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The influence of the convention on the rights of persons with disabilities on the European court of human rights in the area of mental health law: Divergence and unexplored potential

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ABSTRACT

This article explores how the European Court of Human Rights has applied the norms of the UN Convention on the Rights of Persons with Disabilities (CRPD) in the area of mental health law. The European Court was initially receptive to the CRPD, including the UN Committee on the Rights of Persons with Disabilities' call for a repeal of legislation permitting involuntary psychiatric hospitalisation, but later distanced itself from it. The CRPD has nevertheless influenced how the European Court approached (a) involuntary hospitalisation, (b) separating detention from treatment, (c) restraints and other forms of ill-treatment in institutions, and (d) disability-neutral detention based on disability. Despite the two treaty bodies' different jurisprudential methodology and their different assumptions about the role of medical and legal professionals, the CRPD can continue to influence the European Court in areas such as less restrictive alternatives to coercive treatment, the relevance of capacity, and the importance of personal integrity for mental health treatment.

1. Introduction

The adoption of the Convention on the Rights of Persons with Disabilities (hereinafter CRPD) brought a radical change to the understanding of the rights of users of mental health services in international law. According to the interpretation of the UN Committee on the Rights of Persons with Disabilities (hereinafter CRPD Committee), Article 14 of the CRPD prohibits involuntary hospitalisation and involuntary treatment of all persons with disabilities, including persons with psychosocial disability. This presents a clear challenge to mental health laws across the world, which provide for involuntary detention and treatment of persons with disabilities in combination with other factors, such as dangerousness.

Not all human rights bodies have accepted the CRPD Committee's approach. The European Court of Human Rights (hereinafter European Court or Court), one of the most influential human rights tribunals in the world and certainly on the European continent,[1] has been cautious about endorsing the CRPD, and has been oscillating from openly embracing it to ignoring it. Its engagement with the CRPD has resulted in very progressive developments in some areas, and important setbacks in others.

This article analyses how the debate about the CRPD's interpretation affected the European Court's standards on detention and psychiatric treatment of persons with disabilities. It shows how the CRPD became relevant in the European Court's jurisprudence, and how the newer case law departed from harmonizing the two sets of standards. It assesses the underlying reasons which prevent the European Court from fully accepting the CRPD in this area.

The European Court's position towards the CRPD is an issue that is not only relevant to the avoidance of fragmentation of international law.[2] States parties to the European Convention on Human Rights (hereinafter ECHR) are also parties to the CRPD; they have obligations to follow both treaties. How these states resolve the relationship between the two sets of norms has enormous implications for mental health law reform and for the understanding and adherence to the rights of persons with psychosocial disabilities across Europe. These debates on the national level will be influenced by the European Court's arguments. They also affect the CRPD's acceptance worldwide; strong resistance from

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[1] Van Dijk, P., & Van Hoof, G.J.H (1998). *Theory and practice of the European Convention on Human Rights*. Martinus Nijhoff Publishers.

[2] True-Frost, C. C. (2022). Listening to Dissonance at the Intersections of International Human Rights Law. *Michigan Journal of International Law*, 43, 361–421.

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other human rights bodies might result in the CRPD Committee losing authority, or changing its position. On the other hand, understanding the European Court's resistance can result in clearer CRPD standards, capable of convincing sceptics about their value. As the analysis shows, some decisions of the European Court already provided arguments to refine the CRPD Committee's understanding of the CRPD, notably the question of detention on the grounds of dangerousness based on a disability-neutral measure.

Several authors assessed the relevance of the CRPD for the European Court and its potential to affect the latter's standards in, among others, the area of mental health law.[3] They expressed predictions and hypotheses about the possible limits of convergence between the two instruments, and offered suggestions regarding how the jurisprudence of the two bodies might develop.[4] This article tests some of these predictions based on the European Court's most recent decisions. It reviews how the case law evolved to adopt and then reject the CRPD in general, and how this affected developments in areas such as involuntary hospitalisation, involuntary treatment, ill-treatment, and disability-neutral detention on the basis of dangerousness. It analyses the European Court's underlying reasons for departing from the CRPD's Committee's interpretations. It concludes by showing that despite the European Court's unwillingness to reject involuntary hospitalisation, the CRPD is still relevant for the ECHR in the area of mental health law. Questions such as the social model of disability, less restrictive alternatives, and the right to integrity have unexplored potential to improve the European Court's standards. On the other hand, classifying disability-specific measures as discrimination have not proved to be successful in influencing the European Court's position.

2. The right to liberty in the CRPD and the ECHR

The CRPD follows the structure of other human rights treaties, and thus contains several articles which could be relevant for mental health patients. The most important is Article 14, the right to liberty, which other treaty bodies typically use to review and justify involuntary hospitalisation.[5] CRPD's Article 14 contains the usual requirements of lawfulness and avoidance of arbitrariness found in other treaties, adding the provision of reasonable accommodation. In addition, and contrary to other treaties, it also declares that "the existence of a disability shall in no case justify a deprivation of liberty".[6] The literal reading of this provision prohibits states from using mental illness as a justification for detention; that is, the prohibition of involuntary psychiatric hospitalisation, for which the patient's mental illness is a necessary criterion. Several commentators endorsed this reading,[7] while others reject it on the ground that it would lead to absurd results: many patients unable or unwilling to consent would remain untreated and endanger themselves or others.[8]

During the CRPD negotiations, several proposals were made to expressly abolish involuntary psychiatric hospitalisation and treatment in the treaty.[9] The resulting compromise text is not explicit about these goals, but they can be nevertheless achieved through interpretation. The CRPD Committee adopted a consistent categorical interpretation of Article 14 rejecting involuntary hospitalisation through its concluding observations,[10] a decision in the case of *Noble v. Australia*,[11] and its General Comment No. 1 on Legal Capacity.[12] Other UN bodies, notably the UN High Commissioner on Human Rights, also endorsed this position soon after the CRPD's entry into force.[13] In contrast, some UN bodies, most importantly the Human Rights Committee, declined to

