capacity permits him or her to do so.

3. Consideration should be given to legal arrangements whereby, even when representation in a particular area is necessary, the adult may be permitted, with the representative's consent, to undertake specific acts or acts in a specific area.

4. Whenever possible the adult should be enabled to enter into legally effective transactions of an everyday nature.

Principle 4 — Publicity

The disadvantage of automatically giving publicity to measures of protection or similar legal arrangements should be weighed in the balance against any protection which might be afforded to the adult concerned or to third parties.

Principle 5 — Necessity and subsidiarity

1. No measure of protection should be established for an incapable adult unless the measure is necessary, taking into account the individual circumstances and the needs of the person concerned. A measure of protection may be established, however, with the full and free consent of the person concerned.

2. In deciding whether a measure of protection is necessary, account should be taken of any less formal arrangements which might be made, and of any assistance which might be provided by family members or by others.

Principle 6 — Proportionality

1. Where a measure of protection is necessary it should be proportional to the degree of capacity of the person concerned and tailored to the individual circumstances and needs of the person concerned.

2. The measure of protection should interfere with the legal capacity, rights and freedoms of the person concerned to the minimum extent which is consistent with achieving the purpose of the intervention.

Principle 7 — Procedural fairness and efficiency

1. There should be fair and efficient procedures for the taking of measures for the protection of incapable adults.

2. There should be adequate procedural safeguards to protect the human rights of the persons concerned and to prevent possible abuses.

Principle 8 — Paramountcy of interests and welfare of the person concerned

1. In establishing or implementing a measure of protection for an incapable adult the interests and welfare of that person should be the paramount consideration.

2. This principle implies, in particular, that the choice of any person to represent or assist an incapable adult should be governed primarily by the suitability of that person to safeguard and promote the adult's interests and welfare.

3. This principle also implies that the property of the incapable adult should be managed and used for the benefit of the person concerned and to secure his or her welfare.

Principle 9 — Respect for wishes and feelings of the person concerned

1. In establishing or implementing a measure of protection for an incapable adult the past and present wishes and feelings of the adult should be ascertained so far as possible, and should be taken into account and given due respect.

2. This principle implies, in particular, that the wishes of the adult as to the choice of any person to represent or assist him or her should be taken into account and, as far as possible, given due respect.

3. It also implies that a person representing or assisting an incapable adult should give him or her adequate information, whenever this is possible and appropriate, in particular concerning any major decision affecting him or her, so that he or she may express a view.

Principle 10 — Consultation

In the establishment and implementation of a measure of protection there should be consultation, so far as reasonable and practicable, with those having a close interest in the welfare of the adult concerned, whether as representative, close family member or otherwise. It is for national law to determine which persons should be consulted and the effects of consultation or its absence.

Part III — Procedural principles

Principle 11— Institution of proceedings

1. The list of those entitled to institute proceedings for the taking of measures for the protection of incapable adults should be sufficiently wide to ensure that measures of protection can be considered in all cases where they are necessary. It may, in particular, be necessary to provide for proceedings to be initiated by a public official or body, or by the court or other competent authority on its own motion.

2. The person concerned should be informed promptly in a language, or by other means, which he or she understands of the institution of proceedings which could affect his or her legal capacity, the exercise of his or her rights or his or her interests unless such information would be manifestly without meaning to the person concerned or would present a severe danger to the health of the person concerned.

Principle 12 — Investigation and assessment

1. There should be adequate procedures for the investigation and assessment of the adult's personal faculties.

2. No measure of protection which restricts the legal capacity of an incapable adult should be taken unless the person taking the measure has seen the adult or is personally satisfied as to the adult's condition and an up-to-date report from at least one suitably qualified expert has been submitted. The report should be in writing or recorded in writing.

Principle 13 — Right to be heard in person

The person concerned should have the right to be heard in person in any proceedings which could affect his or her legal capacity.

Principle 14 — Duration, review and appeal

1. Measures of protection should, whenever possible and appropriate, be of limited duration. Consideration should be given to the institution of periodical reviews.

2. Measures of protection should be reviewed on a change of circumstances and, in particular, on a change in the adult's condition. They should be terminated if the conditions for them are no longer fulfilled.

3. There should be adequate rights of appeal.

Principle 15 Provisional measures in case of emergency

If a provisional measure is needed in a case of emergency, principles 11 to 14 should be applicable as far as possible according to the circumstances.

Principle 16 — Adequate control

There should be adequate control of the operation of measures of protection and of the acts and decisions of representatives.

Principle 17 — Qualified persons

1. Steps should be taken with a view to providing an adequate number of suitably qualified persons for the representation and assistance of incapable adults.

2. Consideration should be given, in particular, to the establishment or support of associations or other bodies with the function of providing and training such people.

Part IV — The role of representatives

Principle 18 — Control of powers arising by operation of law

1. Consideration should be given to the need to ensure that any powers conferred on any person by operation of law, without the intervention of a judicial or administrative authority, to act or take decisions on behalf of an incapable adult are limited and their exercise controlled.

2. The conferment of any such powers should not deprive the adult of legal capacity.

3. Any such powers should be capable of being modified or terminated at any time by a measure of protection taken by a judicial or administrative authority.

4. Principles 8 to 10 apply to the exercise of such powers as they apply to the implementation of measures of protection.

Principle 19 — Limitation of powers of representatives

1. It is for national law to determine which juridical acts are of such a highly personal nature that they cannot be done by a representative.

2. It is also for national law to determine whether decisions by a representative on certain serious matters should require the specific approval of a court or other body.

Principle 20 — Liability

1. Representatives should be liable, in accordance with national law, for any loss or damage caused by them to incapable adults while exercising their functions.

2. In particular, the laws on liability for wrongful acts, negligence or maltreatment should apply to representatives and others involved in the affairs of incapable adults.

Principle 21 — Remuneration and expenses

1. National law should address the questions of the remuneration and the reimbursement

2. Distinctions may be made between those acting in a professional capacity and those acting in other capacities, and between the management of personal matters of the incapable adult and the management of his or her economic matters.

Part V — Interventions in the health field

Principle 22 — Consent

1. Where an adult, even if subject to a measure of protection, is in fact capable of giving free and informed consent to a given intervention in the health field, the intervention may only be carried out with his or her consent. The consent should be solicited by the person empowered to intervene.

2. Where an adult is not in fact capable of giving free and informed consent to a given intervention, the intervention may, nonetheless, be carried out provided that:

   a. it is for his or her direct benefit, and

   b. authorisation has been given by his or her representative or by an authority or a person or body provided for by law.

3. Consideration should be given to the designation by the law of appropriate authorities, persons or bodies for the purpose of authorising interventions of different types, when adults who are incapable of giving free and informed consent do not have a representative with appropriate powers. Consideration should also be given to the need to provide for the authorisation of a court or other competent body in the case of certain serious types of intervention.

4. Consideration should be given to the establishment of mechanisms for the resolution of any conflicts between persons or bodies authorised to consent or refuse consent to interventions in the health field in relation to adults who are incapable of giving consent.

