Convention-compliant approaches to the execution of judgements concerning involuntary detention and treatment on mental health ground

Legislative and policy development process: general guidelines*

Summary: ***1.*** *Scope of the work.* ***2****. The concept of deinstitutionalization.* ***3****. Empowerment of the individual according to Article 8 of the ECHR.* ***4****. Inner theoretical problems in the dual function of deprivation of liberty contemplated by Article 5 § 1(e).* ***5****. About physical restraints in psychiatric patients.* ***6.*** *Conclusions.*

1. Scope of the work

The aim of this analysis consists in emphasizing effective practices, successful policies and adequate normative measures capable of preventing and reducing involuntary detentions and obligatory treatments on mental health ground. For this purpose, two guidelines could be considered as patterns for implementing least restrictive option and developing a better legal environment, this way complying to the European Convention on Human Rights standards; over Europe, different constitutional paths and specific legal frames impose accurately selected solutions that must be coherent with an environment in which Human rights and Fundamental freedoms must be protected and promoted through formal legal safeguards, as well as substantial effective policies concerning mental health promotion.

* Dr. PHD. **Daniele Piccione**, *Qualified Professor in Constitutional Law, Senior Counsellor of the Italian Senate, Rome.*

Involuntary detentions are the consequence of social determinants; the very relevant sub-paragraph of Article 5 § 1 (e), of the European Convention on Human Rights indirectly identifies specific factors increasing the risk of privation or limitation of personal liberty. Among them weakness or inefficiency of public health systems to address coverage of general health, including mental health, is the first social determinant to deal with. This reveals the direct correlation between social protection on one hand and personal liberty on the other hand.

2. The concept of deinstitutionalization

The European Court of human rights has stated that "*there must be a relationship between the ground of permitted deprivation of liberty relied on and the place and conditions of detention*" ([1]).

There is, in fact, a definite link between the institutional frame in which deprivation of liberty is executed and the single cases of involuntary treatments on mental health ground.

Accordingly, United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) encourages national policies to walk on the path of deinstitutionalization; this is the first cornerstone to focus on. This said, the Court has held that deprivation of liberty is legally justified only where other, less severe, measures have been considered and found to be insufficient to safeguard the individual or the public interest which might require that the person concerned be detained.

This statement implies to recognize that the overall frame of mental health services on the ground constitutes a filter through which the individual might obtain a response to his mental health needs, so to prevent the deprivation of personal

([1]) See **X vs Finland,** no.34806/04, § 212, 3 July 2012.

liberty. When we speak of mental health supports, we are then facing one social determinant of personal liberty ([2]). This confirms the interdependence between social protection of mental health on one ground, and effective safeguard of personal liberty on the other ground ([3]). In fact, one of the traditional goals of deinstitutionalizing policies is to address and overcome issues in institutions still dealing with the following aspects ([4]):

a. obligatory sharing of assistants with others and no or limited influence as to who provides the assistance; **b.** isolation and segregation from independent life in the community; **c.** lack of control over day-to-day decisions; **d**. lack of choice for the individuals concerned over with whom they live; **e.** rigidity of routine irrespective of personal will and preferences; **f.** identical activities in the same place for a group of individuals under a certain authority; **g.** paternalistic approach in service provision; **h.** supervision of living arrangements; **i**. disproportionate number of persons with disabilities in the same environment.

Conversely, an efficient community - based network of settings constitutes a precious tool to create a diaphragm between mental health problems and deprivation of personal liberty. Nevertheless, the transition from institutionalizing settings to a community - based facilities network should be systematically approached to become effective([5]).

The absence or the removal of one or more of the institutional elements are not sufficient to characterize a setting as "community – based". In fact, there is no

([2]) For this theoretical approach, see **M. Marmot - R. Wilkinson**, *Social determinants of Health*, 2nd Edition, Oxford University Press.

([3]) See already **D. Piccione**, *Social Rights as Determinants of Freedom in the Constitutional State*, in *Materiali per una storia della cultura giuridica*, Fasc. no. 2/2021.

([4]) This list of factors is exposed in **Committee on the Rights of Persons with Disabilities,** *Guidelines on deinstitutionalization, including emergencies*, October 2022.

([5]) For a general overview, see Guidance on community mental health services: promoting person-centered and rights - based approaches. **Geneva: World Health Organization**, 2021.

prevention of limitations of personal liberty in settings where adults with a mental health condition continue to be subjected to substituted decision-making or to compulsory treatment, or where they have shared assistants; settings located "in the community" where service providers set a routine and deny autonomy; or "homes" where the same service provider packages housing and support together ([6]).