[3] Seatzu, F. (2018). The Convention on the Rights of Persons with Disabilities and International Human Rights Law. *International Human Rights Law Review,* 7, 82–102; Favalli, S. (2018). The United Nations Convention on the Rights of Persons with Disabilities in the Case Law of the European Court of Human Rights and in the Council of Europe Disability Strategy 2017–2023: 'from Zero to Hero', *Human Rights Law Review*, 18, 517–538; Lewis, O., & Campbell, A. (2017). Violence and abuse against people with disabilities: A comparison of the approaches of the European Court of Human Rights and the United Nations Committee on the Rights of Persons with Disabilities. *International Journal of Law and Psychiatry*, 53, 45–58; Broderick, A. (2018). The United Nations Convention on the Rights of Persons with Disabilities and the European Convention on Human Rights: a tale of two halves or a potentially unified vision of human rights? *Cambridge International Law Journal*, 7(2), 199–224; Lewis, O. (2018). Council of Europe. In: L. Waddington, & A. Lawson (Eds.), *The UN Convention on the Rights of Persons with Disabilities in Practice: A Comparative Analysis of the Role of Courts* (pp. 89–130), Oxford University Press; Nilsson, A. (2021). *Compulsory Mental Health Interventions and the CRPD: Minding Equality*. Hart; Fennell, P., & Khaliq, U. (2011). Conflicting or complementary obligations? The UN Disability Rights Convention, the European Convention on Human Rights and English law. *European Human Rights Law Review*, 6, 662–674; Bartlett, P. (2012a). The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law. *The Modern Law Review*, 75(5), 752–778.

[4] Flynn, E. (2016). Disability, Deprivation of Liberty and Human Rights norms: Reconciling European and International Approaches. *International Journal of Mental Health and Capacity Law*, 22, 75–101; Series, L. (2015). Legal Capacity and Participation in Litigation: Recent Developments in the European Court of Human Rights. In: L. Waddington, G. Quinn, & E Flynn (Eds.), *European Yearbook of Disability Law Volume 5*, Intersentia; Lewis, O. (2011). Advancing legal capacity jurisprudence. *European Human Rights Law Review*, 6, 700–714; Bartlett, P. (2012b). A mental disorder of a kind or degree warranting confinement: examining justifications for psychiatric detention. *The International Journal of Human Rights*, 16(6), 831–844.

[5] See, for example, the UN Human Rights Committee's approach in *A v. New Zealand* (Communication no. 754/97, Decision issued on 15 July 1999).

[6] Article 14(1)(b) of the CRPD.

[7] Minkowitz, T. (2007). The United Nations Convention on the Rights of Persons with Disabilities and the right to be free from nonconsensual psychiatric interventions. *Syracuse Journal of International Law and Commerce*, 34(2), 405–428; Bartlett, P. (2009). The United Nations convention on the rights of persons with disabilities and the future of mental health law. *Psychiatry*, 8(12), 496–498; Nilsson, A. (2014). Objective and reasonable? Scrutinising compulsory mental health interventions from a non-discrimination perspective. *Human Rights Law Review*, 14(3), 459–485; Gooding, P. (2017). *A new era for mental health law and policy: Supported decision-making and the UN convention on the rights of persons with disabilities*. Cambridge University Press.

[8] Dawson, J. (2015). A realistic approach to assessing mental health laws' compliance with the UNCRPD. *International Journal of Law and Psychiatry*, 40, 70–79.; Freeman, M. C. et al. (2015). Reversing hard won victories in the name of human rights: a critique of the General Comment on Article 12 of the UN Convention on the Rights of Persons with Disabilities. *The Lancet Psychiatry*, 2 (9), 844–850., Scholten, M. and Gather, J. (2018). Adverse consequences of article 12 of the UN Convention on the Rights of Persons with Disabilities for persons with mental disabilities and an alternative way forward. *Journal of Medical Ethics*, 44,226–233; Perlin, M. L. (2013). "Striking for the Guardians and Protectors of the Mind": The Convention on the Rights of Persons with Mental Disabilities and the Future of Guardianship Law, Penn State Law Review 117, 1159–1190 (2013).

[9] Fennell & Khaliq (2011), op. cit., 666.

[10] For example, CRPD Committee, Concluding Observations: Haiti, UN Doc CRPD/C/HTI/CO/1 (13 April 2018), para 27; CRPD Committee, Concluding Observations: Slovenia, UN Doc CRPD/C/SVN/CO/1 (5 March 2018) para 23; CRPD Committee, Concluding Observations: Republic of Korea, UN Doc CRPD/C/KOR/CO/1 (29 October 2014) para 26.

[11] *Noble v. Australia* (CRPD Committee, Communication no. 7/2012, views adopted on 2 September 2016, CRPD/C/16/D/7/2012).

[12] CRPD Committee (2013). General Comment No. 1 on Article 12: Equal recognition before the law, CRPD/C/11/4 (hereinafter cited as General Comment No. 1).

[13] United Nations High Commissioner for Human Rights (2009). Annual Report of the United Nations High Commissioner for Human Rights and Reports of the Office of the High Commissioner and the Secretary General, Thematic Study by the Office of the United Nations High Commissioner for Human Rights on enhancing awareness and understanding of the Convention on the Rights of Persons with Disabilities, A/HRC/10/48.

follow this approach.[14] In their General Comment No. 35 on the Right to Liberty, they explicitly permitted involuntary hospitalisation: they rejected proposals to harmonise their standards with the CRPD,[15] and stated that the "existence of a disability shall not *in itself* justify a deprivation of liberty", but coupled with other criteria, such as dangerousness, it could satisfy the requirements of the International Covenant on Civil and Political Rights.[16] This standard is worded similarly to one that was explicitly rejected during the CRPD negotiations.[17]

As a reaction to the Human Rights Committee's General Comment No. 35,[18] the CRPD Committee adopted its Guidelines on Article 14.[19] The Guidelines have an unclear legal status; they are not a General Comment, whose legal value is also contested.[20] Nevertheless, they constitute the most detailed standards and the CRPD Committee's current thinking on involuntary hospitalisation and treatment.[21]

The Guidelines make clear that the CRPD Committee considers detention on the ground of impairment contrary to the CRPD, even if it is coupled with other factors, such as dangerousness.[22] This makes it impossible to detain somebody against their will for the purpose of mental health treatment. The Committee clarified that persons with disabilities can be prosecuted under criminal law if they commit harm against others, but a separate track of mental health treatment for such acts is not allowed.[23] The Guidelines also stress that treatment can be provided only with consent, which all persons have legal capacity to provide, reinforcing the interconnectedness of Articles 14 and 12.[24] The CRPD Committee has been interpreting Article 12 consistently as requiring that all persons with disabilities are able to exercise their legal capacity on an equal basis with others,[25] rejecting all forms of substitute decision-making, including in the area of mental health treatment.[26]

The Guidelines leave open the question of whether detention based purely on dangerousness, without a reference to disability, could be permissible under the CRPD.[27] As part 3.4 below shows, the European Court, surprisingly, might have provided the missing argument to the Guidelines' interpretation.