Principle 23 — Consent (alternative rules)

If the government of a member state does not apply the rules contained in paragraphs 1 and 2 of Principle 22, the following rules should be applicable:

1. Where an adult is subject to a measure of protection under which a given intervention in the health field can be carried out only with the authorisation of a body or a person provided for by law, the consent of the adult should nonetheless be sought if he or she has the capacity to give it.

2. Where, according to the law, an adult is not in a position to give free and informed consent to an intervention in the health field, the intervention may nonetheless be carried out if:

   a. it is for his or her direct benefit, and

   b. authorisation has been given by his or her representative or by an authority or a person or body provided for by law.

3. The law should provide for remedies allowing the person concerned to be heard by an independent official body before any important medical intervention is carried out.

Principle 24 — Exceptional cases

1. Special rules may be provided by national law, in accordance with relevant international instruments, in relation to interventions which, because of their special nature, require the provision of additional protection for the person concerned.

2. Such rules may involve a limited derogation from the criterion of direct benefit provided that the additional protection is such as to minimise the possibility of any abuse or irregularity.

Principle 25 — Protection of adults with a mental disorder

Subject to protective conditions prescribed by law, including supervisory, control and appeal procedures, an adult 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.

Principle 26 — Permissibility of intervention in emergency situation

When, because of an emergency situation, the appropriate consent or authorisation cannot be obtained, any medically necessary intervention may be carried out immediately for the benefit of the health of the person concerned.

Principle 27 — Applicability of certain principles applying to measures of protection

1. Principles 8 to 10 apply to any intervention in the health field concerning an incapable adult as they apply to measures of protection.

2. In particular, and in accordance with principle 9, the previously expressed wishes relating to a medical intervention by a patient who is not, at the time of the intervention, in a state to express his or her wishes should be taken into account.

Principle 28 — Permissibility of special rules on certain matters

Special rules may be provided by national law, in accordance with relevant international instruments, in relation to interventions which are necessary in a democratic society in the interest of public safety, for the prevention of crime, for the protection of public health or for the protection of the rights and freedom of others.

United Nations and WHO Declarations and Guidelines

- 'The protection of persons with mental illness and the improvement of mental health care' (Universal Declaration of Human Rights, UN Resolution of 1991, No. A/RES/46/119, 75th Plenary Meeting);
- The United Nations Declaration on the Rights of Mentally Retarded Persons, proclaimed by General Assembly resolution 2856 (XXVI) of 20 December 1971.
- The United Nations Declaration on the Rights of Disabled Persons, Proclaimed by General Assembly resolution 3447 (XXX) of 9 December 1975;
- The Guidelines for the Promotion of Human Rights of Persons with Mental Health Disorders (WHO/MNH/MND/95.4).

INTERNATIONAL CONVENTIONS & PRINCIPLES

A. UNITED NATIONS

Principles for the protection of persons with mental illness and the improvement of mental health care.

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

The exercise of the rights set forth in these Principles may be subject only to such limitations as are prescribed by law and are necessary to protect the health or safety of the person concerned or of others, or otherwise to protect public safety, order, health or morals or the fundamental rights and freedoms of others

Determination of mental illness	Principle 4	1. A determination that a person has a mental illness shall be made in accordance with internationally accepted medical standards. 2. A determination of mental illness shall never be made on the basis of political, economic or social status, or membership of a cultural, racial or religious group, or any other reason not directly relevant to mental health status. 3. Family or professional conflict, or non-conformity with moral, social, cultural or political values or religious beliefs prevailing in a person's community, shall never be a determining factor in diagnosing mental illness.

		4. A background of past treatment or hospitalization as a patient shall not of itself justify any present or future determination of mental illness. 5. No person or authority shall classify a person as having, or otherwise indicate that a person has, a mental illness except for purposes directly relating to mental illness or the consequences of mental illness.
Standards of care	Principle 8	2. Every patient shall be protected from harm, including unjustified medication, abuse by other patients, staff or others or other acts causing mental distress or physical discomfort.
Treatment	**Principle 9**	**1. Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others.** **4. The treatment of every patient shall be directed towards preserving and enhancing personal autonomy.**
Medication	Principle 10	1. Medication shall meet the best health needs of the patient, shall be given to a patient only for therapeutic or diagnostic purposes and shall never be administered as a punishment or for the convenience of others. Subject to the provisions of paragraph 15 of Principle 11, mental health practitioners shall only administer medication of known or demonstrated efficacy. 2. All medication shall be prescribed by a mental health practitioner authorized by law and shall be recorded in the patient's records.
Consent to treatment	**Principle 11**	**6. Except as provided in paragraphs 7, 8, 12, 13, 14 and 15 below, a proposed plan of treatment may be given to a patient without a patient's informed consent if the following conditions are satisfied:** **(a) The patient is, at the relevant time, held as an involuntary patient;** **(b) An independent authority, having in its possession all relevant information, including the information specified in paragraph 2 above, is satisfied that, at the relevant time, the patient lacks the capacity to give or withhold informed consent to the proposed plan of treatment or, if domestic legislation so provides, that, having regard to the patient's own safety or the safety of others, the patient unreasonably withholds such consent; and** **(c) The independent authority is satisfied that the proposed plan of treatment is in the best interest of the patient's health needs.** **11. Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose. All instances of physical restraint or involuntary seclusion, the reasons for them and their nature and extent shall be recorded in the patient's medical record. A patient who is restrained or secluded shall be kept under humane conditions and be under the care and close and regular supervision of qualified members of the staff. A personal representative, if any and if relevant, shall be given prompt notice of any physical restraint or involuntary seclusion of the patient.** **15. Clinical trials and experimental treatment shall never be carried out on any patient without informed consent, except that a patient who is unable to give informed consent may be admitted to a clinical trial or given experimental treatment, but only with the approval of a competent, independent review body specifically constituted for this purpose.**
Resources for mental health facilities	**Principle 14**	**2. Every mental health facility shall be inspected by the competent authorities with sufficient frequency to ensure that the conditions, treatment and care of patients comply with these Principles.**

Monitoring and remedies	**Principle 22**	**States shall ensure that appropriate mechanisms are in force to promote compliance with these Principles, for the inspection of mental health facilities, for the submission, investigation and resolution of complaints and for the institution of appropriate disciplinary or judicial proceedings for professional misconduct or violation of the rights of a patient.**
Implementation	**Principle 23**	**1. States should implement these Principles through appropriate legislative, judicial, administrative, educational and other measures, which they shall review periodically.** **2. States shall make these Principles widely known by appropriate and active means.**
Scope of principles	Principle 24	These Principles apply to all persons who are admitted to a mental health facility.
Saving of existing rights	Principle 25	There shall be no restriction upon or derogation from any existing rights of patients, including rights recognized in applicable international or domestic law, on the pretext that these Principles do not recognize such rights or that they recognize them to a lesser extent.

