THE MENTAL HEALTH ACT 2001:
PATERNALISTIC OR RIGHTS-BASED?

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1. The Mental Health Act 2001 has been described as ‘paternalistic in intent’ by the Supreme Court,¹ and as ‘of a paternal character’ by the High Court.²

2. ‘Paternalism’ is defined in the Concise Oxford Dictionary as ‘... 2. (Of government, legislation, etc.) limiting the freedom of the subject by well-meant regulations’.

3. The purpose of this short paper is to question whether the Mental Health Act 2001 is properly understood as paternalistic in intent, particularly in light of modern, international human rights standards.

4. In Mental Health Law and Practice,³ Darius Whelan has carried out a detailed analysis of ‘paternalism’ and ‘the best interests principle’ by reference to Irish jurisprudence.⁴ This paper hopes to add, in a very small way, to that analysis by referring to the core rights enshrined in international human rights instruments, and in particular the right to autonomy.

5. International conventions and recommendations to which the State is a party are not binding in Irish law unless enacted by the Oireachtas into domestic law.⁵ However, in R.T. v. The Director of the Central Mental Hospital⁶ the President of the High Court, Mr Justice Costello, had regard to international conventions and recommendations in considering the constitutionality of the Mental Treatment Act 1945. He stated (underlining added):

The reasons why the Act of 1945 deprives persons suffering from mental disorder of their liberty are perfectly clear. It does so for a number of different and perhaps overlapping reasons — in order to provide for their care and treatment, for their own safety, and for the safety of others. Its object is essentially benign. But this objective does not justify any restriction designed to further it. On the contrary, the State's duty to protect the citizens rights becomes more exacting in the case of weak and vulnerable citizens, such as those suffering from mental disorder. So, it seems to me that the constitutional imperative to which I have referred requires the Oireachtas to be particularly astute when depriving persons suffering from mental disorder of their liberty and that it should ensure that such legislation should contain adequate safeguards against abuse and error in the interests of those whose welfare the legislation is designed to support. And in considering such safeguards regard

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¹ E.H. v. Clinical Director of St. Vincent’s Hospital, Supreme Court, 28th May, 2009.
³ Thomson Reuters, 2009.
⁴ See pages 21-30.
⁵ See, for example, Kavanagh v. Governor of Mountjoy Prison [2002] 3 IR 97
should be had to the standards set by the Recommendations and Conventions of International Organisations of which this country is a member.\textsuperscript{7}

6. This paper focuses on the following conventions and recommendations to which Ireland is a party:

(i) the UN Convention on the Rights of Persons with Disabilities, which Ireland signed on 30\textsuperscript{th} March, 2007, and intends to ratify;
(ii) the Council of Europe’s Committee of Ministers’ Recommendation Rec (2004) 10 concerning the protection of human rights and dignity of persons with mental disorder;
(iii) the United Nations General Assembly’s Resolution 46/119 on the Protection of Persons with Mental Illness and the Improvement of Mental Health Care;


7. One of the fundamental rights which is recognised in international human rights law is the patient’s right to autonomy. The exercise of this right can raise difficult issues of capacity and the right to legal representation, so a short section is also included outlining the European Court of Human Rights’ view of the procedural safeguards that should apply in determining capacity, and reference is made to a decision of the Supreme Court of Montana in respect of the role of the legal advocate.

**Section 4 of the Mental Health Act 2001**

8. As the Mental Health Bill 2001 was passing through the Oireachtas, the Minister for State at the Department of Health and Children, Mary Hanafin, stated:

“\textit{At the core of the Bill is the need to address the civil and human rights of persons receiving care and treatment in our psychiatric services.}”\textsuperscript{8}

9. The importance of the patient’s fundamental rights is underlined by section 4 of the Mental Health Act 2001, which provides:

\begin{flushleft}(1) In making a decision under this Act concerning the care or treatment of a person (including a decision to make an admission order in relation to a person), the best interests of the person shall be the principal consideration with due regard being given to the interests of other persons who may be at risk of serious harm if the decision is not made.
(2) Where it is proposed to make a recommendation or an admission order in respect of a person, or to administer treatment to a person, under this Act, the person shall, so far as is reasonably practicable, be notified of the proposal and be entitled to make representations in relation to it and before deciding
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\textsuperscript{7} At page 79.
\textsuperscript{8} 166 Seanad Debates Col. 1440.
the matter due consideration shall be given to any representations duly made under this subsection.

(3) In making a decision under this Act concerning the care or treatment of a person (including a decision to make an admission order in relation to a person) due regard shall be given to the need to respect the right of the person to dignity, bodily integrity, privacy and autonomy.

10. Thus, section 4 requires that a person is consulted and listened to in respect of proposed treatment and admission; that due regard must be had to a person’s ‘dignity’, ‘bodily integrity’, ‘privacy’ and ‘autonomy; and that a patient’s ‘best interests’ must be the ‘principal consideration’ where decisions are made in respect of treatment or admission. These requirements are consistent with international standards on patients’ rights.

E.H. v. Clinical Director of St. Vincent’s Hospital,9 and M.R. v. Cathy Byrne10

11. In E.H. v. Clinical Director of St. Vincent’s Hospital, Kearns J (as he then was), speaking for a unanimous five-judge Supreme Court, stated:

Any interpretation of the term in the Act must be informed by the overall scheme and paternalistic intent of the legislation as exemplified in particular by the provisions of sections 4 and 29 of the Act. Such an approach to interpretation in this context was approved by this Court in the course of a judgment delivered by McGuinness J. in Gooden v. St. Otteran’s Hospital [2005] 3 I.R. 617 when, in relation to s. 194 of the Mental Treatment Act 1945 she emphasised that a purposive construction of the section was appropriate, stating at pp. 633 to 634:-

“In interpreting s. 194, therefore, it would in my view be right to consider the purpose of the Act of 1945 as a whole.... At first reading the wording of s. 194 appears clear and unambiguous. If, however, it is interpreted literally as providing an absolute right to physical release from the hospital and as preventing any use of the machinery of s. 184 or the making of a reception order while the patient is still in the hospital, the logical result is that the only person for whom a reception order cannot in any circumstances be made is a voluntary patient who has given notice of discharge. During the 72 hour period of notice he is inviolate and at the end of it he must be physically released. This situation would apply even if the patient in question was so mentally ill as to be a danger either to himself or the public. That this is the effect of a literal interpretation of s. 194 is candidly admitted by counsel for the applicant.”

I pause only to state that at least in that case, unlike the present one, counsel appears to have been willing to consider the impact and likely effect on the patient of an order made directing release. McGuinness J. then continued:-

“In In re Philip Clarke [1950] I.R. 235 the former Supreme Court considered the constitutionality of s. 165 of the Act of 1945. O’Byrne J.