Other articles of the CRPD are also relevant for promoting the rights of persons with psychosocial disabilities, most importantly 15 (freedom from torture), 16 (freedom from exploitation), article 17 (the right to integrity), 25 (the right to health), 12 (legal capacity), 19 (right to independent living), and others. Some psychiatric practices can be reviewed under more articles. Some of these articles do not have a direct counterpart in the ECHR.[28] The obligations following from the articles overlap and are directly relevant for each other.[29] Until a General Comment or more case law from the CRPD Committee clarifies the articles' relationship to each other, developments under any of them can be directly relevant for psychiatric practices, and consequently for the European Court.

The direct counterpart of CRPD's Article 14 is the ECHR's Article 5, the right to liberty, which in sub-paragraph (1)(e) explicitly permits the detention of "persons of unsound mind". This has been interpreted consistently as involuntary hospitalisation for the purpose of psychiatric treatment.[30] The European Court has developed a rich jurisprudence reviewing involuntary hospitalisation, starting with *Winterwerp v. the Netherlands* in 1979.[31]

Since *Winterwerp*, the Court has found a violation on this account in dozens of cases. However, it has never declared involuntary hospitalisation, as such, contrary to the ECHR; it has always accepted it as a legitimate measure in principle.[32] According to critiques, the Court did not succeed in substantially limiting medical discretion.[33] It infused it with rights-based language, providing some protection to patients,[34] but it did not develop its own substantive criteria concerning acceptability of treatment. The Court requires detention to comply with criteria of domestic mental health laws, which justify detention typically on the ground of dangerousness to others or self, or the even vaguer "deterioration of conditions".[35] The Court never rejected any of the justifications found in domestic law – it always found a violation because these were not appropriately applied to meet the ECHR's requirements.[36] It also never questioned or overruled medical expertise.[37]

Other articles of the CRPD have some limited relevance for psychiatric patients. The Court reviewed restraints under Article 3, the prohibition of torture and other forms of ill-treatment. In the case of restraints applied in psychiatric hospitals, this lead to the infamous *Herczegfalvy v. Austria* judgment, which concerned a violent patient,

[14] For a detailed account of UN bodies' differing positions on CRPD's Article 14, see Doyle Guilloud, S. (2019). The right to liberty of persons with psychosocial disabilities at the United Nations: A tale of two interpretations. *International Journal of Law and Psychiatry,* 66, 101,497.

[15] Chalken, S. (2014, May 27). Re: Urgent request to amend the Human Rights Committee's draft version of General Comment No. 35 (CCPR/C/107/R.3) on Article 9 (Right to liberty and security of person) bringing it in line with the UN Convention on the Rights of Persons with Disabilities.

[16] Human Rights Committee (2014). General Comment No. 35. Article 9: Liberty and security of person, CCPR/C/107, para. 19 (emphasis added).

[17] Fennell & Khaliq (2011), op. cit., 666.

[18] Guilloud (2019), op. cit., 3.

[19] Committee on the Rights of Persons with Disabilities (2015). Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities: The right to liberty and security of persons with disabilities, A/72/55 (hereinafter cited as Guidelines on Article 14).

[20] Doyle Guilloud (2019), op. cit., 3; Martin, W., & Michalowski, S. (2014) The Legal Status of General Comments. *Essex Autonomy Project*, MoJ/EAP UNCRPD Project.

[21] Gooding, P., & Flynn, E. (2015). Querying the call to introduce mental capacity testing to mental health law: Does the doctrine of necessity provide an alternative? *Laws*, 4(2), 245–271.

[22] Guidelines on Article 14, op. cit., para. 13.

[23] *Id.*, para. 14.

[24] *Id.*, para. 11.

[25] Arstein-Kerslake, A., & Flynn, E. (2016). The General Comment on Article 12 of the Convention on the Rights of Persons with Disabilities: a roadmap for equality before the law. *The International Journal of Human Rights* 20(4), 471–490.

[26] CRPD General Comment No. 1, *op. cit.,* paras. 40–42.

[27] *Id.*, para. 13.

[28] Some elements of the right to legal capacity, the right to independent living, or the right to integrity can be found in the European Court's case law, notably under Article 8 (the right to respect for private life), but the European Convention does not contain separate articles guaranteeing these rights.

[29] See sections in the CRPD Committee's general comments on relationship with other provisions of the Convention, for example General comment No. 4 on the right to inclusive education, 25 November 2016, paras. 44–58.

[30] See, for example, for one of the early authorities, *Ashingdane v. the United Kingdom*, no. 8225/78, judgment of 28 May 1985.

[31] *Winterwerp v. the Netherlands*, no. 6301/73, judgment of 24 October 1979.

[32] See *Hutchison Reid v. the United Kingdom*, no. 50272/99, judgment of 20 February 2003, for an example of a case where the Court had to consider and accepted the legitimacy of hospitalisation in the case of a person who was not treatable.

[33] Fennell, P. (2012). Institutionalising the community: the codification of clinical authority and the limitations of rights based approaches. In: B. McSherry, & P. Weller (Eds.). *Rethinking Rights-Based Mental Health Laws* (pp. 13–50). Hart, 22.

[34] Weller, P. (2012). Lost in Translation: Human Rights and Mental Health Law. In: B. McSherry, & P. Weller (Eds.). *Rethinking Rights-Based Mental Health Laws* (pp. 51–72). Hart, 55.

[35] See, for example, *Sabeva v. Bulgaria*, no. 44290/07, judgment of 10 June 2010.

[36] Brown, J. (2016). The changing purpose of mental health law: From medicalism to legalism to new legalism. *International Journal of Law and Psychiatry*, 47, 1–9; Szmukler, G., & Gostin, L. O. (2021). Mental Health Law: 'Legalism' and 'Medicalism' – 'Old' and 'New'. In: G. Ikkos, & N. Bouras (Eds.). *Mind, State and Society* (pp. 69–83). Cambridge University Press.