Declaration on the Rights of Mentally Retarded Persons

Proclaimed by General Assembly resolution 2856 (XXVI) of 20 December 1971

Right to a guardian	**Para. 5**	**5. The mentally retarded person has a right to a qualified guardian when this is required to protect his personal well-being and interests.**
Protection from abuse	Para. 6	6. The mentally retarded person has a right to protection from exploitation, abuse and degrading treatment. If prosecuted for any offence, he shall have a right to due process of law with full recognition being given to his degree of mental responsibility.
Legal safeguards	**Para. 7**	**7. Whenever mentally retarded persons are unable, because of the severity of their handicap, to exercise all their rights in a meaningful way or it should become necessary to restrict or deny some or all of these rights, the procedure used for that restriction or denial of rights must contain proper legal safeguards against every form of abuse. This procedure must be based on an evaluation of the social capability of the mentally retarded person by qualified experts and must be subject to periodic review and to the right of appeal to higher authorities.**

Declaration on the Rights of Disabled Persons

Proclaimed by General Assembly resolution 3447 (XXX) of 9 December 1975

Right to protection	Para. 10	10. Disabled persons shall be protected against all exploitation, all regulations and all treatment of a discriminatory, abusive or degrading nature.
Right to legal aid	Para. 11	11. Disabled persons shall be able to avail themselves of qualified legal aid when such aid proves indispensable for the protection of their persons and property. If judicial proceedings are instituted against them, the legal procedure applied shall take their physical and mental condition fully into account.

B. WORLD HEALTH ORGANISATION

The Guidelines for the Promotion of Human Rights of Persons with Mental Health Disorders (WHO/MNH/MND/95.4)

The instrument aims to depict basic legal principles for the field of mental health with as little influence as possible from given cultures or legal traditions. Embodiment of these principles into the legal body of a jurisdiction in a format, structure and language that suit local requirements is best handled on an ad hoc basis by state authorities.

Promotion of Mental Health and Prevention of Mental Disorders	Principle 1	Everyone should benefit from the best possible measures to promote their mental well-being and to prevent mental disorders.
Access to Basic Mental Health Care	Principle 2	Everyone in need should have access to basic mental health care.
Mental Health Assessments in Accordance with Internationally Accepted Principles	**Principle 3**	**Mental health assessments should be made in accordance with internationally accepted medical principles and instruments (e.g: WHO's ICD-10 Classification of Mental and Behavioural Disorders - Clinical Descriptions and Diagnostic Guidelines, Tenth Revision, 1992).**
Provision of the Least Restrictive Type of Mental Health Care	**Principle 4**	**Persons with mental health disorders should be provided with health care which is the least restrictive.**
Self-Determination	**Principle 5**	**Consent is required before any type of interference with a person can occur.**
Right to be Assisted in the Exercise of Self-Determination	Principle 6	In case a patient merely experiences difficulties in appreciating the implications of a decision, although not unable to decide, he/she shall benefit from the assistance of a knowledgeable third party of his or her choice.
Availability of Review Procedure	Principle 7	There should be a review procedure available for any decision made by official (judge) or surrogate (representative, e.g. guardian) decision-makers and by health care providers.
Automatic Periodical Review Mechanism	Principle 8	In the case of a decision affecting integrity (treatment) and/or liberty (hospitalization) with a long-lasting impact, there should be an automatic periodical review mechanism.
Qualified Decision-Maker	Principle 9	Decision-makers acting in official capacity (e.g. judge) or surrogate (consent-giving) capacity (e.g. relative, friend, guardian) shall be qualified to do so.
Respect of the Rule of Law	Principle 10	Decisions should be made in keeping with the body of law in force in the jurisdiction involved and not on another basis nor on an arbitrary basis.

C – JUDICIAL DECISION-MAKING[267]

Mental health law comprises two main areas: the circumstances in which detention and other forms of compulsion are justified and decision-making on behalf of people who in law lack the capacity to make their own decision(s).

The statutory criteria to be applied in both areas almost always confer considerable discretion on the judge or tribunal. This recognises the reality that personal welfare cases are personal (person-based) and fact sensitive. Consequently, the law variously requires the court or tribunal in very general terms to consider whether detention or compulsion is 'necessary' or 'appropriate' or 'justified' or what decision is in the relevant person's 'best interests'.

The qualities required of the judge

At its most prosaic, the judge needs to know the relevant law and procedure and to be a competent evaluator of evidence. This ensures that the decisions of the court are lawful and if that is the sole concern of the judiciary it suffices.

For anyone concerned with the quality of the decision-making — whether a citizen continues to be detained who could have been released, whether a citizen has been released without an adequate understanding of the dangers they pose to themselves or others, whether a decision made as being in a person's best interests adds to their woe rather than their happiness — a great deal more is required. Sympathy, empathy and compassion are important but other judicial qualities are also necessary and perhaps equally important. In particular, experience in the field, understanding and courage are key attributes.

Experience

It is unsatisfactory to seek to determine principles by reason only, without regard for human experience of the world within which principles are formulated and applied. Our value judgements are judgements about experienced objects.[268]

Unless it consists only of making the same mistakes over many years, experience of front-line practice is advantageous in any field but especially so in mental health law.

The purpose served by compassion is to alleviate suffering. Achieving this requires that a judge's interventions are efficient and effective.

We do not need to think about what we know. Relevant experience cuts down on thinking time and increases a judge's efficiency and effectiveness.

267 This part of the paper is taken from A Eldergill, Compassion and the Law: A Judicial Perspective, Elder Law Journal Vol. 5, No. 4, 11.2015.

268 J Dewey, The Quest for Certainty (Milton, Balch & Co, 1929), at p 265.

If the judge's knowledge and experience of the lives of people experiencing mental ill-health is based on reading, literally paper-thin, their decisions are less likely to be effective.

A judge who has experience of working *in situ* with people who are experiencing acute or chronic mental health problems will have dealt many times before with the vast majority of legal situations which they face. This enables them to calibrate the likely effect of their decisions on the lives of those affected by them. Unlike the judge whose experience of the experiences of others is limited to the bench, who usually never knows or sees first-hand the consequences of their final orders, the former will know from their experience of outcomes what is likely to be an effective response and what not, and which strategies tend to maximise or minimise the happiness of the person concerned.

Understanding

There are limits to our imaginative understanding. Therefore, personal interaction, listening and observation are important as catalysts to understanding and empathy. Provided that the person is not hard-hearted, spending time with people who are experiencing mental ill-health triggers a desire to understand their feelings, experiences, hopes and fears. From this a range of insights emerge in relation to life in psychiatric units, run-down housing, police stations and prisons, and the daily struggles of service users, their families and professionals. Containment on an acute psychiatric ward is a frightening, and in itself largely untherapeutic, experience at the best of times, the more so if the person is unfamiliar with the environment.