9 Supreme Court, 28th May, 2009.
10 [2007] 3 IR 211.
who delivered the judgment of the court, described the general aim of the Act of 1945 at pp. 247 to 248 thus:

"The impugned legislation is of a paternal character, clearly intended for the care and custody of persons suspected to be suffering from mental infirmity and for the safety and well-being of the public generally. The existence of mental infirmity is too widespread to be overlooked, and was, no doubt, present to the minds of the draftsmen when it was proclaimed in Article 40.1 of the Constitution that, though all citizens, as human beings are to be held equal before the law, the State, may, nevertheless, in its enactments, have due regard to differences of capacity, physical and moral, and of social function. We do not see how the common good would be promoted or the dignity and freedom of the individual assured by allowing persons, alleged to be suffering from such infirmity, to remain at large to the possible danger of themselves and others."

This passage has been generally accepted as expressing the nature and purpose of the Act of 1945. The Act provides for the detention of persons who are mentally ill, both for their own sake and for the sake of the common good."

I do not see why any different approach should be adopted in relation to the Mental Health Act, 2001, nor, having regard to the Convention, do I believe that any different approach is mandated or required by Article 5 of the European Convention of Human Rights.

12. In *M.R. v. Cathy Byrne*,¹¹ the High Court (Ó Néill J) stated:

[17] Before embarking upon a consideration of the issues which have arisen in this case it is well to establish in general the correct approach when dealing with legislation of the kind involved here. It has been said and indeed it is common case that in approaching the construction of the Act, the purposive approach is to be adopted, and the following passage from the judgment of McGuinness J. in *Gooden v. St. Otteran's Hospital* (2001) [2005] 3 I.R. 617 where she is speaking of the Mental Treatment Act 1945 and says the following, at p. 633, illustrates the point:—

"I respectfully accept Denham J.’s analysis of the principles of interpretation as set out in that judgment. In interpreting s. 194, therefore, it would in my view be right to consider the purpose of the Act of 1945 as a whole. It is a wide ranging statute, dealing with all aspects of provision of treatment for those suffering from mental illness, ranging from the building of mental hospitals to details of their administration and staffing and to the reception and care of patients. It is divided into distinct but related parts. Section 194 occurs in that part of the Act which deals with voluntary patients in mental hospitals. It cannot, however, be read entirely in isolation from those parts of the Act which deal with patients who had been committed to mental hospitals as a result of reception orders. Still less should it be read in

¹¹[2007] 3 IR 211.
isolation from the surrounding sections in the same part, and in particular s. 195.”

[18] The same approach is in my view entirely appropriate in respect of the interpretation of the Act of 2001, which repealed the whole of the Mental Treatment Act 1945, other than Part VIII and ss. 241, 276, 283 and 284. In addition the Act of 2001 also repealed the whole of the Mental Treatment Act 1953, the whole of the Mental Treatment (Detention in Approved Institutions) Act 1961 and the whole of the Mental Treatment Act 1961 other than ss. 39 and 41. As is apparent from the preamble to the Act, the Act is a piece of legislation which comprehensively deals with the involuntary admission of persons suffering from mental disorders to approved centres and establishes the Mental Health Commission and Mental Health Tribunals and an Inspector of Mental Health Services for the purposes of the independent review of the involuntary admission of persons to approved centres.

[19] In re Philip Clarke [1950] I.R. 235 the former Supreme Court, when considering the constitutionality of s. 165 of the Mental Treatment Act 1945, in the judgment of O’Byrne J. delivering the judgment of the court, described the general aim of the Act of 1945 as follows, at pp. 247 and 248:-

“The impugned legislation is of a paternal character, clearly intended for the care and custody of persons suspected to be suffering from mental infirmity and for the safety and well-being of the public generally. The existence of mental infirmity is too widespread to be overlooked, and was, no doubt, present to the minds of the draughtsmen when it was proclaimed in Art. 40.1, of the Constitution that, though all citizens, as human beings are to be held equal before the law, the State may, nevertheless, in its enactments, have due regard to differences of capacity, physical and moral, and of social function. We do not see how the common good would be promoted or the dignity and freedom of the individual assured by allowing persons, alleged to be suffering from such infirmity, to remain at large to the possible danger of themselves and others. The section is carefully drafted so as to ensure that the person, alleged to be of unsound mind, shall be brought before, and examined by, responsible medical officers with the least possible delay. This seems to us to satisfy every reasonable requirement, and we have not been satisfied, and do not consider that the Constitution requires, that there should be a judicial inquiry or determination before such a person can be placed and detained in a mental hospital. The section cannot, in our opinion, be construed as an attack upon the personal rights of the citizen. On the contrary it seems to us to be designed for the protection of the citizen and for the promotion of the common good.”

[20] In my opinion having regard to the nature and purpose of the Act of 2001 as expressed in its preamble and indeed throughout its provisions, it is appropriate that it is regarded in the same way as the Mental Treatment Act 1945, as of a paternal character, clearly intended for the care and custody of persons suffering from mental disorder.

And at p224:
Before going on to deal with the facts of this case it is appropriate to draw attention to s. 4 of the Act of 2001 which in my opinion gives statutory expression to the kind of paternalistic approach mandated in In re Philip Clarke [1950] I.R. 235 and approved in Croke v. Smith (No. 2) [1998] 1 I.R. 101 and also, as mentioned earlier, in Gooden v. St. Otteran's Hospital (2001) [2005] 3 I.R. 617.

13. The Supreme Court’s view that the 2001 Act is ‘paternalistic in intent’ derives from sections 4 and 29 of the Act and previous judicial attitudes to the Mental Treatment Act 1945. The High Court also relied on section 4 and previous judicial opinion on the Mental Treatment Act 1945 in holding that the 2001 Act was paternalistic.

14. With respect to the judgments above, it is not clear why section 4 should be regarded as paternal in nature. It focuses on the patient’s fundamental rights and requires that these be respected in any decision concerning admission or treatment. As for section 29 of the 2001 Act, it provides:

Nothing in this Act shall be construed as preventing a person from being admitted voluntarily to an approved centre for treatment without any application, recommendation or admission order rendering him or her liable to be detained under this Act, or from remaining in an approved centre after he or she has ceased to be so liable to be detained.

The Act’s recognition of a person’s right to admit himself or herself to hospital voluntarily, and its protection of this right ahead of involuntary admission, is consistent with human rights principles such as the rights to autonomy, to equal treatment before the law, to respect for one’s dignity and private life, and to protection from unjustifiable discrimination, and it is not clear why the Supreme Court regarded it as paternalistic.

15. The reliance in E.H. and M.R. on the judgments in Gooden and In re Philip Clarke is surprising where the latter two judgments related to the Mental Treatment Act 1945 and not to the Mental Health Act 2001. The 1945 Act may have been paternalistic but it was the subject of much criticism in recent years, judicial as well as extra-judicial, as out of date and inadequate for the supervision of mental health care. The 2001 Act was passed in order to bring our mental health legislation in line with the requirements of the European Convention on Human Rights. There seems no reason to regard the 2001 Act as akin to the 1945 Act.
International human rights standards

16. As stated above, the conventions and recommendations referred to below are not binding in Irish law. But they do help set the context within which the Mental Health Act 2001, and in particular section 4, may be understood and applied.

