Introduction and Broad Context

Peter Bartlett
Peter.bartlett@nottingham.ac.uk

[Paper for "Of Unsound Mind": Convention-compliant approaches to the execution of judgments concerning involuntary detention and treatment on mental health ground. Strasbourg, 27 March 2024, Agora building, room G03]

[Powerpoint slides for this presentation are also available. The ☸ symbol indicates where in the presentation the slides progress.]

☸

Introduction to the day –

- Thank you for joining us. Thank-you to the Liechtenstein Presidency of the Committee of Ministers and the Department for the Execution of Judgments of the European Court of Human Rights for their spearheading of this project. And as part of the organizing team, thank-you to the other speakers.

- First case in this area to the ECHR was *Winterwerp v the Netherlands,* decided in 1979. After a fairly slow start, there is now if not a flood, a strong current of cases, covering a fairly wide array of situations, legal structures, national jurisdictions, and ECHR articles. It became clear early on that we were not going to be able to cover all of this.

    - Focus today is on civil detention. Will cover an array of subject areas – esp. Art 3 (freedom from inhuman treatment or punishment), 5 (right to liberty), 8 (privacy and family life). We will also be discussing ways forward in policymaking at the level of member states relating to the issues raised – how we should be thinking about compulsion, and alternatives to institutionalization and compulsion.

    - That means we had to leave some things out. We could equally have had day-long conferences on issues of criminal detention, or on guardianship regimes and mental health in social services/social care homes. We do not want our current focus to detract from those issues (where some of the same issues arise as we will discuss today, but which also have complexities of their own) – but we already have a lot to cover for a one-day conference.

Context

The world has of course changed since the Council of Europe was established and the ECHR written, shortly after the second world war. The challenge we are all facing (in this field as in so

many others) is how to keep human rights standards under the ECHR relevant and appropriate in the twenty-first century, while acknowledging the text of the convention.

Today is a day about ensuring the enforcement and implementation of ECtHR judgments, but a look to the wider world also makes sense.

☸

Let us deal with the United Nations Convention on the Rights of Persons with Disabilities (CRPD) right off the top, because it will be in the minds of many of us, as it is the other major international legal framework affecting most of us.

> The CRPD (see https://www.ohchr.org/en/treaty-bodies/crpd) was passed by General Assembly in December 2006 and came into effect 2008. All (or virtually all?) CoE members have signed it; and the considerable bulk have ratified it. Whether it is directly enforceable in your jurisdiction will of course depend on your domestic law.
>
> The CRPD has been the cause of considerable debate and discussion. The eye-catching issues are based in its strong views of non-discrimination. In particular, CRPD Committee has been highly critical of the use of compulsion of people with mental health difficulties, when it would not be used for people without those conditions.
>
> Today, when the subject is implementation of ECHR judgments, is not the time to debate the detail of that. The question it is worth thinking about for a moment is whether we understand the CRPD as a marker of how attitudes have changed already, or a document to bring about future change. Like most human rights conventions, I think it is both. For today, I think we want to recognize that it is a clear marker (one among many!) that views of people with disabilities both in international law and in civil society have changed a great deal in the last decades. The days when people with disabilities could be routinely institutionalized, often for life, 'in their own interests', and kept out of sight and out of mind, are now meant to be well past: we are now to understand these people as real and active citizens, with the human rights that entails. That is a big shift since the time the ECHR was drafted.
>
> That is something we cannot ignore. While there are certainly fairly clear divisions between the conventions, I think for today it will be more productive to focus on their communalities; and I do think there is a good deal of potential common ground between the CRPD and both where the ECHR has moved, and where it may move in the future.
>
> As I said, there will be differences. We are not, I think, going to get the ECtHR to say that compulsory detention is always forbidden: to do that, the court need essentially to

delete the relevant words of art 5(1)(e), which allows detention of 'persons of unsound mind'.

As noted above, this is an area where caselaw is developing. It is dangerous of me to speculate here, but I do think we are seeing (and will continue to see) increasing insistence that decisions by local actors are made carefully, and the court breathing more nuanced meanings into terms already in the caselaw such as 'medically necessary', 'warranting detention' and 'in an appropriate place'.

I think it unlikely that the ECtHR will move away from doctors as key actors in the processes of human rights in this area (and will as such be in conflict with the CRPD, at least according to orthodox interpretations), but there is a good deal left to play for in asking what forms and standards of care doctors will be expected to comply with (I will get to that in a shortly). It is worth remembering that *Winterwerp* and similar cases arose in the context of the cold war and abuses of psychiatry in the former Soviet Union; the case law was therefore intended in part to ensure that psychiatry in the CoE did not go down that route. The Court might still, therefore, see the medical profession as a protector and promotor of human rights, when or if it has adopted appropriate human rights values. We will see where future cases brought before the court lead.

I would suggest that the relationship between the CRPD and the ECHR may be a good deal more complex and nuanced than some of the discussion of previous years would suggest. Both are living instruments; productive dialogue is likely to be the way forward. [I'll stop this line here – anyone who is interested in discussing this further, chat to me over lunch!]

☸

Council of Europe

I would note though that some of the strong interpretation of the CRPD has entered at least some parts of the Council of Europe conceptual universe – again a reminder that the world really is moving on in ways States Parties really cannot ignore.

Some of that was flagged in the introductory remarks to this conference by M Marc Cools and Mr Christos Giakoumopolos, who emphasized both the human and rule of law issues of concern to the Council of Europe in this aria.