Part of this understanding is a practical awareness of the limits of legislation and judicial orders. The law provides a useful framework for managing conflict, conferring authority, enforcing legal duties and restraining the unlawful exercise of power. It cannot solve family conflict and resentment, that feeling of not being a loved or favoured child, a scarcity of resources, the disease process itself or the fact that the person concerned must soon die. It is a relatively ineffective means of modifying personal behaviour and attitudes —'he that complies against his will, Is of his own opinion still' — so that one can legislate for marriage but not for a happy marriage. Although it can provide a framework for managing violence associated with mental disorder, it cannot significantly reduce these risks. That this is so is clear following most psychiatric homicides and suicides. Had the professional carers foreseen what was about to happen, they had power under the law to intervene. That they did not intervene was due, not to any lack of legal powers, but to the fact that they did not foresee what was about to occur. Yet no amount of laws and orders can improve foresight.

What one can always do is no harm: there are many we cannot help but none we cannot avoid harming. This principle is as important to the practice of law as it is to the practice of medicine: The 'wicked are wicked, no doubt, and they go astray and they fall, and they come by their deserts; but who can tell the mischief which the very virtuous do?'[269]

Practical experience in the field also provides some understanding of the problems and natural limits of science, medicine and in particular psychiatry.

269 WM Thackeray, The Newcomes (Bradbury & Evans, 1855).

Many lawyers new to the area think of medicine as a science and tend to believe that words like disease and schizophrenia have established meanings which are universally accepted by medical practitioners. This is an idealized view and the tendency to regard both legal and medical terms as having value-free fixed meanings rather than as expressing concepts is misplaced. For example, ideas about what causes mental disorder depend on how normal mental health and, by elimination, mental disorder are defined. Classifications of mental disorders are unstable and the nosology of mental disorders (the study of their classification and relationship to one another) is split into rival schools. Although a single patient may acquire many different diagnoses over time, these are rarely explicable in terms of corresponding objective changes in their condition.

Underlying the question of nosology is that of ontology: the study of whether things actually exist in the real world or are merely products of our own ways of studying and classifying the world. The following passage is a good example of the essence of the problem:[270]

> *'Your pier-glass or extensive surface of polished steel made to be rubbed by a housemaid, will be minutely and multitudinously scratched in all directions; but place now against it a lighted candle as a centre of illumination, and lo ! the scratches will seem to arrange themselves in a fine series of concentric circles round that little sun. It is demonstrable that the scratches are going everywhere impartially, and it is only your candle which provides the flattering illusion of a concentric arrangement, its light falling with an exclusive optical selection. These things are a parable. The scratches are events, and the candle is the egoism of any person now absent …'*

Classifying certain paintings as abstract may, as with mental disorder, be based on a conception that their essential distinguishing feature is a lack of any order. If so, the objects may be placed in the class 'disordered' but attempting to minutely sub-divide these disordered objects in Linnean fashion may be contradictory and offend reality. Consequently, Allport's view of psychiatric classifications was that 'all typologies place boundaries where boundaries do not belong ... each theorist slices nature in any way he chooses and finds only his own cuttings worthy of admiration'.[271]

These practical problems arise from the fact that it is not illnesses per se which are being classified but people — litigants or parties in a judicial context — suffering from illness. Each patient has some attributes which they share with all patients, certain attributes which they share with some but not all patients, and yet other attributes unique to that individual. Because this is so, the same disorder or disease is likely to affect all people identically in certain respects, different classes of people distinguished by certain key attributes in ways common only to members of the class, and each person within a class in yet other ways peculiar to them. Variability 'is the law of life. As no faces are the same, so no two bodies are alike, and no two individuals react alike and behave alike under the abnormal conditions which we know as disease'.[272] The clinical picture is 'most often profoundly coloured and

270 G Eliot, Middlemarch (Penguin English Library, 1965) at p 297.

271 G Allport, Personality: A Psychological Interpretation (Henry Holt & Co, 1937), at pp 295-296.

272 Sir W Osler, Medical Education in Counsels and Ideals (Houghton Mifflin, 2nd ed., 1921.

sometimes decisively shaped by factors specific to the individual and his environment. Hence the notorious difficulty in identifying separate disease processes in psychiatry'.[273]

The lessons for the judge are to concentrate on this individual's circumstances and unhappiness, to listen to them in the hope of understanding what it is they need from us and before interfering to be mindful that we are all profoundly ignorant and will be revealed as such by future generations. Seek the truth but beware those who have found it.

Courage

It is the courage to acknowledge and then accept risks inherent to mental health practice which is the most important quality of all for judges, social workers and psychiatrists.

The weak practitioner or judge will choose the least 'risky' option, which they take to be the one least likely to result in harm to the person's physical safety. It makes *them* less anxious and is the least 'risky' if appealed. The judge will set a high bar on the level of understanding necessary for autonomous decision-making and fall back on false ideas such as that best interests is an objective test based on professional opinion.

Such an approach leaves little room for compassionately promoting the happiness of people who value their freedom because freedom comes at a price in terms of safety and safety bears a price in terms of freedom. It is not possible to have it both ways. If the individual has clear feelings and beliefs about the life they wish to lead, the compassionate option may be the one which allows them to lead that life, even for a short period, rather than the one freest of risks. A ship is safest in harbour but that is not what ships are for.

The purpose of compulsory powers, including 'best interests' interventions, is not to eliminate that element of risk in human life which is a consequence of being free to act and to make choices and decisions.

Nor, strange though it may sound, is their purpose to protect an individual from risks which arise when their understanding of substantial risks, or their capacity to control behaviour associated with such risks, is significantly impaired by mental disorder.

Compulsory powers are means not ends. The purpose of compulsory powers is to increase human happiness or to reduce human suffering.

Consequently, when decision-making for incapacitated people we are seeking the outcome which maximises the individual's happiness not, if different, the one which is safest.

All personal welfare decisions involve balancing competing risks of unhappiness of which the risk of physical harm is but one. Deprivation of liberty and compulsory treatment risk the loss of employment, family contact, self-esteem and dignity; unnecessary loss of liberty; institutionalisation; social isolation; and disabling adverse effects.

273 WA Lishman, Organic Psychiatry, The Psychological Consequences of Cerebral Disorder (Blackwell Scientific Publications, 2nd ed., 1987), at p 3.