[37] Reid, K. (2015). *A Practitioner's Guide to the European Convention on Human Rights*. Sweet & Maxwell, 832.

who was strapped to a hospital bed for long periods, sometimes weeks.[38] Such severe restraints, applied for such a long duration, would have been very likely considered unjustifiable ill-treatment in another setting, for example against prisoners or persons arrested at police stations. But the European Court created an exception under Article 3 specifically for persons with psychosocial disabilities when it held that the measure does not constitute inhuman treatment if its use was a "therapeutic necessity"; that is, if a psychiatrist decides a person should be strapped to a bed for weeks, it is acceptable.[39] This standard provides very wide deference to medical practitioners,[40] and was considered by commentators as one of the main reasons why so few complaints concerning psychiatric care reach the European Court.[41]

In *Matter v. Slovakia*, the Court decided that legal capacity restrictions constitute an interference with the right to private life under Article 8 of the ECHR.[42] Since then, the Court has found several times that guardianship measures violate Article 8,[43] or Article 6, the right to a fair trial.[44] The right to private life contains other obligations important for persons with psychosocial disability, such as a nascent freedom to consent to treatment.[45]

The CRPD's adoption led to intensive debate about the permissibility of involuntary hospitalisation and its justifications. The Guidelines on Article 14 are currently the CRPD Committee's leading standard, but their status and acceptance by other human rights bodies is questioned. They are not clear on what alternatives to detention should be offered and could be acceptable to help in difficult situations of harm to others and suicide. Nevertheless, modest optimism was present in academic circles that the dialogue between the European Court and the CRPD could contribute to answering some of these questions,[46] and could provide the necessary impetus to strengthening the ECHR standards, which have failed to deliver sufficient protection against medical discretion.[47]

3. The CRPD's reception by the European Court

To understand how the European Court implemented, and later rejected, the CRPD Committee's position on involuntary hospitalisation, we have to situate these developments in a wider context of the European Court's reception of the CRPD. The European Court initially embraced the CRPD in its decisions. The first judgment mentioning the CRPD, *Glor v. Switzerland,* recognised disability as a protected ground for the purpose of equal treatment under Article 14 of the ECHR.[48] In the second judgment, *Alajos Kiss v. Hungary*, the Court declared persons with mental disabilities a protected class on account of the historic prejudices they suffered, and declared that any restrictions on their rights must be reviewed with strict scrutiny.[49] In *Enver Sahin v. Turkey,* the Court opined that the CRPD should be taken into consideration in interpreting the ECHR "to achieve harmony with other rules of international law of which it forms part".[50] In a series of subsequent cases, the Court found in favour of persons with disabilities in areas such as, *inter alia*, inclusive education,[51] the right to vote,[52] guardianship,[53] lack of disability-specific benefits or pensions,[54] and lack of disability-specific tax exemptions.[55] In all these judgments, the Court cited the CRPD as a relevant international document, sometimes explicitly adopting its standards as relevant for interpreting the ECHR.[56]

The European Court's enthusiasm for the CRPD was short-lived. In a series of cases adopted between 2018 and 2021, the Court distanced itself from the CRPD, respectively the CRPD Committee's interpretation of it, sometimes overruling its own earlier case law. Initially, this took place implicitly. In the case of *Delecolle v. France*, the Court approved the restriction on the right to marry of an elderly man placed under guardianship.[57] Despite the CRPD's clear relevance, the judgment does not refer to it, and therefore does not elaborate on the contradiction between the holding and the CRPD's prohibition of these kinds of restrictions.[58] Similarly, in *Dupin v. France*, the European Court approved the exclusion of a young boy with autism from mainstream education.[59] This decision went against earlier case law praising the CRPD for stressing the central values of "the ability of persons with disabilities to live autonomously with a fully-developed sense of dignity and self-respect".[60] Yet *Dupin* did not address this contradiction, and failed to mention the CRPD at all.

When the Court was challenged on its position of the CRPD's relevance, it could no longer remain silent on the issue.[61] After holding that the CRPD is not binding on it,[62] it provided additional factors determining the relevance of the CRPD in a pair of cases concerning the right to vote of persons with disabilities. In *Strøbye and Rosenlind v. Denmark*, the Court in substance overruled its own *Alajos Kiss v. Hungary* judgment when it approved the disenfranchisement of two persons placed under guardianship.[63] To justify its departure from the clear prohibition of disenfranchisement in Article 29 of the CRPD, the Court explained that

[38] *Herczegfalvy v. Austria*, no. 10533/83, judgment of 24 September 1992.
[39] *Id.,* para. 82.
[40] The standard was recently challenged in the case of Clipean and Iapara v. Moldova, no. 39468/17, currently pending before the Second Section of the European Court of Human Rights; see Third party intervention by the Council of Europe Commissioner for Human Rights, Application No. 39468/17 Eugeniu Clipea and Virginia Iapara v. the Republic of Moldova, CommDH(2021)19, Strasbourg, 17 June 2021, para. 39.
[41] Lewis, O. (2002). Protecting the Rights of People with Mental Disabilities: The European Convention on Human Rights. *European Journal of Health Law*, 9, 293–320, 305.
[42] *Matter v. Slovakia*, no. 31534/96, judgment of 5 July 1999.
[43] *X. v. Croatia*, no 11223/04, judgment of 17 July 2008; *Stanev v. Bulgaria*, no. 36760/06, judgment of 17 January 2012); *Sýkora v. the Czech Republic*, no. 23419/07, 22 November 2012.
[44] *H.F. v. Slovakia*, no. 54797/00, judgment of 8 November 2005; *Berková v. Slovakia*, no. 67149/01, judgment of 24 March 2009; *Salontaji-Drobnjak v. Serbia*, no. 36500/05, judgment of 13 October 2009.
[45] *X. v. Finland*, no. 34806/04, judgment of 3 July 2012.
[46] Lewis (2011), op. cit.; Series (2015), op. cit.
[47] Bartlett, P. (2013). Rethinking Herczegfalvy: the Convention and the control of psychiatric treatment. In E. Brems (Ed.) *Diversity and European human rights: rewriting judgments of the ECHR* (pp. 352–381). Cambridge University Press, 354.
[48] *Glor v. Switzerland*, no. 13444/04, judgment of 30 April 2009, para. 80.
[49] *Alajos Kiss v. Hungary*, no. 38832/06, judgment of 20 May 2010, para. 42.
[50] *Enver Şahin v. Turkey,* no. 23065/12, judgment of 30 January 2018, para. 53.
[51] *Çam v. Turkey*, no. 51500/08, judgment of 23 February 2016.
[52] *Harmati v. Hungary*, no. 63012/10, judgment of 21 October 2014.
[53] *Shtukaturov v. Russia*, no. 44009/05, judgment of 27 March 2008.
[54] *Belli and Arquier-Martinez v. Switzerland*, no. 65550/13, judgment of 18 December 2018; *Bíró v. Hungary*, no. 236/12, judgment of 18 October 2016; *Todorov and others v. Bulgaria*, no. 50705/11, judgment of 13 July 2021; *Sili v. Ukraine*, no. 42903/14, 8 July 2021.
[55] *Guberina v. Croatia*, no. 23682/13, judgment of 22 March 2016.
[56] See, for example, *Çam v. Turkey*, op. cit., para. 53 and 65.
[57] *Delecolle v. France*, no. 37646/13, judgment of 25 October 2018.
[58] CRPD General Comment No. 1, *op. cit.,* paras. 29 and 31 explicitly mention the right to marry.
[59] *Dupin v. France*, no. 2282/17, decision of 18 December 2018.
[60] *Enver Şahin v. Turkey*, op. cit., para. 63.
[61] *Fernandes de Oliveira v. Portugal* [GC], no. 78103/14, judgment of 31 January 2019, Partly concurring, partly dissenting opinion of Judge Pinto de Albuquerque joined by Judge Harutyunyan.
[62] *Rooman v. Belgium* [GC], no. 18052/11, judgment of 31 January 2019, para. 205.
[63] Fiala-Butora, J., Stein, M. A., & Smith, H. S. (2021). Strøbye and Rosenlind v Denmark: A Surprising Departure from the European Court of Human Right's Disability Voting Rights Jurisprudence. *European Human Rights Law Review,* 27 (2), 201–206, 205.