Deinstitutionalization should be interpretated as a wider concept under two different perspectives. First, every institution, including those run and controlled by non-State actors, should be included in deinstitutionalization reforms. Secondly, deinstitutionalizing policies tend to reduce the impact of all the Mental health settings where a person can be deprived of his liberty for each of all the following purposes: observation, care, treatment or preventive detention.

There is a double effect that should be considered when deinstitutionalization is intensively implemented as a political guideline in each State part; impact reduction of those institutions dedicated to deprivation of personal liberty is certainly relevant. The effect on informal and implicit limitation of personal liberty should also be considered, since loss of autonomy in daily life can often result in a factual limit to self - determination. Hence, States that are part of the Council of Europe should recognize that living independently and being included in the community refer to life settings outside residential institutions of all kinds, in accordance with article 19 of the UNCRDP. Such a conclusion constitutes evidence of the circular connection within deinstitutionalization as a political guideline on mental health, protection of personal liberty and full respect of the wishes of people capable of expressing their will ([7]).

Broadly speaking, the content of article 19 of the UNCRDP falls under a similar sphere of action respect to Article 8 of the Convention which protects a person's physical and psychological integrity and mental health as a determinant part of private

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([6]) See again **Committee on the Rights of Persons with Disabilities,** *Guidelines on deinstitutionalization, including emergencies*, cited above.

([7]) Such a cornerstone for measures taken without or against prior consultation of the person which should require strict and careful scrutiny, see **N. v. Romania**, no. 59152/08, § 146, 28 November 2017.

life. Furthermore, deinstitutionalizing approaches match with another relevant statement of the Court: establishments for persons “detained” on mental health ground are adequate only under two conditions: 1. the institution must ensure appropriate treatment of persons with mental disorder; 2. facilities, logistic conditions, general adequacy of the place where detention takes place should be measured in the perspective of reintegration into society ([8]).

3. Empowerment of the individual according to Article 8 of the ECHR

Often the Court’s case law has emphasized the feeling of inferiority as well as powerlessness which is typical of people suffering from a mental disorder. This circumstance calls for another pervading guideline which should be followed by State Parties that is to promote empowerment of people living the experience of mental disorder. Empowerment means something different from the general safeguard according to which any protective measure should reflect as far as possible the wishes of people capable of expressing their will. Empowering the individual through legislative measures aims to enlarge the effective capacity of vulnerable persons. This determines the reduction of space for paternalistic approaches in the relationship between the individual and the public authorities. Reduction of the area of people considered entirely incapable of deciding for themselves implies a parallel contraction of cases in which medical authorities are held responsible to decide, if necessary, by force. As a turning point, mental capacity and legal capacity should not be ‘conflated’, and impaired decision-making skills should never serve as a justification for suspension of legal capacity according to the reaffirmed principle of informed consent ([9]).

([8]) See **W.D. v. Belgium**, no. 73548/13, § 113, 6 September 2016.

([9]) **Committee on the Rights of Persons with Disabilities.** Eleventh session, 31 March–11 April 2014. General comment No. 1 (2014)**,** Article 12: equal recognition before the law.

Accordingly, the Court ruling seems to call for empowering processes as determinant on many grounds, such as: duration of involuntary hospitalization; shift from voluntary to involuntary permanence in some psychiatric facility; interpretation of effective consent and full exercise of legal capacity. Anyhow, empowerment can play a role only when considered as a concrete practice which can be implemented in the pathways of care, at the center of transformation processes ([10]).

Many issues are related since there is evidence that deprivation of individual legal capacity often continues to be justified when persons are examined in psychiatric hospitals instead of in community-based facilities. A cornerstone to link deinstitutionalization and empowerment is the development of a person-centered recovery plan (PTS) through which proportionate support is available, reflecting the needs of the individual ([11]). This strengthens the relation between the legal context and the individual, so to enlarge and foster social inclusion.

Therefore, Court's case law should also drive States to break the vicious circle linking involuntary placement in psychiatric hospitals and forcible examination to establish whether the person should be deprived of legal capacity. An appropriate treatment should always tend to the cooperation with the affected individual. Explicit legislative provisions on this ground could be found in the legal frame concerning obligatory treatments and that could be considered as a pattern for legislative development processes to follow.

([10]) See **R. Mezzina**, *Innovations in Mental Health Services Delivery: International Experiences and Trends*, World HNP series, in press.

([11]) *Comprehensive mental health service networks: promoting person-centered and rights-based approaches*. **Geneva: World Health Organization**; 2021 (Guidance and technical packages on community mental health services: promoting person-centered and rights-based approaches), p. 48.