While we must do our best to assess the risks to a person's physical safety in any decisions we make for them in truth it is difficult to impossible to predict outcomes:[274]

a. A risk can in theory be measured and is the basis of actuarial prediction — in theory because in practice all of the critical variables never are known. The risk depends on the situation but the situations in which the person may find themselves in the future can only be speculated upon.

b. Because future events can never be predicted, it is important to put in place an adequate system for supervising an incapacitated person whose own safety may potentially be at risk or who may pose a threat to the safety of others. However, this approach is not fail-safe: it is based on the assumption that most episodes of harm do not erupt like thunderstorms from clear skies. In reality, as with weather systems, only the pattern of events for the next 24 hours can usually be forecast with some accuracy; and contact with supervisors is less regular.

c. Even a very low risk from time to time becomes an actuality. However careful the assessment, it is inevitable that some individuals will later take their own lives, come to harm or commit a serious offence.

d. An outcome is often the result of a complex series of events and the choice of one particular causal factor may be arbitrary.

e. Small differences in one key variable can result in vastly different behaviours and outcomes: just as a sudden change in the physical state of water into steam or ice occurs with the rise or fall of temperature beyond a critical level so the addition of a small additional stress on an individual may have a profound effect on their mental state or behaviour.

f. All harm and violence takes place in the present and the past is a past, and so unreliable, guide to present and future events.

g. Understanding the situations in which a person has previously been harmed or been dangerous, and avoiding their repetition, can give a false sense of security about the future. Although life is understood backwards, it must be lived forwards, and the difference between explanation and prediction is significant: explanation relies on hindsight, prediction on foresight, and the prediction of future risk involves more than an explanation of the past.

h. Predictions are most often founded not on fact but on 'retrospective predictions' of what occurred in the past ('retrodiction').

274 A Eldergill, 'Is Anyone Safe? Civil Compulsion under the Draft Mental Health Bill', Journal of Mental Health Law, Dec 2002; A Eldergill, Mental Health Review Tribunals: Law and Procedure (Sweet and Maxwell, London, 1997).

A judge must have sufficient courage to accept that all decisions in mental health are risk-laden and not be paralysed by this or practise too defensively. The primary purpose of the personal welfare provisions of the Mental Capacity Bill was a desire to protect and increase the autonomy, happiness, dignity and independence of vulnerable people, not that the legislation should be used as a risk management tool.

Empathy, sympathy and compassion

Translating a compassionate desire to alleviate a person's suffering into effective compassion in the form of a remedy is difficult without some understanding of what is causing their suffering and what it is that makes them happy or fulfilled.

If the person understands the causes of their unhappiness and can communicate this it may simply be a case of listening to them so that little empathy is required.

If, however, they are confused, embarrassed, depressed, anxious, experiencing hallucinations, affected by delusional beliefs or have a severe learning disability then empathy is important.

While medicine benefits from a traditional scientific approach and the objective recording of a patient's symptoms and signs, these symptoms and signs are the external public manifestation of inner mental processes. Seeking out the underlying causes and associations, the private unobservable conflicts, requires empathy and without it there can be no understanding of the individual or the causes of their symptoms.

Because this is so the development and application of sympathy and intuitive understanding becomes a prerequisite for the *objective* observation of mental phenomena in others. Consequently, Jaspers wrote that 'natural science is indeed the groundwork of psychopathology and an essential element in it but the humanities are equally so and, with this, psychopathology does not become any less scientific but scientific in another way'.[275]

The same can be said of the law. The notion that judicial objectivity requires being dispassionate and that objective decision-making is contaminated by empathy, sympathy and compassion is impossible to support. A person's behaviour is determined by the way in which they perceive reality at any moment and not by reality as it can be described in physical objective terms. It is not in accordance with reason or logic for a judge not to value, or to dismiss or disregard, beliefs expressed by the relevant person which the judge believes are irrational or illogical.

In the first place, because mental illness is often the response of an individual to their life situation one must always ask the threefold question: 'Why did this person break down, in this way, at this time?' The person's beliefs and feelings offer the judge an insight into the underlying causes or triggers of their illness and distress, and an opportunity to ensure that the judge's order adequately responds to their situation and needs.

275 K Jaspers, General psychopathology (Manchester University Press, 1962).

Secondly, if their beliefs are unlikely to change one must seek to develop and hopefully agree a plan which can accommodate them. The case of ***Re P (capacity to tithe inheritance) (2014)***[276] involved a gentleman with a history of schizophrenia who wished to tithe 10% of his inheritance to the Church of the Latter Day Saints. The case is a typical example of this principle:

> 123. *The law has always sought to show due respect for liberty of conscience and religious belief and the European Convention on Human Rights reinforces this. Even if a person lacks capacity in law to make a religious gift, there remains the need to show respect for genuinely held beliefs and values. Good reasons are required to interfere in matters of conscience and spiritual belief. A person's religion is no less real to them because some of their beliefs may be coloured by illness and their conscience is no less offended when they are not permitted to practise their religion. In MS's case, both his conventional and unconventional religious beliefs are well-established and unlikely to change in time. This is not a situation where ambiguous beliefs are being reinforced or acted on precipitously, or it is likely that he will regret his tithe in the foreseeable future. His religion is now part of his life and is embedded in his existence. What he wishes is now his will. Even if his choice is founded on a belief that facts exist which do not, it is now his authentic voice and a true expression of his mind and the world within which he moves; and, like everyone, he needs to find peace.*

Thirdly, in some cases it may be upsetting or damaging to the individual to attempt to modify their beliefs if they are performing a protective function. A not uncommon example would be an increased risk of suicide.

Because proceedings involve a person's personal welfare, an objective 'rational' decision is one based on the subjective personal feelings of the relevant people: how they will feel if the judge chooses one alternative rather than another; the effect on their happiness, self-esteem and so on.

Only a patient may lack 'insight' if one artificially defines the word as referring only to the patient's awareness of the abnormality of their experiences and the fact that their symptoms are evidence of the presence of a mental illness which requires treatment. If one prefers the natural meaning of seeing within and understanding — understanding one's own mental processes or those of another, which is the meaning adopted by psychologists — then a doctor and a judge may also lack insight. The content of any judgment and any medical report consists of the contents of the patient's mind as elicited and interpreted by the contents of the judge's or doctor's mind. If the judge or doctor is uninterested in the patient's problems and the underlying causes, being interested only in obtaining enough information to sustain a judgment or diagnosis, such a narrow field of view necessarily leads to a narrow understanding of the overall situation.

276 Re P (capacity to tithe inheritance) [2014] EWCOP B14 (COP), [2014] All ER (D) 46 (Apr), (2014) 17 CCLR 229, [2014] WTLR 931.

If it is fundamental to the person's happiness to be at liberty then considerable weight must be given to this. The importance of individual liberty is of the same fundamental importance to incapacitated people who still have clear wishes and preferences about where and how they live as it is for those who remain able to make capacitous decisions. This desire to determine one's own interests is common to almost all human beings. Society is made up of individuals, and each individual wills certain ends for themselves and their loved ones, and not others, and has distinctive feelings, personal goals, traits, habits and experiences. Because this is so, most individuals wish to determine and develop their own interests and course in life, and their happiness often depends on this.