the CRPD must be balanced against other international instruments which provide for disability-specific restrictions on the right to vote.[64] It pointed to the Venice Commission's Code of Good Conduct on Electoral Matters as an example, but it did so in a very unconvincing way. The Code is an older regional soft-law instrument, which does not have the same standing as the newer, global, binding CRPD.[65] Moreover, the Code had in fact been amended in the meanwhile to be CRPD-compliant,[66] but the Court cited its older version to show a contradiction between the two.[67]

Lastly, in *Caamaño Valle v Spain* the Court had to decide about the disenfranchisement of a young woman with an intellectual disability after an individual assessment of her voting capacity.[68] A similar measure had already been explicitly declared to be contrary to the CRPD by the CRPD Committee's decision in *Bujdosó and 5 Others v. Hungary*.[69] To distance itself from that finding, the Court held that it is "not bound by interpretations given to similar instruments by other bodies".[70] While this implies that even though the CRPD Committee's views are not binding on the Court, the CRPD itself could be. The Court then also curtailed the latter possibility. It opined that although the ECHR should be interpreted in harmony with the CRPD, this should be done only "as far as possible".[71] The Court in the specific case also pointed to a lack of European consensus in favour of an absolute right to vote, to show that there was no political support behind this particular norm.[72] However, as aptly pointed out by the dissent of Judge Lemmens, there was in fact a consensus on upholding the CRPD among European countries, which the majority tacitly ignored.[73]

As these cases show, the European Court's position on the CRPD has changed in recent years. It will likely evolve in the future, because the latest decisions are unconvincing and inconsistent, and therefore do not provide adequate guidance for future cases where applicants might invoke the CRPD. These developments also affected the European Court's adaptation of the CRPD's norms in the area of mental health law.

3.1. Involuntary hospitalisation

The first case to raise the CRPD before the European Court in the context of involuntary psychiatric hospitalisation was *Sýkora v. the Czech Republic*.[74] It concerned, *inter alia*, the applicant's detention in a psychiatric hospital with the consent of his guardian, who had never met him before. The Court found a violation of the right to liberty, holding that the guardian's acceptance of hospitalisation was not sufficient to make it voluntary from the applicant's perspective.[75] Indeed, the domestic authorities' acceptance of the guardian's decision deprived the applicant of the legal safeguards available to involuntary patients. *Sýkora* extended the Court's earlier holding from *H.L. v. the United Kingdom* on what can be accepted as valid consent for hospitalisation,[76] and confirmed its ground-breaking post-CRPD decision of *Stanev v. Bulgaria*, which extended the protection of Article 5 to long-term social care institutions, holding that a guardian's consent is not sufficient to make placement there voluntary.[77] *Sýkora*'s outcome was in line with the CRPD, but the Court arrived at it with a different reasoning than the CRPD Committee: it did not reject involuntary hospitalisation as such, only in the circumstances of the specific case. This signalled that the Court in future cases might be reluctant to fully embrace the CRPD.

In a series of subsequent cases concerning Article 5, the Court referenced the CRPD, but did not elaborate on its relevance for its own standards.[78] When it found in favour of the applicants, it did so because their hospitalisation did not conform to the *Winterwerp* criteria[79]; if the criteria were met, the Court accepted the hospitalisation, and did not refer to the CRPD.[80] This approach permitted the Court to avoid addressing the uncomfortable question of the relationship of the CRPD and the ECHR in the area of the right to liberty. In the case of *Ruiz Rivera v. Switzerland*, which resulted in finding a violation regarding the applicant's continued detention without a new psychiatric assessment, the concurring opinion of Judge Sajó raised the clear relevance of the CRPD for the question of detention of persons of unsound mind.[81] Yet the majority remained silent on the matter and did not address the CRPD's relevance.

The question of the ECHR's relationship to the CRPD was finally settled in a string of five decisions adopted between 2017 and 2019. The Court had to address the matter when it was faced not with the permissibility of involuntary hospitalisation, but with the opposite question, whether states are obliged under Article 2, the right to life, to impose some restrictions on psychiatric patients to protect them from suicide. Pre-CRPD, the Court held that states have an obligation to prevent suicide of persons in their custody,[82] but did not derive from this an obligation to impose restrictions on psychiatric patients.[83]

Post-CRPD, the question first arose in *Hiller v. Austria*, which concerned the suicide of a young man who was involuntarily hospitalised in a psychiatric hospital.[84] To support his reintegration, and in line with the principle of least restrictive measures, the hospital transferred him to an open ward, from where he escaped and killed himself. The case was brought under Article 2, the right to life, but the victim's right to liberty was central in the argumentation. The Court decided that the authorities did not fail in their obligations to protect the young man's life, because they could not impose restrictions on him. To support this position, the Court declared that "today's paradigm in mental health care is to give persons with mental disabilities the greatest possible personal freedom in order to facilitate their re-integration into society".[85] The Court cited interpretations of Article 14 of the CRPD by the UN Office of the High Commissioner for Human Rights (OHCHR) and the UN Special Rapporteur on the Right to Health, which argued for "[t]he absolute prohibition of detention on the basis of disability".[86]

The Court did not explicitly endorse the OHCHR standard, but it was nevertheless criticised for its position by the concurring opinion of Judge Sajó. In the first explicit analysis of the relevance of the CRPD for involuntary hospitalisation under the ECHR, Judge Sajó pointed out that