The UN Convention on the Rights of Persons with Disabilities

17. The UN Convention on the Rights of Persons with Disabilities was signed by Ireland on 30th March, 2007, and although not yet ratified, it is understood to be the State’s intention that it ratify it. The Convention came into effect on 3rd May, 2008, following ratification by ten States.

18. At its core are the principles of respect for dignity and autonomy and for the freedom to make one’s own choices, and the principles of equal treatment and of non-discrimination.

19. Among the recitals in the Preamble are the following:

(c) Reaffirming the universality, indivisibility, interdependence and interrelatedness of all human rights and fundamental freedoms and the need for persons with disabilities to be guaranteed their full enjoyment without discrimination,

(e) Recognizing that disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others,

(h) Recognizing also that discrimination against any person on the basis of disability is a violation of the inherent dignity and worth of the human person,

(m) Recognizing the valued existing and potential contributions made by persons with disabilities to the overall well-being and diversity of their communities, and that the promotion of the full enjoyment by persons with disabilities of their human rights and fundamental freedoms and of full participation by persons with disabilities will result in their enhanced sense of belonging and in significant advances in the human, social and economic development of society and the eradication of poverty,

(n) Recognizing the importance for persons with disabilities of their individual autonomy and independence, including the freedom to make their own choices,

(o) Considering that persons with disabilities should have the opportunity to be actively involved in decision-making processes about policies and programmes, including those directly concerning them
20. The core human rights principles of dignity, autonomy, equality and independence are set out in Article 3 which has been described as ‘the moral compass of the Convention’. It states:

The principles of the present Convention shall be:
(a) Respect for inherent dignity, individual autonomy including the freedom to make one’s own choices, and independence of persons;
(b) Non-discrimination;
(c) Full and effective participation and inclusion in society;
(d) Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;
(e) Equality of opportunity;
(f) Accessibility;
(g) Equality between men and women;
(h) Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

21. Article 4 sets out the ‘General obligations’ of contracting States and includes the following:

1. States Parties undertake to ensure and promote the full realization of all human rights and fundamental freedoms for all persons with disabilities without discrimination of any kind on the basis of disability. To this end, States Parties undertake:
   (a) To adopt all appropriate legislative, administrative and other measures for the implementation of the rights recognized in the present Convention;
   (b) To take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices that constitute discrimination against persons with disabilities;
   (c) To take into account the protection and promotion of the human rights of persons with disabilities in all policies and programmes;
   (d) To refrain from engaging in any act or practice that is inconsistent with the present Convention and to ensure that public authorities and institutions act in conformity with the present Convention;
   (e) To take all appropriate measures to eliminate discrimination on the basis of disability by any person, organization or private enterprise ...  

22. Article 5 guarantees equality and non-discrimination:

1. States Parties recognize that all persons are equal before and under the law and are entitled without any discrimination to the equal protection and equal benefit of the law.
2. States Parties shall prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds.

3. In order to promote equality and eliminate discrimination, States Parties shall take all appropriate steps to ensure that reasonable accommodation is provided.

4. Specific measures which are necessary to accelerate or achieve de facto equality of persons with disabilities shall not be considered discrimination under the terms of the present Convention.

23. Article 12 is headed ‘Equal recognition before the law’ and provides:

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.
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.

24. Of Article 12, one academic has commented:

The standard laid down in Article 12 contrasts with civil systems that use a medical model where all rights and powers affecting lives are removed based on a general assessment of capacity. Guardianship that is overly broad, and other substitute decision-making mechanisms, form part of the traditional armoury for dealing with incapacity and have negative connotations of over-intrusiveness and paternalism. There have been calls for supported rather than substituted decision-making from many quarters. One commentator, referring to substitute decision-making as ‘the stranglehold of the past’ states that the substitution of judgements by others is not prohibited by Article 12 but ‘... that an inclusive and universal concept of legal capacity is essential if the prejudice against persons with disability is to be “disassembled”.’ There must be an assessment of continuing legal capacity even where there is a substitute
decision-maker for all decisions and actions. A system of advocacy is essential to enable this new capacity formulation to be effective.13

25. Equal treatment and the recognition that persons with a mental disability have enforceable rights in law including the right to respect for their dignity and autonomy are surely the principles that underpin the Mental Health Act 2001. If so, the Act represents a shift from the older concept of ‘paternalism’ towards autonomy and the recognition and protection of patients’ rights including the right to have their liberty restricted as little as possible. This shift reflects modern international human rights principles.

A diversion: capacity and the role of the advocate

Capacity

26. Article 12 of the Convention on the Rights of Persons with Disabilities recognises the rights of disabled persons to equality before the law and to support, if required, in exercising their legal capacity. The issue of capacity is, of course, extremely important. It is not uncommon for treating doctors to approach a legal challenge to their conduct brought on behalf of a patient by stating that the patient does not have capacity to either instruct a lawyer or to play a role in the decision that is the subject of legal challenge. Where such an assertion is made, there should be proper procedural safeguards in place to determine the issue of capacity and, if a person is held to lack capacity, to assist that person by way of assisted or substituted decision-making.

27. In Mental Disability and the European Convention on Human Rights,14 the authors state:

_The presence of a mental disability must be distinguished from the determination of the mental capacity of an individual. The former is determined by a medical assessment; the latter is a question of an individual’s ability to make a particular decision. Frequently, people with even quite severe mental health problems or intellectual disabilities may nonetheless have capacity to make decisions. The most detailed study on this question compared people admitted to psychiatric institutions to people living in the community and to those hospitalised for a cardiac disorder. The study tested understanding of information relevant to treatment decisions, appreciation of that information, and reasoning ability. It showed that about half of people diagnosed with schizophrenia, and approximately three-quarters of people diagnosed with depression, showed no impairment on any of these tests [fn – T.Grisso and P. Appelbaum, ‘The MacArthur Treatment Competence Study III: Ability of Patients to Consent to Psychiatric and Medical Treatments’, 19(2) Law and Human Behaviour 149 at 169]. It is simply wrong to assume that people with mental disorder are necessarily unable to make decisions: most can._

Further, it cannot be assumed that because an individual lacks capacity for some decisions that he or she lacks capacity for all. From a human rights perspective, the issue is whether the individual sufficiently understands and appreciates the information relevant to the specific decisions to be made. If so, he or she has capacity to make the decision.15

28. The European Court of Human Rights has held that a determination of capacity falls within the ‘fair trial rights guarantee’ provided by Article 6 of the European Convention on Human Rights. In the case of Matter v. Slovakia,16, the European Court of Human Rights stated:

The purpose of the proceedings is to determine whether or not legal capacity can be restored to the applicant, i.e. whether or not he is entitled, through his own acts, to acquire rights and undertake obligations set out, inter alia, in the Civil Code. Their outcome is therefore directly decisive for the determination of the applicant’s “civil rights and obligations”. Accordingly, Article 6.1 is applicable.17

29. In the seminal case of Winterwerp v. the Netherlands,18, where the applicant was detained on the grounds of his mental health and challenged the legality of this detention and the consequent effect that he was held to lack the capacity to administer his property, the Court stated:

73. The Government doubt whether Article 6 para. 1 (art. 6-1) is applicable to the facts of the case. They incline to the view that what is in issue is a question of status rather than a civil rights and obligations as such. The Court does not share this opinion. The capacity to deal personally with one’s property involves the exercise of private rights and hence affects "civil rights and obligations" within the meaning of Article 6 para. 1 (art. 6-1) (see the König judgment of 28 June 1978, Series A no. 27, p. 32, para. 95). Divesting Mr. Winterwerp of that capacity amounted to a "determination" of such rights and obligations.