The enduring impression left after spending many years visiting psychiatric wards is not one of fear or dangerousness, but of suffering and an often disarming kindness on the part of those who have lost their liberty. Although compelled to submit to the will of others, and forced to accept medication which, if mentally beneficial, often produces severe physical discomfort, and may physically disable for life, most patients remain dignified and courteous, and retain the compassion to respond to the plight of others in a similarly unfortunate situation. Equally remarkable is their striving to be free members of society after many years outside society, even when many other higher faculties are profoundly impaired. A hospital is not a prison but for the individual concerned both involve detention and a complete loss of that right most important to them, so that Byron's words — 'Eternal spirit of the chainless Mind! / Brightest in dungeons, Liberty! thou art' — are often an apt description of the individual's predicament. This desire for autonomy, and many people cannot conceive of a life which is worthwhile and fulfilling without such self-determination, is not to be confused with any desire to abuse liberty, and so not to be caught up in contemporary controversies about how the law should respond to those who show a disregard for the law and for civic responsibility. While it is sometimes necessary to deprive an individual of their liberty on the ground of mental disorder, and one must have the courage to do that where necessary, one must always be appreciative of the enormity of the act — of the fact that the right enjoyed by those others present, and denied to this individual, is the most important right known to English law.

The critical error which a judge must avoid is an analysis of the person's best interests which disregards or downplays their wishes, feelings, values and beliefs in the perverted belief that objectivity is undermined by subjective considerations.

What we are seeking is objective analysis not objective outcomes. The law requires objective analysis of a subject not an object. The incapacitated person is the subject. Therefore, it is their welfare in the context of their wishes, feelings, beliefs and values that is important.

This is the principle of beneficence which asserts an obligation to help others further their important and legitimate interests, not one's own. Meaningful sustainable progress, as opposed to the mere management of symptoms, requires engaging with the person and their life and exploring how they can be assisted to live a life which they find fulfilling. This requires the judge to emotionally evaluate their evidence and to try to feel and understand what the case and possible outcomes mean for them. Empathy and compassion become instruments of justice and in this context a more intelligent justice.

One may hear lawyers say that such cases 'turns on the judge's values'.

Whatever the truth of that observation as a statement of reality it is misleading as a statement of law. The judge's role is to ascertain the values, beliefs wishes and feelings of the relevant individual and then to decide what is in their best interests having regard to their values, beliefs, wishes and feelings, not the judge's.

If the facts of two residence cases are identical except that one of the individuals places their health and safety first and the other their liberty, their different values may well mean it is in the best interests of one to live in a care home and the other in their own home.

The only value the judge needs is not to impose what they themselves value on the two individuals. The judge is their servant. As William Hazlitt once said, 'The love of liberty is the love of others. The love of power is the love of ourselves'.

D – PRINCIPLES OF MENTAL HEALTH LAWS

When legislating or working in this area, it is useful to bear the following principles in mind:[277]

1. It is unsatisfactory to seek to determine principles by reason only, without regard for human experience of the world within which principles are formulated and applied. Our value judgments are judgments about experienced objects.[278]

2. There are many reasons to limit state intervention in people's lives: errors in law spread their negative effects throughout the nation as opposed to individual errors that are limited in scope; the damage of erroneous laws affect citizens more than legislators, who are thus less inclined to repeal them; it takes longer to repair the damage done by legislation than the damage done by individuals by their own private choices; because of the constant watch of critics, politicians are less inclined to publicly admit error and undo the damage done; politicians are more inclined than citizens to make decisions based on political gain and prejudice, rather than principle.[279]

3. An effective democratic Constitution separates powers, the aim being to keep executive powers in check and under proper scrutiny, and so to secure good government. This is necessary because the 'whole art of government consists in the art of being honest',[280] and 'it is not by the consolidation, or concentration of powers, but by their distribution, that good government is effected.'[281]

4. Promoting liberty, protecting individuals from harm caused by those at liberty, and those not at liberty from abuse by those who are, alleviating suffering, and restoring to health those whose health has declined, are all legitimate objectives, in that they reflect values embraced by virtually all members of our society.[282]

5. We are, however, 'faced with choices between ends equally ultimate, and claims equally absolute, the realisation of some of which must inevitably involve the sacrifice of others.'[283] Whether individuals 'should be allowed certain liberties at all depends on the priority given by society to different values, and the crucial point is the criterion by which it is decided that a particular liberty should or should not be allowed, or that its exercise is in need of restraint.'[284]

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277 A Eldergill, Is Anyone Safe? Civil Compulsion under the Draft Mental Health Bill, 'Journal of Mental Health Law', January 2003; A Eldergill in Court of Protection Handbook, ed. A Ruck-Keene (LAG, London), 2014, pp76–79.

278 J Dewey, The Quest for Certainty (Milton, Balch & Co, 1929), at p 265.

279 Benjamin Constant: Political Writings (trans. and ed. B Fontana), Cambridge University Press 1988.

280 Thomas Jefferson: Rights of British America, 1774. The Writings of Thomas Jefferson, Memorial Edition (ed., Lipscomb & Bergh), Washington, DC, 1903-04.

281 Thomas Jefferson: Autobiography, 1821. The Writings of Thomas Jefferson, Memorial Edition (ed., Lipscomb & Bergh), Washington, DC, 1903-04, 1:122.

282 Eldergill, AC, Mental Health Review Tribunals — Law and Practice (Sweet & Maxwell, 1997), p.45.

283 Berlin, Sir I, Four Essays on Liberty (Oxford University Press, 1969), p.168.

284 Dias, RWM., Jurisprudence (Butterworths, 5th ed., 1985), p.109.

6. When enacting mental health legislation, the legislature has generally sought to erect a balanced legal structure that harmonises three things: individual liberty; bringing treatment to bear where treatment is necessary and can be beneficial; the protection of the public.[285] Those we describe as 'patients' are themselves members of the public, so that the law must seek to ensure that members of the public are not unnecessarily detained, and also that they are protected from those who must necessarily be detained.

7. The purpose of compulsory powers, including 'best interests' interventions, is not to eliminate that element of risk in human life which is a consequence of being free to act and to make choices and decisions. Nor, strange though it may sound, is their purpose to protect an individual from risks which arise when their understanding of substantial risks, or their capacity to control behaviour associated with such risks, is significantly impaired by mental disorder. That is its function but not its purpose: compulsory powers are means not ends. The purpose of compulsory powers is to increase human happiness or to reduce human suffering.

8. Consequently, when decision-making for incapacitated people we are seeking the outcome which maximises the individual's happiness not, if different, the one which is safest. All personal welfare decisions involve balancing competing risks of unhappiness of which the risk of physical harm is but one. Deprivation of liberty and compulsory treatment risk the loss of employment, family contact, self-esteem and dignity; unnecessary loss of liberty; institutionalisation; social isolation; and disabling adverse effects.

9. The use of compulsion has been permitted when significant harm is foreseeable if an individual remains at liberty. While we must do our best to assess the risks to a person's physical safety in any decisions we make for them in truth it is difficult to impossible to predict outcomes.

10. Other risks are, constitutionally, matters for citizens to weigh in their own minds. The purpose of compulsion is not to eliminate that element of risk in human life that is simply part of being free to act and to make choices and decisions. A person who obeys our laws is entitled to place a high premium on their liberty, even to value it more highly than their health. Subject to the stated limits, people are entitled to make what others regard as errors of judgement, and to behave in a manner which a doctor regards as not in their best interests, in the sense that it does not best promote health.