[64] *Strøbye and Rosenlind v Denmark*, no. 25802/18, judgment of 2 February 2021.
[65] Doyle Guilloud (2019), op. cit., 10.
[66] European Commission for Democracy Through Law (19 December 2011), Revised Interpretative Declaration to the Code of Good Practice in Electoral Matters on the Participation of People with Disabilities in Elections, Study No.584/2010, CDL-AD(2011)045, para.II.2.
[67] *Strøbye and Rosenlind v Denmark*, op. cit., para. 68 and 112.
[68] *Caamaño Valle v Spain*, no. 43564/17, judgment of 11 May 2021.
[69] *Bujdosó and 5 Others v. Hungary* (CRPD Committee, Communication No. 4/2011, 20 September 2013, CRPD/C/10/D/4/2011).
[70] *Caamaño Valle v Spain*, no. 43564/17, judgment of 11 May 2021, para. 54.
[71] *Id.*
[72] *Id.*, para. 59
[73] *Id.*, Dissenting opinion of Judge Lemmens, para. 8.
[74] *Sýkora v. the Czech Republic*, op. cit.
[75] *Id.*, para. 68.
[76] *H.L. v the United Kingdom*, no. 45508/99, 5 October 2004, para. 91.
[77] *Stanev v. Bulgaria*, op. cit.
[78] See, for example, *Koroviny v. Russia*, no. 31974/11, judgment of 27 May 2014; *Kuttner v. Austria*, no. 7997/08, judgment of 16 July 2015; *Hadžimejlić and Others v. Bosnia and Herzegovina*, no. 3427/13, judgment of 3 February 2016.
[79] For example, *Blokhin v. Russia*, no. 47152/06, judgment of 23 March 2016.
[80] For example, *Haidn v. Germany*, no. 6587/04, judgment of 13 April 2011.
[81] *Ruiz Rivera v. Switzerland*, no. 8300/06, judgment of 18 February 2014, Concurring Opinion of Judge Sajó.
[82] *Keenan v the United Kingdom*, no. 27229/95, judgment of 3 April 2001; *Reynolds v the United Kingdom*, no. 2694/08, judgment of 13 March 2012.
[83] Flynn, E. (2016), 88.
[84] *Hiller v. Austria*, no. 1967/14, judgment of 22 February 2017.
[85] *Id.*, para. 54.
[86] *Id.*, para. 36.

the CRPD Committee's interpretation prohibits "the detention of persons with disabilities based on the perceived danger to themselves or to others".[87] According to Sajó, the "emerging trend in international law" led to the victim's death, and the Court was wrong to endorse it.[88] According to Sajó, while in the specific circumstances of the case the authorities were not responsible for the loss of life, the Court should not reject the permissibility of involuntary hospitalisation as such.

Judge Motoc issued a dissenting opinion in the case, also criticising the Court for endorsing the CRPD. She argued that "the duty to protect the right to life should not be sacrificed in an attempt to comply with the above-mentioned recent trend in healthcare", and asked for a balance to be struck between "providing this 'open' medical care, while still ensuring that the hospital authority imposes certain safeguards" to protect patients' lives.[89]

Hiller showed that while the Court is open to expand the limits of freedom in involuntary hospitalisation, those limits are uncertain. The Court's phrase "the greatest possible personal freedom" could mean accepting the CRPD standard, but the Court did not do that explicitly. As Sajó's concurring opinion and Motoc's dissenting opinion pointed out, there are contrary considerations which the European Court must take into account, and it is likely to weigh them differently than the CRPD Committee.

Four months later, a similar issue arose before the same Section of the Court in *Fernandes de Oliveira v. Portugal,* which concerned the suicide of a voluntary psychiatric patient who left the hospital's premises without permission.[90] Judge Motoc this time managed to convince her colleagues about the need for restrictive measures, and the Chamber found a violation of the right to life due to the authorities' inability to control the victim's movements. The Court distanced itself from the CRPD, arguing that "treatment under an 'open door' regime cannot exempt the State from its obligations to protect mentally ill patients from the risks they pose to themselves", and "a fair balance must be struck between the State's obligations under Article 2 of the ECHR and the need to provide medical care in an 'open door' regime, having in account the individual needs of special monitoring of suicidal patients".[91] The Court distinguished the case from *Hiller* on the ground that Mr. Oliveira was a known suicide risk,[92] and also held that his status as a voluntary patient should not have detracted from the hospital's obligation to closely supervise him.[93]

Notwithstanding the somewhat different circumstances of the two victims, the resulting standards of *Hiller* and *Fernandes de Oliveira* were at odds with each other. They were reconciled by the European Court's Grand Chamber, which overturned the Chamber judgment in *Fernandes de Oliveira v. Portugal* on 31 January 2019.[94] The Grand Chamber held that the state was not responsible for the victim's death, only for the subsequent ineffective investigation. It held that the authorities could not impose restrictive measures on the victim, a voluntary patient, because these would go contrary to international law requirements.[95]

The decision received a scathing critique from the partly dissenting opinion of Judge Pinto de Albuquerque, who pointed out that the majority failed to address the legal question, namely whether the Court should conform to the CRPD Committee's interpretation of the CRPD.[96] He pointed out that several international human rights bodies reject the CRPD Committee's approach, and the Court failed to engage with this "countertrend in international law".[97] He proposed that the "right to life prevails over the right to liberty",[98] and the Court sided with the "culture of death",[99] not out of concern for patients' freedom, but "the strict financial interest in safeguarding the hospital authorities from legal challenges to 'excessively restrictive measures'".[100]

On the same day, a differently composed Grand Chamber decided the case of *Rooman v. Belgium*, which finally explicitly addressed the CRPD's relevance for involuntary hospitalisation under the ECHR.[101] That case concerned the applicant's detention in a psychiatric centre for committing serious offences, without therapy being provided to him which could facilitate his eventual release. The Chamber decided that the lack of therapy constituted inhuman treatment, but, surprisingly, did not violate the right to liberty, because the applicant was detained in an appropriate institution.[102] The Grand Chamber corrected this course, and found a partial violation of the right to liberty, but not for the period when some form of psychological consultation was offered to the applicant. The Court explicitly distanced itself from the CRPD; it acknowledged that the CRPD Committee's Guidelines on Article 14 prohibit involuntary detention, but the ECHR's "Article 5, as currently interpreted, does not".[103]

Rooman and *Fernandes de Oliveira* are not entirely in harmony, but *Rooman* is more explicit on the relevant point, and this is the decision later followed and referenced by the Court when discussing the CRPD's relationship to the ECHR.[104] It can be therefore considered the leading case on this issue. The Court made it clear that it currently does not wish to interpret Article 5 of the ECHR in compliance with the CRPD Committee's interpretation of Article 14 of the CRPD. The European Court will accept involuntary psychiatric hospitalisation of persons with psychosocial disability if that hospitalisation conforms to the Court's criteria. The criteria are not static, but they do not reach the level of the CRPD.