74. The applicant lost the capacity to administer his property on his confinement in a psychiatric hospital (see paragraph 32 above). Clearly, in relation to the initial "emergency" detention directed by the burgomaster (see paragraphs 12 and 23 above), there had been no court hearing in compliance with Article 6 para. 1 (art. 6-1) of the Convention. The subsequent periods of confinement were, it is true, authorised at regular intervals by the Amersfoort District Court and the Utrecht and ‘s-Hertogenbosch Regional Courts. However, the present judgment has already drawn attention to certain aspects of the procedure followed on these occasions and, notably, to the fact that neither in law nor in practice was Mr. Winterwerp afforded the opportunity of being heard, either in person or through a representative (see paragraph 61 above). What is more, that procedure was concerned solely with his deprivation of liberty. Consequently,

15 At page 4.
17 At paragraph 51.
18 24th October, 1979, Application No. 6301/73.
it cannot be taken as having incorporated a "fair hearing", within the meaning of Article 6 para. 1 (art. 6-1), on the question of his civil capacity.

75. By way of general argument, the Government contend that there was no breach of Article 6 para. 1 (art. 6-1) since the provisions of the Mentally Ill Persons Act safeguard the civil rights of the detained person of unsound mind who, by the very reason of his proven mental condition, needs to be protected against his own inability to manage his affairs.

The Court does not agree with this line of reasoning. Whatever the justification for depriving a person of unsound mind of the capacity to administer his property, the guarantees laid down in Article 6 para. 1 (art. 6-1) must nevertheless be respected. While, as has been indicated above in connection with Article 5 para. 4 (art. 5-4) (see paragraphs 60 and 63), mental illness may render legitimate certain limitations upon the exercise of the "right to a court", it cannot warrant the total absence of that right as embodied in Article 6 para. 1 (art. 6-1) (see the above-mentioned Golder judgment, pp. 18 and 19, paras. 36, 38 and 39).

76. There has accordingly been a breach of Article 6 para. 1 (art. 6-1).

30. In Shitukaturov v. Russia, a district court had decided on the applicant’s incapacity without hearing or seeing the applicant, or obtaining any submissions from him. The court based its decision on a written medical report by a forensic psychiatrist, which the applicant had not seen and had had no opportunity to challenge. The application for a declaration of incapacity had been brought by the applicant’s mother. She was not questioned by the court, and the prosecutor who participated in the hearing supported her application without having seen the applicant prior to the hearing. The European Court of Human Rights held that the process violated Article 6 of the Convention. It stated:

1. General principles

66. In most of the previous cases before the Court involving “persons of unsound mind”, the domestic proceedings concerned their detention and were thus examined under Article 5 of the Convention. However, the Court has consistently held that the “procedural” guarantees under Article 5 §§ 1 and 4 are broadly similar to those under Article 6 § 1 of the Convention (see, for instance, Winterwerp, cited above, § 60; Sanchez-Reiss v. Switzerland, judgment of 21 October 1986, Series A no. 107; Kampanis v. Greece, 13 July 1995, Series A no. 318-B; and Ilijkov v. Bulgaria, no. 33977/96, § 103, 26 July 2001). Therefore, in deciding whether the incapacitation proceedings in the present case were “fair”, the Court will have regard, mutatis mutandis, to its case-law under Article 5 § 1 (e) and Article 5 § 4 of the Convention.

67. The Court recalls that in deciding whether an individual should be detained as a “person of unsound mind”, the national authorities are to be recognised as having a certain margin of appreciation. It is in the first place for the national authorities to evaluate the evidence adduced before them in a particular case; the Court’s task is to review under the Convention the decisions of those authorities (see Luberti v. Italy, judgment of 23 February 1984, Series A no. 75, § 27).

19 27th June, 2008, Application No. 44009/05.
68. In the context of Article 6 § 1 of the Convention, the Court assumes that in cases involving a mentally ill person the domestic courts should also enjoy a certain margin of appreciation. Thus, for example, they can make the relevant procedural arrangements in order to secure the good administration of justice, protection of the health of the person concerned, etc. However, such measures should not affect the very essence of the applicant's right to a fair trial as guaranteed by Article 6 of the Convention. In assessing whether or not a particular measure, such as exclusion of the applicant from a hearing, was necessary, the Court will take into account all relevant factors (such as the nature and complexity of the issue before the domestic courts, what was at stake for the applicant, whether his appearance in person represented any threat to others or to himself, etc.).

2. Application to the present case

69. It is not disputed that the applicant was unaware of the request for incapacitation made by his mother. Nothing suggests that the court notified the applicant proprio motu about the proceedings (see paragraph 10 above). Further, as follows from the doctor's report of 12 November 2004 (see paragraph 13 above), the applicant did not realise that he was being subjected to a forensic psychiatric examination. The Court concludes that the applicant was unable to participate in the proceedings before the Vasilyevsky District Court in any form. It remains to be ascertained whether, in the circumstances, this was compatible with Article 6 of the Convention.

70. The Government argued that the decisions taken by the national judge had been lawful in domestic terms. However, the crux of the complaint is not the domestic legality but the “fairness” of the proceedings from the standpoint of the Convention and the Court's case-law.

71. In a number of previous cases (concerning compulsory confinement in a hospital) the Court confirmed that a person of unsound mind must be allowed to be heard either in person or, where necessary, through some form of representation – see, for example, Winterwerp, cited above, § 60. In Winterwerp the applicant's freedom was at stake. However, in the present case the outcome of the proceedings was at least equally important for the applicant: his personal autonomy in almost all areas of life was at issue, including the eventual limitation of his liberty.

72. Further, the Court notes that the applicant played a double role in the proceedings: he was an interested party, and, at the same time, the main object of the court's examination. His participation was therefore necessary not only to enable him to present his own case, but also to allow the judge to form her personal opinion about the applicant's mental capacity (see, mutatis mutandis, Kovalev v. Russia, no. 78145/01, §§ 35-37, 10 May 2007).