11. This desire to determine one's own interests is common to human beings, and so not to be portrayed as an abuse of liberty. On the one hand stands liberty, a right which the legislature and the law should always favour and guard, on the other licence, a wilful use of liberty to contravene the law, which the law must of necessity always punish.

285 Hansard, H.C. Vol. 605, col. 276.

12. Any power given to one person over another is capable of being abused. No legislative body should be deluded by the integrity of their own purposes, and conclude that unlimited powers will never be abused because they themselves are not disposed to abuse them.[286] Mankind soon learns to make interested uses of every right and power which they possess or may assume.[287]

13. This risk of abuse is multiplied if the individual is not free to escape abuse, is incapacitated or otherwise vulnerable, or their word is not given the same weight as that of others. Children and adults with mental health problems are particularly at risk and the law has usually afforded them special protection.

14. This protection involves imposing legal duties on those with power, conferring legal rights on those in their power, and independent scrutiny of how these powers and duties are exercised. The effectiveness of such schemes depends on whether, and to what extent, they are observed.

15. This is a matter of constitutional importance, for the observance of legal rights and the rule of law are the cornerstones of all liberal democracies. The rule of law 'implies the subordination of all authorities, legislative, executive [and] judicial … to certain principles which would generally be accepted as characteristic of law, such as the ideas of the fundamental principles of justice, moral principles, fairness and due process. It implies respect for the supreme value and dignity of the individual.'[288]

16. In any legal system, 'it implies limitations on legislative power, safeguards against abuse of executive power, adequate and equal opportunities of access to legal advice and assistance, … proper protection of the individual and group rights and liberties, and equality before the law … It means more than that the government maintains and enforces law and order, but that the government is, itself, subject to rules of law and cannot itself disregard the law or remake it to suit itself.'[289]

17. In framing these principles and laws, the legislature has sought to be just, justice being 'a firm and continuous desire to render to everyone that which is his due.'[290]

18. When new laws are necessary, they should impose minimum powers, duties and rights; provide mechanisms for enforcing duties and remedies for abuse of powers; be unambiguous, just, in plain language, and as short as possible.

19. Because there is a long record of experimentation in human conduct, cumulative verifications give these principles a well-earned prestige. Lightly to disregard them is the height of foolishness.[291]

286 Thomas Jefferson: Notes on Virginia Q.XIII, 1782. Memorial Edition (supra), 2:164.
287 Thomas Jefferson: Notes on Virginia Q.XIII, 1782. Memorial Edition (supra), 2:164.
288 David M Walker, The Oxford Companion to Law (Clarendon Press, Oxford, 1980), p.1093.
289 Ibid.
290 Justinian, Inst., 1, 1.
291 Dewey, J, Human Nature and Conduct (Allen & Unwin, 1922).

E – ABOUT THE AUTHOR

ANSELM ELDERGILL – RESUME – MAY 2019

PUBLIC SERVICE

Judge of the Court of Protection (mental health/incapacity court) from 2010 onwards

> *24 significant judgments reported in the All England Reports Digest, Community Care Law Reports, Court of Protection Law Reports, Wills and Trusts Law Reports, Mental Health Law Online and Bailii*

Member of the United Nations Expert Judicial Group on Capacity and Access to Justice, 2018.

Chairman of the Mental Health Tribunal Legislative Reform Working Group – Ministry of Justice & Department of Health Independent Review of the Mental Health Act, 2018.

Legal Aid Lawyer of the Year Special Award, 2019 (conferred on the President of the Family Division of the High Court the previous year):

> *"This is only the third time the LAPG Committee has chosen to make Special Awards, which celebrate campaigners and others who make an exceptional contribution to legal aid and access to justice. The previous recipients included Baroness Doreen Lawrence OBE, who was honoured in 2012.*
>
> *LAPG Special Awards are reserved for truly exceptional individuals who have achieved incredible things, often alongside of their day to day legal practice. Anselm was a mental health lawyer for 25 years, and is a true legend in this field. He now sits as a District Judge in the Court of Protection, and has been responsible for developing the law in relation to people with impaired capacity, in ways far beyond his formal status as a judge. He has made an incomparable contribution to the protection of those with mental illness. Through his 1997 book 'Mental Health Review Tribunals', he shared his expertise, and equipped many practitioners to represent the most vulnerable clients in a way that would not otherwise have been possible in what was a developing area of law. It explicitly recognised the Tribunal as a way of enforcing civil rights and had a transformative effect. Now that he is on the bench, Anselm has lost none of his approachability, and remains vigilant to ensure people can exercise their rights."*

Mental Health Act Commissioner, 1992-1998

Chairman of the Mental Health Act Commission Law & Ethics Committee

Head of Mental Health Act Commission Statutory Complaints Investigations

Chairman of the Review of National Statutory Complaints Investigations Procedures (Department of Health)

Member of the Mental Health Act Commission's Mentally Disordered Offenders' Committee and author of its papers on the reform of Part III of the Mental Health Act 1983

Legal adviser to Mental Health Commission in Dublin (training lawyers in the Republic of Ireland on their new mental health tribunal scheme)

Legal member of the Mental Health Commission for Northern Ireland in Belfast

Chairman of the MHCNI's Committee on Mental Health Law Reform

Advising Her Majesty's Prison Service on the procedures for discretionary lifers' hearings

Legal Chairman of ten Government Inquiries following the commission of homicides and numerous inquiries into suicides and serious incidents of abuse, including:

2008 – Inquiry into the Death of GB, CNWL, London. In print.

2006 – Chairman of the Independent Inquiry into the Care and Treatment of Alfred Garner and six other patients (Westminster). 4,000 pages of evidence. Report 137 pages + appendices.

2004 – Chairman of two independent inquiries following homicides (Birmingham). 12,000 pages of evidence. Report 173 + xii pages.

2002 – Chairman of the Confidential Review of the X Eating Disorders Unit (London). 2,600 pages of evidence. Report 94 pages.

2003 – Chairman of one independent inquiry following homicide (Kent). 14,000 pages of evidence. Report 283 + xvi pages (+ appendices).

2002 – Chairman of three independent inquiries following homicides (Hampshire). 13,000 pages of evidence. Report 173 + viii pages.

2000 – Chairman of two independent inquiries following homicides (Berkshire). 13,500 pages of evidence. Two reports: 73 + viii pages and 79 + vi pages.

Tribunal Judge, 2005-2011

Assistant Coroner, Essex

Member of two Department of Health Reviews of Mental Health Review Tribunal decision-making, pre-2000.

Legal aid practitioner in south London and Kentish Town working on behalf of people with mental health problems for 25 years.

ACADEMIA

Honorary Professor of Mental Capacity Law, University College, London (UCL is ranked 7th in the QS World University Rankings)

Lecturer and trainer, Academy of European Law (European Judicial College): Mental Health Law, Disability Law, Human Rights, Criminal law; Lecturer and trainer, Judicial College for England & Wales.