Rooman is certainly disappointing for disability-rights advocates promoting the CRPD, especially after the initial set of cases where the European Court showed an openness to apply the CRPD. That, however, does not mean that the CRPD lost all relevance for the Court in this area. We will return to that issue after analysing developments in related fields, and assessing what could cause the different approaches to involuntary hospitalisation by the two treaty bodies, the European Court and the CRPD Committee.

3.2. Involuntary treatment

The CRPD Committee considers involuntary treatment to be a separate issue from involuntary hospitalisation. Treatment has to be provided by consent regardless of the patient's status,[105] and according to the CRPD Committee everybody has legal capacity to provide and refuse consent.[106]

[87] *Id.*, Concurring opinion of Judge Sajó, para. 3.
[88] *Id.*
[89] *Id.*, Dissenting opinion of Judge Motoc.
[90] *Fernandes de Oliveira v. Portugal*, no. 78103/14, judgment of 28 March 2017.
[91] *Id.*, para. 73.
[92] *Id.*, para. 75.
[93] *Id.*, para. 73.
[94] *Fernandes de Oliveira v. Portugal* [GC], no. 18052/11, judgment of 31 January 2019.
[95] *Id.*, para. 121.
[96] *Id.*, Partly concurring, partly dissenting opinion of Judge Pinto de Albuquerque, joined by Judge Harutyunyan, para. 45.
[97] *Id.,* para. 21.
[98] *Id.,* para. 21.
[99] *Id.,* para. 53.
[100] *Id.,* para. 21.
[101] *Rooman v. Belgium* [GC], no. 18052/11, judgment of 18 July 2017.
[102] *Rooman v. Belgium*, no. 18052/11, judgment 18 July 2017.
[103] *Rooman v. Belgium* [GC], op. cit., para. 205.
[104] *Caamaño Valle v Spain*, op. cit., para. 54.
[105] Guidelines on Article 14, op. cit., para. 11.
[106] General Comment no. 1, op. cit., para. 41.

The latter view might not be shared by all other human rights bodies,[107] but at the very least they could see merit in the argument that involuntary detention and involuntary treatment rest on different premises, and therefore require different justifications[108]: the first is concerned primarily with dangerousness, the second with lack of capacity.[109]

In contrast, the European Court considers involuntary treatment as part of involuntary hospitalisation under Article 5. If the hospitalisation was justified, then any medical treatment provided in the hospital is justified by extension, and does not need to be separately reviewed by the Court.[110] Even if a person with full legal capacity is refusing treatment and is medicated by force, if they are detained in the hospital lawfully, their treatment is permitted under the ECHR.[111] The Court thus does not separate the question of detention from treatment without consent, and does not apply different criteria, for example lack of capacity, to the latter. Under Article 5 the Court only held so far that if the detention's purpose is treatment, then it must be effected in an appropriate institution such as a hospital.[112]

After the CRPD's adoption, a few attempts to separate detention from treatment appeared in the European Court's jurisprudence. In *X. v. Finland*, the Court found a separate violation of the right to private life under Article 8 of the ECHR for the applicant's involuntary treatment, because the domestic law had no procedure to regulate decision-making over treatment.[113] A similar argument was raised by the applicant in the above-mentioned decision of *Sýkora v. the Czech Republic*.[114] In that case, despite finding that the applicant's hospitalisation was unjustified, and, contrary to the domestic bodies' assertions, he had capacity to decide on treatment, the Court did not find a separate violation under Article 8 with regard to the applicant's medical treatment.[115] This was a missed opportunity to follow up on *X. v. Finland* and elaborate on the standards of involuntary treatment as an interference with the right to private life separating it from the question of the person's status in the hospital.

The Court got closer to separating detention from treatment in *Plesó v. Hungary*, where the applicant was hospitalised on the ground that his condition, paranoid schizophrenia, would deteriorate if not treated.[116] The respondent government argued before the European Court that the domestic courts found that the applicant lacked insight to his illness, and therefore endangered his own health by refusing treatment. The applicant, relying on the CRPD, explained that he had never been deprived of his legal capacity, and therefore his objection to treatment was valid. The Court rejected as circular the argument that the applicant's refusal to undergo treatment is proof of his lack of insight into his condition. Instead, it considered it the exercise of his self-determination. The Court expressly called this the person's "right to be ill", grounding it in the "inalienable right to self-determination".[117] It also emphasised the applicant's intact legal capacity, regretting that no weight was attributed to a competent person's lack of consent. The Court drew attention to its *X v. Finland* decision, noting that involuntary hospitalisation often entails forced medication, which is an interference with the right to physical integrity.[118] The Court thus separated detention from treatment, highlighting the role of capacity in consent and the permissibility of rejecting forced treatment.

The *Plesó* decision has the potential to accommodate the interests of persons with psychosocial disability not to be treated against their will. Coupled with the above-mentioned *X v. Finland* judgment, the Court showed some openness to protect the integrity of the body and mind of psychiatric patients. The "right to be ill" is essentially the right to remain disabled, which is a choice adults can make according to this decision. Even if this right is not absolute in the Court's understanding, capacity to consent to treatment is now a factor to be explicitly considered under the ECHR, which future applicants can rely on to develop the Court's understanding of involuntary mental health treatment separately from detention.

3.3. Ill-treatment in mental health institutions

An area where the CRPD has so far had little impact on the European Court is the prohibition of ill-treatment. Some commentators argue that the CRPD should recognize abuses committed against persons with disabilities as torture,[119] because this would provide better protection for victims.[120] Others argue that the CRPD already did so and its correct interpretation leads to classifying some practices as torture.[121] The CRPD Committee has not been entirely consistent about declaring it such, but it nevertheless did so on certain occasions.[122]

The European Court had an opportunity to follow suit in *Shtukaturov v. Russia*, but it declined to do so.[123] In that case, the applicant was hospitalised after an arbitrary procedure, by the permission of his guardian, and claimed that he was treated heavily with neuroleptics. The Court, however, did not find a violation of the right to be free from ill-treatment under article 3 of the ECHR, arguing that the applicant provided "no evidence that the medication in question had the unpleasant effects he was complaining of", and that his health had "not

[107] For the European Court's contrary position, see *Delecolle v. France*, op. cit.