73. The applicant was indeed an individual with a history of psychiatric troubles. From the materials of the case, however, it appears that despite his mental illness he had been a relatively autonomous person. In such circumstances it was indispensable for the judge to have at least a brief visual contact with the applicant, and preferably to question him. The Court concludes that the decision of the judge to decide the case on the basis of documentary evidence, without seeing or hearing the applicant, was unreasonable and in breach of the principle of adversarial proceedings enshrined in Article 6 § 1 (see Mantovanelli v. France, judgment of 18 March 1997, Reports of Judgments and Decisions 1997-II, § 35).
74. The Court has examined the Government's argument that a representative of the hospital and the district prosecutor attended the hearing on the merits. However, in the Court's opinion, their presence did not make the proceedings truly adversarial. The representative of the hospital acted on behalf of an institution which had prepared the report and was referred to in the judgment as an “interested party”. The Government did not explain the role of the prosecutor in the proceedings. In any event, from the record of the hearing it appears that both the prosecutor and the hospital representative remained passive during the hearing, which, moreover, lasted only ten minutes.

75. Finally, the Court recalls that it must always assess the proceedings as a whole, including the decision of the appellate court (see C.G. v. the United Kingdom, no. 43373/98, § 35, 19 December 2001). The Court notes that in the present case the applicant's appeal was disallowed without examination, on the ground that the applicant had no legal capacity to act before the courts (see paragraph 41 above). Regardless of whether or not the rejection of his appeal without examination was acceptable under the Convention, the Court merely notes that the proceedings ended with the first-instance court judgment of 28 December 2004.

76. The Court concludes that in the circumstances of the present case the proceedings before the Vasileostrovskiy District Court were not fair. There has accordingly been a violation of Article 6 § 1 of the Convention.

31. In Shukatorov, the European Court of Human Rights also held that there was a breach of Article 8 of the Convention. The Court held:

B. Admissibility

83. The parties agreed that the judgment of 28 December 2004 amounted to an interference in the applicant's private life. The Court recalls that Article 8 “secures to the individual a sphere within which he or she can freely pursue the development and fulfilment of his personality” (see Brüggeman and Scheuten v. Germany, no. 6959/75, Commission's report of 12 July 1977, Decisions and Reports 10, p. 115, § 55). The judgment of 28 December 2004 deprived the applicant of his capacity to act independently in almost all areas of life: he was no longer able to sell or buy any property on his own, to work, to travel, to choose his place of residence, to join associations, to marry, etc. Even his liberty could henceforth have been limited without his consent and without any judicial supervision. In sum, the Court concludes that the deprivation of legal capacity amounted to an interference with the private life of the applicant (see Matter v. Slovakia, no. 31534/96, § 68, 5 July 1999).

84. The Court further notes that this complaint is not manifestly ill-founded within the meaning of Article 35 § 3 of the Convention. It further notes that it

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20 Article 8 provides:

1. Everyone has the right to respect for his private and family life, his home and his correspondence.

2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.
is not inadmissible on any other grounds. It must therefore be declared admissible.

C. Merits

85. The Court reiterates that any interference with an individual's right to respect for his private life will constitute 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” in the sense that it was proportionate to the aims sought.

86. The Court took note of the applicant's contention that the measure applied to him had not been lawful and had not pursued any legitimate aim. However, in the Court's opinion it is not necessary to examine these aspects of the case, since the decision to incapacitate the applicant was in any event disproportionate to the legitimate aim invoked by the Government for the reasons set out below.

1. General principles

87. The applicant claimed that full incapacitation had been an inadequate response to the problems he experienced. Indeed, 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. However, as a rule, in such a complex matter as determining somebody's mental capacity, the authorities should enjoy a wide margin of appreciation. This is mostly explained by the fact that the national authorities have the benefit of direct contact with the persons concerned and are therefore particularly well placed to determine such issues. The task of the Court is rather to review under the Convention the decisions taken by the national authorities in the exercise of their powers in this respect (see, mutatis mutandis, Bronda v. Italy, judgment of 9 June 1998, Reports 1998-IV, p. 1491, § 59).

88. At the same time, the margin of appreciation to be accorded to the competent national authorities will vary in accordance with the nature of the issues and the importance of the interests at stake (see Elsholz v. Germany [GC], no. 25735/94, § 49, ECHR 2000-VIII). A stricter scrutiny is called for in respect of very serious limitations in the sphere of private life.

89. Further, the Court reiterates that, whilst Article 8 of the Convention 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” (see Görgülü v. Germany, no. 74969/01, § 52, 26 February 2004). The extent of the State's margin of appreciation thus depends 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 (see, mutatis mutandis, Sahin v. Germany, no. 30943/96, §§ 46 et seq., 11 October 2001).

2. Application to the present case

90. First, the Court notes that the interference with the applicant's private life was very serious. As a result of his incapacitation the applicant became fully dependant on his official guardian in almost all areas of life. Furthermore, “full incapacitation” was applied for an indefinite period and could not, as the applicant's case shows, be challenged otherwise than through the guardian, who opposed any attempts to discontinue the measure (see also “Relevant Domestic Law” above, paragraph 52).
91. Second, the Court has already found that the proceedings before the Vasilievostrovskiy District Court were procedurally flawed. Thus, the applicant did not take part in the court proceedings and was not even examined by the judge in person. Further, the applicant was unable to challenge the judgment of 28 December 2004, since the City Court refused to examine his appeal. In sum, his participation in the decision-making process was reduced to zero. The Court is particularly struck by the fact that the only hearing on the merits in the applicant's case lasted ten minutes. In such circumstances it cannot 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 this Court.

92. Third, the Court must examine the reasoning of the judgment of 28 December 2004. In doing so, the Court will have in mind the seriousness of the interference complained of, and the fact that the court proceedings in the applicant's case were perfunctory at best (see above).

93. The Court notes that the District Court relied solely on the findings of the medical report of 12 November 2004. That report referred to the applicant's aggressive behaviour, negative attitudes and “anti-social” lifestyle; it concluded that the applicant suffered from schizophrenia and was thus unable to understand his actions. At the same time, the report did not explain what kind of actions the applicant was unable of understanding and controlling. The incidence of the applicant's illness is unclear, as are the possible consequences of the applicant's illness for his social life, health, pecuniary interests, etc. The report of 12 November 2004 was not sufficiently clear on these points.

94. The Court does not cast doubt on the competence of the doctors who examined the applicant and accepts that the applicant was seriously ill. However, in the Court's opinion 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. However, the questions to the doctors, as formulated by the judge, did not concern “the kind and degree” of the applicant's mental illness. As a result, the report of 12 November 2004 did not analyse the degree of the applicant's incapacity in sufficient detail.

95. It appears that the existing legislative framework did not leave the judge another choice. The Russian Civil Code distinguishes between full capacity and full incapacity, but it does not provide for any “borderline” situation other than for drug or alcohol addicts. The Court refers in this respect to the principles formulated by Recommendation No. R (99) 4 of the Committee of Ministers of the Council of Europe, cited above in paragraph 59. Although these principles have no force of law for this Court, they may define a common European standard in this area. Contrary to these principles, Russian legislation did not provide for a “tailor-made response”. As a result, in the circumstances the applicant's rights under Article 8 were limited more than strictly necessary.