4. Inner theoretical problems in the dual function of deprivation of liberty contemplated by Article 5 § 1(e)

A big issue about treatments of psychological disorders concerns the well-known dual function in deprivation of liberty contemplated by Article 5 § 1(e): on one hand deprivation acts protecting society (and the individual himself) from a danger, and on the other hand, the measure should ensure a therapeutic function related to the person. Certainly, the leading cases ([12]) for analyzing the relation between the two functions enlighten the floor to efficient strategies for policy makers on the ground of mental health. There is unmistakable evidence that institutions specifically dedicated to persons deprived of liberty constantly reveal that the purpose of protecting society becomes dominating and tends to erase the measures aimed at discharging the therapeutic function ([13]). To tackle such a tendency, legislators can count on some remedies: for instance, integration of so-called forensic care within general mental healthcare drives towards a rehabilitation model that helps and supports people with long-term mental health problems and a criminal history (or otherwise considered as "socially dangerous"), instead of determining their long-term containment for public protection.

Moreover, given that there are two common legal grounds for authorizing involuntary admission of people with mental disorders, "dangerousness/safety" criteria should be eliminated in favor of the "need for treatment" criteria, with no specific reference to classification of danger about risk levels or thresholds. Thus, the need for treatment, when connected to the right to health and healthcare, also reduces the space for legal coercion although it cannot prevent psychiatric abuse.

([12]) See **Rooman v Belgium**, [GC], no. 18052/11, § 190, 31 January 2019.

([13]) However, for a sharp statement on this matter, see **European Parliament**, REPORT on mental health (2023/2074(INI)) Committee on Environment, Public Health and Food Safety: "when conditions are treated in isolation the outcome is less successful".

5. About physical restraints in psychiatric patients

Finally, in psychiatric treatments, few words should be dedicated to the theme of physical restraints on patients. Court's case-law clearly affirms two principles: 1. physical restraints can be employed only as a matter of last resort; 2. furthermore, coercive measures should not be prolonged beyond the moment in which immediate or imminent harm to the patient or others will result.

Despite the sharp content of this ruling, national legislative policies about the employment of coercive measures remain somehow erratic. The non-regulation legislative option is based on the approach that physical restraints should be considered strictly forbidden, for they determine a total sacrifice of personal liberty.

The opposite paradigm consists in a legislative discipline limiting the employment of physical restraints.

None of the two options can solve the problem of an exaggerated and un-proportional employment of physical restraints. Nonetheless, there are few elements to recall. Coercive intervention in psychiatry, when legitimized by mental health legislation, tilts the cost-benefit balance for psychiatric patients in the wrong direction. Innovative policies and plans, changes in legislation and re-configuring mental health services in the perspective of deinstitutionalization are important, but it is likely that these initiatives could only generate a more positive ambient for reducing coercion.

In the long run, further steps in achieving reduction of coercion are linked to fundamental changes in clinical practice and culture of psychiatry.

5. Conclusions

Successful reduction in community-based coercion is rarely replicated in hospital settings. This factor emerges from observations of WHO analysis over the outcomes of mental health programs even in non-European countries. This allows to emphasize

the connection between deinstitutionalization policies and the spreading of no-restraint strategies on mental health ground.

Thus, the closure of large psychiatric hospitals and other similar institutions is still the principal mainstream task with the ostensible aim of restoring a condition of full rights for people with mental health problems who underwent long-term internment. Court's case law demonstrates how harsh is the struggle of safeguarding rights during long-term periods of deprivation of liberty in psychiatric institutions.

Secondly, articulation of the range of community-based services for mental health (including crisis response services, community mental health centers, hospital-based services, community outreach services, peer support services and supported living services) ([14]) should be developed according to Court's caselaw. For this purpose, maximum attention should go to recovery principles and full integration of mental health into general health services.

Thirdly, systemizing an evidence-based range of ways of minimizing involuntary care might enlarge the outcomes of political, legal and social action. This should imply combining emancipation of clinical professionals from institutional thinking and fostering good practices in mental health and social care. This combination vastly improves the prospects of a whole life and an effective protection of social inclusion for persons with mental disorders.

Finally, Court's caselaw pushes towards forging an amalgam or convergence of strategies: overcoming old and new asylums (i.e. against involuntary treatments and institutional placements), developing community-based services and advocating for citizen's rights by means of empowering people with mental health conditions.

([14]) See. **Geneva: World Health Organization**, Key direction no. III, for mental health policy, strategy and systems in *Guidance on community mental health services: promoting person-centered and rights-based approaches*, quoted above, p. 183.