Visiting Professor of Mental Health Law, Northumbria University

Alexander Maxwell Law Scholarship (the leading UK law scholarship for barristers and solicitors)

David Hallett Prize for Government

Member of the editorial board of the *Journal of Mental Health Law*

Member of the editorial board of *Medicine, Science & the Law*

1400-page textbook on Mental Health Law (reprinted twice)

Extensive publications and conferences record, at home and abroad, for publications such as *The Princeton University Law Journal*, Johns Hopkins University, *The Journal of Forensic Psychiatry* and *The Guardian,* including:

Mental Health Review Tribunals — Law & Practice (Sweet & Maxwell, lxxvii, 1333 pages). Sold out and reprinted twice

Court of Protection Handbook (Co-author, LAG, London, 928pp, 2014,3rd ed. due 2018)

Mental Health Law (The Law Society, London, 2019)

The Patient's Voice (Ed. J Young-Mason, Davis & Co, Philadelphia, 2015)

Compassion and the Law: A Judicial Perspective (Elder Law Journal Vol. 5 No. 4, November 2015, pp 392-398). This article was delivered as a paper at a one-day international symposium on 'Law and Compassion', hosted by the Institute of Advanced Legal Studies in London and funded by the Socio-Legal Studies Association

Psychopathy, the law and individual rights, 'Princeton University Law Journal', Volume III, Issue 2, Spring 1999 (abstract published in The Guardian newspaper)

The Best is the Enemy of the Good: Part II, 'Journal of Mental Health Law', December 2008; The Best is the Enemy of the Good: Part I, 'Journal of Mental Health Law', May 2008

'The law and individual rights' in Personality Disorder and Serious Offending (ed. Newrith et al.), Hodder Arnold, Oxford, 2006

The Principles of Mental Health Legislation, 'Philosophy, Psychiatry and Psychology', Johns Hopkins University, 2005

Is Anyone Safe? Civil Compulsion under the Draft Mental Health Bill, 'Journal of Mental Health Law', December 2002.

The Legal Structure of Mental Health Services, 'Journal of Mental Health Law', September 2002

The Mental Health Act Commission, 'Journal of Forensic Psychiatry', March 2002

'Reforming Inquiries following Homicides', JMHL, October 1999

The legal logistics of independent inquiries: Common steps and principles for navigating through tragedy, British Journal of Health Care Management, May 1998

Social Exclusion and Mental Health, Mental Health Lawyers Association Occasional Paper, June 2004

Lecturer at numerous national and international conferences.

Recent conference presentations include lecturing at the European Judicial College in Trier (training EU judges on mental health and mental capacity law), delivering a lecture on mental capacity law to the Lord Chief Justice and other senior judges in Belfast, delivering the keynote address at the annual national 'Taking Stock conference in Manchester (the previous addresses being given by the President of the Family Division, Lady Hale and Lord Justice Baker) and at the Scottish Law Commission Mental Capacity conference in Glasgow; presentations on law reform with the Irish Minister and our Law Commission; a Chatham House conference on press reporting and the Court of Protection; invitational lectures in Dublin on Irish legislative proposals; and delivering a lecture at the Welsh national conference on mental capacity.

Numerous other national and international presentations at institutions such as the Sorbonne addressing subjects such as legislative reform, deprivation of liberty, mental incapacity, criminal law provisions and mentally disordered offenders, comparative mental health law; international law and mental health, homicide inquiries and untoward incident reviews and the European Convention on Human Rights and Mental Health.

DRAFTING

Undertook the government review of the Mental Health Act Commission and formulated proposals for its reform — Legislation Branch, Department of Health. Report 226 + xviii pages, 2001

Appointed by the Department of Health to draft the new departmental guidance and 'sectioning forms' in relation to the deprivation of liberty provisions in the Mental Capacity Act 2005

Appointed by the Department of Health to draft a Mental Health Act Forms Manual for use by the NHS and local social services authorities

Appointed by the Department of Health to draft the community treatment order 'sectioning forms' under the Mental Health Act 2007

Member of the Mental Health Review Tribunal Rules Committee

CRIMINAL LAW

Conduct of murder and manslaughter cases; Preparing over one thousand criminal cases, including rapes, armed robbery, etc; Extensive advocacy experience, including Crown Court bail applications; Attending police stations, identification parades, post-mortems, conferences, trials.

PUBLIC LAW

Judicial review; habeas corpus; chairing government inquiries; Coroner's Court proceedings.

CIVIL & FAMILY LAW

Tort (assault and battery, trespass to the person and to goods, police misconduct); care proceedings; divorce proceedings; Coroners' court proceedings; landlord and tenant (possession proceedings, disrepair, nuisance); contract and partnership law.

MEDIA WORK

This includes leading televised press conferences dealing with the publication of homicide and other reports; interviews for various television programmes on the law (BBC, Channel 4, Canadian TV); advising the BBC's Public Eye series; being interviewed for Law Society and LNTV law training videos; providing comments and articles for daily newspapers, including The Guardian, The Independent and The Times; representations and evidence to Parliament.

PRO BONO WORK

President of the Mental Health Lawyers Association, 2003-2010

President of the Institute of Mental Health Act Practitioners, 2005-2010

Honorary Legal Adviser to the African Regional Council for Mental Health, 2004-2010

Chairman, London NHS Ethics Committee

Chief Assessor, Interviewer and Member of the Law Society's Mental Health Panel

High volume free legal advice service for service users referred by MIND's Legal Department

Legal Adviser to the Tooting Advocacy Project

Inaugural member of the LINK mental health scheme

Founding a 24-hour London police station scheme in the 1980s for people with mental health problems

Writing mental health legal rights leaflets for MIND

Drafting the Law Society's pilot MHRT rights leaflet and application form

Member of Network for the Handicapped

PROFESSIONAL STANDING

Included each year in the Leaders' Profiles — Mental Health section of Chambers' & Partners' A Guide to the Legal Profession. Ranked 1:

> *'Anselm Eldergill is considered "authoritative" and has been recommended again as a leading authority on the Mental Health Act, particularly the detention, tribunal and criminal law provisions' (and in subsequent years)*

> *'The sage of mental health law, he is renowned for being "hugely clever" and "a highly respected academic and commentator" with "the best theoretical approach." A heavyweight practitioner who chairs and is involved in judicial inquiries nationwide.' 2001/02, Ranked 1: '*
>
> *"Academically brilliant," whilst able to "link up law and practice," he has chaired six NHS inquiries concerning mental health patients who have committed serious crimes. In addition to this, his "authoritative, thoughtful and reliable" textbook has … elicited praise for its "empathy for the plight of those suffering from mental health disorders.'*

Chambers Directory, 'Leaders in their Field', USA and Europe volumes

Entry in three volumes of Who's Who in America (USA)

Entry in the Dictionary of International Biography

No complaints to professional body and no claims on professional insurance during 25 years in practice

OTHER POSITIONS HELD

Head of Mental Health Law, Eversheds (one of the largest law firms in the world, with 40 offices across the UK, Europe, Middle East, Africa and Asia).