96. In sum, having examined the decision-making process and the reasoning behind the domestic decisions, the Court concludes that the interference with the applicant's private life was disproportionate to the legitimate aim pursued.
There was, therefore, a breach of Article 8 of the Convention on account of the applicant’s full incapacitation.

32. It follows from the above that a finding of incapacity should be rigorously assessed by an independent tribunal. Whilst in Shtukatorov, the Court determined that there was a breach of Article 8 on the ground of proportionality alone, any finding of incapacity must also be ‘in accordance with law’, which requires that the law must be clear and the basis of the legal finding must be clearly expressed and reasoned.

33. In Kutzner v. Germany, 21, which was a case brought by people with mild intellectual disabilities, the European Court of Human Rights stated that:

... whilst Article 8 contains no explicit procedural requirements, the decision making process leading to measures of interference must be fair and such as to afford due respect to the interests safeguarded by Article 8. 22

34. In H.F. v. Slovakie, 23 the European Court of Human Rights also held that decisions removing legal capacity from individuals engaged Article 6 and 8 rights. The Court also referred authoritatively to the Council of Europe Committee of Ministers’ Recommendation R(99)4 on principles concerning the legal protection of incapable adults, 23rd February, 1999. Principle 13 is headed ‘Right to be heard in person’ and provides: “The person concerned should have the right to be heard in person in any proceedings which could affect his or her legal capacity”. The Recommendation also states that there should be “fair and efficient procedures for the taking of measures for the protection of incapable adults” and that there “should be adequate procedural safeguards to protect the human rights of the persons concerned and to prevent possible abuses”.

35. It may be that the protections provided by the European Convention on Human Rights are mirrored in the citizen’s personal rights under Article 40 of the Constitution. In Re A Ward of Court (No.2), 24 Hamilton CJ stated:

The loss by an individual of his or her mental capacity does not result in any diminution of his or her personal rights recognised by the Constitution, including the right to life, the right to bodily integrity, the right to privacy, including self-determination, and the right to refuse medical care or treatment. The ward is entitled to have all these rights respected, defended, vindicated and protected from unjust attack and they are in no way lessened or diminished by reason of her incapacity.

The role of the advocate

36. What is the lawyer’s role where his client, a patient, may be suffering a breach of his or her legal rights but lacks the capacity to instruct the lawyer to institute a

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22 At paragraph 56.
23 Application No. 54797/00, judgment 8th November, 2005, paragraph 47
24 [1996] 2 IR 79.
legal challenge? In *E.H. v. St. Vincent's Hospital*, the Supreme Court appeared to be of the view that a challenge should only be brought if the lawyer assessed it as being in the patient’s ‘best interests’. The Court stated:

*The fact that s. 17 (1) (b) of the Act of 2001 provides for the assignment by the Commission of a legal representative for a patient following the making of an admission order or a renewal order should not give rise to an assumption that a legal challenge to that patient’s detention is warranted unless the best interests of the patient so demand. Mere technical defects, without more, in a patient’s detention should not give rise to a rush to court, notably where any such defect can or has been cured – as in the present case. Only in cases where there had been a gross abuse of power or default of fundamental requirements would a defect in an earlier period of detention justify release from a later one. As O’Higgins C.J. observed in *State (McDonagh) v. Frawley [1978]* I.R. 131 at 136:-*

> “The stipulation in Article 40, s.4, sub-s.1, of the Constitution that a citizen may not be deprived of his liberty save “in accordance with law” does not mean that a convicted person must be released on habeas corpus merely because some defect or illegality attaches to his detention. The phrase means that there must be such a default of fundamental requirements that the detention may be said to be wanting in due process of law. For habeas corpus, therefore, it is insufficient for the prisoner to show that there has been a legal error or impropriety, or even that jurisdiction has been inadvertently exceeded”*

37. Yet, if it appears to a lawyer that his or her client is detained unlawfully under the Mental Health Act 2001, surely there is a duty to challenge the detention. A person should only be detained in accordance with law and, in the case of a patient detained under the 2001 Act, such a person is reliant, more than most clients, on the advice and conduct of his or her legal team. Is there not an important distinction between whether detention is clinically justified and whether it is lawful? Is it not in a patient’s ‘best interests’ to challenge an act that appears to be in breach of the patient’s statutory or fundamental rights?

38. Does the Supreme Court decision in *E.H.* imply that the lawyer should consider whether release is appropriate, regardless of whether or not it is lawful? What happens if the client wants a challenge to be brought to his or her detention even though release is self-evidently not in his or her best interests? The potential difficulty with the approach suggested in *E.H.* is that it might place the patient’s lawyer in the role of adjudicator rather than advocate for the patient. If a patient’s detention does not appear to comply with statutory requirements, and the patient wants a challenge brought, is it right that the lawyer should refuse to pursue it on the basis that the patient’s illness is such that release would not be appropriate?

39. The *UN Basic Principles for Lawyers* define the core duties of lawyers as follows:

> 13. The duties of lawyers towards their clients shall include:

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25 supra
(a) Advising clients as to their legal rights and obligations, and as to
the working of the legal system in so far as it is relevant to the legal
rights and obligations of their clients;
(b) Assisting clients in every appropriate way, and taking legal action
to protect their interests;
(c) Assisting clients before courts, tribunals or administrative
authorities, where appropriate.

14. Lawyers, in protecting the rights of their clients and in promoting the
cause of justice, shall seek to uphold human rights and fundamental freedoms
recognised by national and international law and shall at all times act freely
and diligently in accordance with the law and recognized standards and ethics
of the legal profession.

Principle 13(b) includes as one of the lawyer’s duties that of taking legal action to
ensure that a patient’s interests are protected. This implies a duty to take legal
action to ensure that a client is only detained where procedural requirements have
been complied with.

40. A helpful analysis of the lawyer’s duties is contained in the decision of the
Supreme Court of Montana in Re the mental health of K.G.F., in which the
Court examined the issue of representation of people under psychiatric detention,
and expressly disapproved of a ‘paternalistic or passive stance’. It relied heavily
on the Guidelines for Involuntary Civil Commitment developed and published by
the Center for State Courts in the U.S. The Supreme Court of Montana stated:

84. To what extent an attorney representing a patient-client in an involuntary
commitment proceeding should adopt an "adversarial" posture is a subject of
extensive debate among state legislatures and commentators, and is noticeably
absent from Title 53, Chapter 21 statutes.
85. As indicated earlier, other states have adopted express statutory
provisions defining this role. See, e.g., Minn. Stat. Ann. § 144.4177 (counsel
shall be a "vigorous advocate on behalf of the client"). As the ‘Commentary to
the Guidelines’ states: "[w]hen an attorney fails to act as an advocate and
assumes a paternalistic or passive stance, the balance of the system is upset,
the defense attorney usurps the judicial role, and the defendant's position goes
unheard." Guidelines, Part E2 Commentary, at 466 (internal quotations
omitted).
86. Accordingly, we agree with the Guidelines as well the approach taken in
Texas, that the proper role of the attorney is to "represent the perspective of the
respondent and to serve as a vigorous advocate for the respondent’s
Further:

To the extent that a client is unable or unwilling to express personal
wishes, the attorney should advocate the position that best safeguards
and advances the client's interest.
Guidelines, Part E2, at 465. Additionally:

26 2001 MT 140.
27 Available at http://www.ncsconline.org.
In the courtroom, an attorney should engage in all aspects of advocacy and vigorously argue to the best of his or her ability for the ends desired by the client.