PACE (Parliamentary Assembly of the CoE) Resolution 2291 (2019) further enjoins CoE member States to 'transition to the abolition of coercive practices in mental health settings', requiring positive programmes and definitive timetables to bring that about. That resolution passed 90-0. [26 June 2019] [https://pace.coe.int/en/files/28038]

The Committee on Human rights and Biomedicine is also very active here – again, significant movement in the last decades – Ms Lwoff will be speaking about that in a moment, and I will not steal her thunder.

A variety of regional and national projects have also looked at (or are currently looking at) legal and institutional reforms. The ones I am most familiar with are through the Cooperation in Police and Deprivation of Liberty (CPDL) Division. A lot of that has been focused on criminal legislation (insanity, prisoners with mental health problems, and fitness to plead, specifically forensic facilities) and conditions in criminal detention – but a lot has been a good deal broader than that. A number of countries have had projects through this division relating to reform of civil mental health law. [see their website, https://www.coe.int/en/web/cooperation-in-police-and-deprivation-of-liberty]

In the last week or so, the Council for Penological Co-operation has considered draft recommendation PC-CP (2023) 8 Rev 3 'Regarding the Promotion of Mental Health and the Management of Mental Disorders of Prisoners and Probationers' – not directly relevant for us today, since it falls in the criminal sphere, but a reminder that mental disability and human rights are very much live areas in the CoE more broadly, not just the ECtHR. And the direction of that document is to harmonise mental health services in a criminal context with those in a civil context – so there are obvious overlaps with what we are looking at today.

I have focused on the Council of Europe here because this is a Council of Europe event. The pressures are of course much more widespread than that, both internationally and in many of our individual countries.

The ground is shifting here – it is not just the ECtHR.

☸

Medical ethics

Codes of medical ethics have been developing and changing over time.

WPA [World Psychiatric Association] Code of Ethics is the most relevant international code of ethics in psychiatry. The original version was passed in Madrid in 1977, and it has been updated periodically since that time. 2020 was a more significant redraft, that reflects some of the ethical and perceptual changes we have been discussing.

Most recent version includes statements such as

> Psychiatrists recognize that optimal clinical care is rendered through collaboration among patients, carers, and clinicians, along with other team

members and they work to resolve differences and encourage cooperation among them. [principle 1(3)]

Psychiatrists advocate for patients' interests in the receipt of appropriate care and for respect of human rights, including reproductive rights. [principle 1(4)]

Principle 2 entitled 'Respect for Patients' autonomy'

The 2011 revision (the most recent before the 2020) included the word 'autonomy' only once, with reference to research subjects.

Does NOT go so far as to preclude compulsory treatment; DOES require an approach of least restrictive option, and 'its purpose [of compulsion] is ultimately to promote and re-establish patients' autonomy and welfare'

'Psychiatrists build relationships with patients that are based on mutual trust, acknowledging patients' role as partners in the process of diagnosis, treatment, and rehabilitation. [principle 2.1]

'Even when patients lack competence to make treatment decisions … psychiatrists nonetheless keep them appropriately informed about their treatment and convey respect for their views.' [principle 2.4]

Promotion of development of rehabilitative services [principle 4.5]

Consistent with this, the WPA has established a working group on 'Implementing alternatives to coercion', jointly with the WHO. This suggests that there is real interest among ethical psychiatrists in moving fairly hard away from compulsion in psychiatry.

Again, the limits of this are to be acknowledged: the WPA does not ban compulsion. This is not CRPD – but it does provide ways forward for ECHR. It suggests a world of positive care and affirming attitudes to people affected by mental disabilities, governed by respect and dignity, where services are to have real therapeutic meaning and where the wishes and feelings of people with mental health difficulties are acknowledged and given respect.

The obvious question is how these are to be enforced (and how far, in some cases, medical professionals really own these ethics). But it is fair to say that we as the public should expect ethical practice, and for governments and courts to ensure that this occurs. This often does not reflect the view of the people on the receiving end of psychiatric services. It is fair to say that I have visited institutions (and read in CPT and similar reports about many others) where these standards and approaches are simply not applied. In some jurisdictions, I suspect that the medical profession is perceived, rightly or wrongly, as a barrier to change (and, sometimes, used by governments as an

excuse not to change). Insofar as that is the case, it is fair that we remind them of their own ethical standards (and support them, as appropriate, to change their practices accordingly). They do NOT conflict – indeed, they largely reflect – standards of ECHR jurisprudence.

☸

Ways forward –

No doubt everyone today will be providing helpful advice for how implementation should happen. I have three points.

- There is huge goodwill internationally (by medics, lawyers, NGOs, and people with lived experience alike) about providing support for States Parties in this: we do all want to see good laws and proper services, well administered. Make use of that goodwill.

- DO include people with lived experience of mental distress in the process of developing new laws and new services. Many reasons for this –

    - It is standard good practice. It is required by the CRPD, and by codes of good practice and ethics.

    - They really will see things that the rest of us will miss

    - If the system is going to be a success, they need to be on side

  Consistent with that – we have included people with lived experience in each of the sessions today.

- WHO handbook – available at https://www.who.int/publications/i/item/9789240080737

    This is the best comprehensive guide to legislative reform I am aware of. It is written in a CRPD context, but that certainly does not detract from the quality.

  Also, looking forward to some of the other papers for today, the WHO has a different good text on development of community services in mental health - https://www.who.int/publications/i/item/9789240025707

☸

We can do this! And it really is time.