Guidelines, Part F5, at 483.

87. The foregoing guidelines create the presumption that a client wishes to not be involuntarily committed. The ultimate decision of whether a patient-respondent should be involuntarily committed, therefore, should not be independently made by counsel. See Tex. Health & Safety Code Ann. § 574.004 (providing that "regardless of an attorney's personal opinion, the attorney shall use all reasonable efforts within the bounds of law to advocate the proposed patient's right to avoid court-ordered mental health services if the proposed patient expresses a desire to avoid the services").

88. Thus, we conclude that pursuant to the foregoing guidelines, evidence that counsel independently advocated or otherwise acquiesced to an involuntary commitment --in the absence of any evidence of a voluntary and knowing consent by the patient-respondent -- will establish the presumption that counsel was ineffective.

41. The Court’s view was that a lawyer must represent his client’s wishes. More difficult, is the situation where a client does not have the capacity to understand and express their desired outcome. The Guidelines relied on by the Montana Supreme Court appear to work on the presumption that a patient does not want to be subjected to involuntary detention. This presumption safeguards the patient’s right to have what might be an unlawful detention challenged.

The Council of Europe’s Committee of Ministers’ Recommendation Rec (2004) 10 concerning the protection of human rights and dignity of persons with mental disorder

42. The importance of the patient’s dignity and autonomy, and of the principle of the least restrictive alternative, has been underlined by the Council of Europe’s Committee of Ministers in its Recommendation Rec (2004) 10 concerning the protection of human rights and dignity of persons with mental disorder. Because this is a Council of Europe recommendation, it informs the interpretation and application of the European Convention on Human Rights and gives important guidance as to minimum human rights standards. It provides inter alia:

Article 1 – Object

1. This Recommendation aims to enhance the protection of the dignity, human rights and fundamental freedoms of person with mental disorder, in particular those who are subject to involuntary placement or involuntary treatment.

2. The provisions of this Recommendation do not limit or otherwise affect the possibility for a member state to grant persons with a mental disorder a wider measure of protection than is stipulated in this Recommendation.

Article 3 – Non-discrimination

1. Any form of discrimination on grounds of mental disorder should be prohibited.
2. Member states should take appropriate measures to eliminate discrimination on grounds of mental disorder.

Article 4 – Civil and political rights
1. Persons with mental disorder should be entitled to exercise all their civil and political rights.
2. Any restrictions to the exercise of those rights should be in conformity with the provisions of the Convention for the Protection of Human Rights and Fundamental Freedoms and should not be based on the mere fact that a person has a mental disorder.

Article 6 – Information and assistance on patients’ rights
Persons treated or placed in relation to mental disorder should be individually informed of their rights as patients and have access to a competent person or body, independent of the mental health service, that can, if necessary, assist them to understand and exercise such rights.

Article 7 – Protection of vulnerable persons with mental disorders
1. Member states should ensure that there are mechanisms to protect vulnerable persons with mental disorders, in particular those who do not have the capacity to consent or who may not be able to resist infringements of their human rights.
2. The law should provide measures to protect, where appropriate, the economic interests of persons with mental disorder.

Article 8 – Principle of least restriction
Persons with mental disorder should have the right to be cared for in the least restrictive environment available and with the least restrictive or intrusive treatment available, taking into account their health needs and the need to protect the safety of others.

Article 12 – General principles of treatment for mental disorder
1. Persons with mental disorder should receive treatment and care provided by adequately qualified staff and based on an appropriate individually prescribed treatment plan. Whenever possible the treatment plan should be prepared in consultation with the person concerned and his or her opinion should be taken into account. The plan should be regularly reviewed and, if necessary, revised.
2. Subject to the provisions of chapter III and Articles 28 and 34 below, treatment may only be provided to a person with a mental disorder with his or her consent if he or she has the capacity to give such consent, or, when the person does not have the capacity to consent, with the authorisation of a representative, authority, person or body provided for by law.
3. When because of an emergency situation the appropriate consent or authorisation cannot be obtained, any treatment for mental disorder that is medically necessary to avoid serious harm to the health of the individual concerned or to protect the safety of others may be carried out immediately.

43. Chapter III is entitled “Involuntary placement in psychiatric facilities, and involuntary treatment, for mental disorder”. It provides inter alia:
Article 16 – Scope of chapter III
The provisions of this chapter apply to persons with mental disorder:
i. who have the capacity to consent and are refusing to the placement or treatment concerned; or
ii. who do not have the capacity to consent and are objecting to the placement or treatment concerned.

Article 17 – Criteria for involuntary placement
1. A person may be subject to involuntary placement only if all the following conditions are met:
i. the person has a mental disorder;
ii. the person’s condition represents a significant risk of serious harm to his or her health or to other persons;
iii. the placement includes a therapeutic purpose;
iv. no less restrictive means of providing appropriate care are available;
v. the opinion of the person concerned has been taken into consideration.

2. The law may provide that exceptionally a person may be subject to involuntary placement, in accordance with the provisions of this chapter, for the minimum period necessary in order to determine whether he or she has a mental disorder that represents a significant risk of serious harm to his or her health or to others if:
i. his or her behaviour is strongly suggestive of such a disorder;
ii. his or her condition appears to represent such a risk;
iii. there is no appropriate, less restrictive means of making this determination; and
iv. the opinion of the person concerned has been taken into consideration.

Article 18 – Criteria for involuntary treatment
A person may be subject to involuntary treatment only if all the following conditions are met:
i. the person has a mental disorder;
ii. the person's condition represents a significant risk of serious harm to his or her health or to other persons;
iii. no less intrusive means of providing appropriate care are available;
iv. the opinion of the person concerned has been taken into consideration.

Article 19 – Principles concerning involuntary treatment
1. Involuntary treatment should:
i. address specific clinical signs and symptoms;
ii. be proportionate to the person's state of health;
iii. form part of a written treatment plan;
iv. be documented;
v. where appropriate, aim to enable the use of treatment acceptable to the person as soon as possible.

2. In addition to the requirements of Article 12.1 above, the treatment plan should:
whenever possible be prepared in consultation with the person concerned and the person's personal advocate or representative, if any;

be reviewed at appropriate intervals and, if necessary, revised, whenever possible in consultation with the person concerned and his or her personal advocate or representative, if any.

3. Member states should ensure that involuntary treatment only takes place in an appropriate environment.

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

Decision

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

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

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

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

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

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

However, the law may provide that when a person is subject to involuntary placement the decision to subject that person to involuntary treatment may be taken by a doctor having the requisite competence and experience, after examination of the person concerned and taking into account his or her opinion.

3. Decisions to subject a person to involuntary placement or to involuntary treatment should be documented and state the maximum period beyond which, according to law, they should be formally reviewed. This is without prejudice to the person's rights to reviews and appeals, in accordance with the provisions of Article 25.

Procedures prior to the decision

4. Involuntary placement, involuntary treatment, or their extension should only take place on the basis of examination by a doctor having the requisite competence and experience, and in accordance with valid and reliable professional standards.

5. That doctor or the competent body should consult those close to the person concerned, unless the person objects, it is impractical to do so, or it is inappropriate for other reasons.

6. Any representative of the person should be informed and consulted.

44. Chapter IV of the Recommendation is entitled ‘Placement of persons not able to consent in the absence of objection’ and consists only of Article 26 which is headed ‘Placement of persons not able to consent in the absence of objection’ and states:
Member states should ensure that appropriate provisions exist to protect a person with mental disorder who does not have the capacity to consent and who is considered in need of placement and does not object to the placement.

The UN Resolution 46/119 on the Protection of Persons with Mental Illness and the Improvement of Mental Health Care

45. The United Nations by way of Resolution 46/119 on the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, adopted by the General Assembly on 17th December, 1994, set out a number of principles (known as ‘the UN Mental Illness Principles’). Principle 1 is headed ‘Fundamental freedoms and basic rights’ and provides;

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

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

46. Principle 9 is headed ‘Treatment’ and provides:

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

47. Principle 11 deals with the need for consent to treatment. Principle 12 is headed ‘Notice of Rights’ and provides:

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

48. Principle 13 is headed ‘Rights and conditions in mental health facilities’ and provides inter alia:
1. Every patient in a mental health facility shall, in particular, have the right to full respect for his or her:
   (a) Recognition everywhere as a person before the law;
   (b) Privacy;
   (c) Freedom of communication, which includes freedom to communicate with other persons in the facility; freedom to send and receive uncensored private communications; freedom to receive, in private, visits from a counsel or personal representative and, at all reasonable times, from other visitors; and freedom of access to postal and telephone services and to newspapers, radio and television.

The WHO Resource Book on Mental Health, Human Rights and Legislation

49. The WHO Resource Book on Mental Health, Human Rights and Legislation was published in 2005 with the aim of assisting countries in the drafting, adopting and implementing of legislation in the area of mental health so that such legislation is consistent with internationally accepted human rights standards and good practice. The Resource Book states inter alia:

   ... in some countries, particularly where legislation has not been updated for many years, mental health legislation has resulted in the violation, rather than the promotion, of human rights of persons with mental disorders. This is because much of the mental health legislation initially drafted was aimed at safeguarding members of the public from “dangerous” patients and isolating them from the public, rather than promoting the rights of persons with mental disorders as people and citizens. Other legislation permitted long-term custodial care of persons with mental disorders who posed no danger to society but were unable to care for themselves, and this too resulted in a violation of human rights. In this context, it is interesting to note that although 75% of countries around the world have mental health legislation, only half (51%) have laws passed after 1990, and nearly a sixth (15%) have legislation dating back to the pre-1960s (WHO, 2001a). Legislation in many countries is therefore outdated and, as mentioned above, in many instances takes away the rights of persons with mental disorders rather than protecting their rights ...

   (page 1)

In accordance with the objectives of the United Nations (UN) Charter and international agreements, a fundamental basis for mental health legislation is human rights. Key rights and principles include equality and non-discrimination, the right to privacy and individual autonomy, freedom from inhuman and degrading treatment, the principle of the least restrictive environment, and the rights to information and participation. Mental health legislation is a powerful tool for codifying and consolidating these fundamental values and principles ...

   (page 3)

An important reason for developing mental health legislation is to protect people’s autonomy and liberty. Legislation can do this in a number of ways. For example, it can:
· Promote autonomy by ensuring mental health services are accessible for people who wish to use such services;
· Set clear, objective criteria for involuntary hospital admissions, and, as far as possible, promote voluntary admissions;
· Provide specific procedural protections for involuntarily committed persons, such as the right to review and appeal compulsory treatment or hospital admission decisions;
· Require that no person shall be subject to involuntary hospitalization when an alternative is feasible;
· Prevent inappropriate restrictions on autonomy and liberty within hospitals themselves (e.g. rights to freedom of association, confidentiality and having a say in treatment plans can be protected); and
· Protect liberty and autonomy in civil and political life through, for example, entrenching in law the right to vote and the right to various freedoms that other citizens enjoy.

In addition, legislation can allow people with mental disorders, their relatives or other designated representatives to participate in treatment planning and other decisions as a protector and advocate ...

Conclusion

50. Modern international human rights standards emphasise the importance of a range of patient’s rights. Respect for a patient’s autonomy and dignity, and the principle of equality before the law, are among the core rights. The materials cited above focus on these rights and, I hope, may assist legal practitioners and others working in the area of mental health to argue that the Mental Health Act 2001 should be applied in a manner that vindicates these fundamental human rights.

51. In ‘A Short Guide to the United Nations Convention on the Rights of Persons with Disabilities’, Professor Gerard Quinn, states that the rights-based perspective on disability is relatively new but that it is in the ascendant:

Notwithstanding the obvious human rights issues that affect persons with disabilities, the default setting for considering disability has not generally been human rights. It has, instead, been a mixture of charity, paternalism and social policy. Indeed, the general social policy response was to maintain people rather than to forge pathways into the mainstream. In a way, it was a perversion of the true mission of social policy.

Migrating the disability issue to the core of human rights has been slow. Perhaps this has something to do with the way the human difference of disability was perceived. In a way, the ‘natural’ distribution of human capacities was seen as separating persons rather than simply complicating human existence ...

All of this accumulated baggage from the past is now firmly on the defensive as to the move to the human rights framework of reference takes root ...

That this revolution has taken so long in the disability field is curious, since one of the main attractions of human rights is its supposedly universal quality.

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28 European Yearbook of Disability Law, Volume 1, 2009, pages 89-114.
In its essence, therefore, the human rights revolution in the context of disability has to do with making the human being behind the disability visible and extending the benefits of ‘the rule of law’ to all and not just to some, or indeed to most. Most importantly, it has to do with treating persons with disabilities as ‘subjects’ with full legal personhood as distinct from ‘objects’ to be managed and cared for.\(^\text{29}\)

It is to be hoped that the rights-based perspective will inform the application of the Mental Health Act 2001.

\(^{29}\) At pages 89-90.