[108] Brosnan, L., & Flynn, E. (2017). Freedom to negotiate: a proposal extricating 'capacity' from 'consent'. *International Journal of Law in Context*, 13(1), 58–76.

[109] Richardson, G. (2012). Autonomy, Guardianship and Mental Disorder: One Problem, Two Solutions. *Current Legal Problems*, 65, 333–354; Dawson, J., & Szmukler, G. (2021). The 'Fusion Law' Proposals and the CRPD. In M. A. Stein; F. Mahomed; V. Patel; & C. Sunkel (Eds.), *Mental Health, Legal Capacity, and Human Rights* (95–108). Cambridge University Press.

[110] *Winterwerp v. the Netherlands*, *op. cit.*, para. 51.

[111] *Grare v. France*, no. 18835/91, decision of 2 December 1992.

[112] *Aerts v. Belgium*, no. 25357/94, judgment of 30 July 1998, para. 46.

[113] *X. v. Finland*, no. 34806/04, judgment of 3 July 2012, para. 220.

[114] *Sýkora v. the Czech Republic*, *op. cit.*

[115] *Id.*, paras. 89–90.

[116] *Plesó v. Hungary*, no. 41242/08, judgment of 2 October 2012.

[117] *Id.*, para 66.

[118] *Id.*, para 65.

[119] Interim Report of the Special Rapporteur on Torture and other cruel, inhuman or degrading treatment or punishment (28 July 2008), A/63/175, para. 70.

[120] Report of the Special Rapporteur on Torture and other cruel, inhuman or degrading treatment or punishment (1 February 2013), Juan E. Méndez, A/HRC/22/53, para. 82.

[121] Tina Minkowitz, The United Nations Convention on the Rights of Persons with Disabilities and the right to be free from nonconsensual psychiatric interventions, 34 Syracuse Journal of International Law and Commerce 405–428 (2007).

[122] CRPD Committee, Concluding Observations: Montenegro, UN Doc CRPD/C/MNE/CO/1 (22 September 2017) para 31; CRPD Committee, Concluding Observations: Serbia, UN Doc CRPD/C/SRB/CO/1 (23 May 2016) para 28; CRPD Committee, Concluding Observations: Republic of Korea, UN Doc CRPD/C/KOR/CO/1 (29 October 2014) para 29.

[123] *Shtukaturov v. Russia*, op. cit., para. 128.

deteriorated as a result of such treatment".[124] This standard is very high to meet for most psychiatric patients. Not surprisingly, no decision since has found involuntary treatment to constitute torture.

The same is true about a categorical prohibition of restraints in institutions.[125] In the past the European Court has been very deferential to states in this area. The leading case still remains *Herczegfalvy v. Austria*, which the European Court has never formally overruled. The question of restraints was raised under Article 3 in *Shtukaturov*, but the Court found no reason to examine it in detail, despite all the other violations found in the case.[126] A partial development came in the judgment of *Bureš v. the Czech Republic*, which concerned, *inter alia*, the applicant being strapped to a bed in a psychiatric centre, which caused him severe injuries.[127] The Court declared the restraints as constituting ill-treatment, and found a violation of the procedural limb of Article 3 due to the domestic authorities' failure to properly investigate the victim's complaints. With this step, the Court partially overruled *Herczegfalvy* in substance without declaring it so, and also extended its doctrine of obligation to investigate from the prison[128] and police violence[129] context to cover psychiatric institutions. The CRPD can play a role in further motivating the Court to improve its standards concerning restraints, but given the Court's position on involuntary hospitalisation, it is unlikely to prohibit all forms of restraints as torture.

3.4. Disability-neutral detention on the ground of dangerousness

One of the open questions under CRPD's Article 14 is whether general detention measures based on dangerousness, without reference to disability, could be justified under the CRPD. Some commentators argue that compliance with the CRPD could be achieved by removing express references to disability in mental health laws' criteria for detention.[130] Others have pointed out that such a step would raise serious ethical issues,[131] and the measure would nevertheless indirectly discriminate against persons with disabilities, therefore it would not comply with the CRPD.[132] Several commentators have criticised the objectivity and reliability of dangerousness and other neutral criteria to justify detention.[133]

The CRPD Committee's Guidelines on Article 14 suggest that disability-neutral measures based on dangerousness are discriminatory because they are disproportionately applied to persons with disabilities. The Committee nevertheless did not outlaw these explicitly: para. 13 of the Guidelines states that detention on the ground of dangerousness "tied to impairment or health diagnosis" is contrary to the CRPD.[134] According to Flynn, this means that the Committee moved away from accepting disability-neutral criteria.[135] Writing before the adoption of the Guidelines, Bartlett considered that a disability-neutral detention measure based on dangerousness would be perhaps compatible with the CRPD, but would be a very unwise step: it would provide states with a repressive tool based on a very unclear category, open to abuse and misuse.[136] Kanter undertook a detailed analysis of detention measures based on dangerousness, and found that they violate the CRPD, *inter alia* because they have a disproportionate effect on persons with disabilities.[137] The CRPD Committee, however, was not yet faced with such disability-neutral measures and it therefore did not have the opportunity to refine its position expressed in the Guidelines.

On the other hand, the European Court did address the issue, in a series of cases against Germany, and provided important considerations for the debate under the CRPD. Germany is one of the few European countries which have adopted a "preventive detention" measure not based directly on mental disorder.[138] It applies to persons who are perceived to be dangerous, who have committed serious criminal acts, but have already served their time, and do not satisfy the criteria for involuntary psychiatric hospitalisation.[139] When their sentence is fulfilled, these persons could be detained further instead of being released into the community.

Preventive detention is difficult to justify under the ECHR, because Article 5 contains a closed list of permissible grounds for detention, and mere dangerousness is not among them. In fact one of Kanter's reasons for rejecting preventive detention was that it could not comply with the ECHR,[140] and other commentators also came to the same conclusion.[141] Nevertheless, the European Court accepted preventive detention in *Bergmann v. Germany*.[142] The Court later confirmed this holding in two subsequent cases.[143] The Grand Chamber finally approved the measure as lawful in *Ilnseher v. Germany*, which concerned a young offender who was found not to have a mental illness, was declared criminally responsible and was properly sentenced by the domestic courts. Yet later, when he served his sentence, instead of releasing him he was

[124] *Id.,* para. 128.

[125] McSherry, B. (2017). Regulating seclusion and restraint in health care settings: The promise of the Convention on the Rights of Persons with Disabilities. *International Journal of Law and Psychiatry*, 53, 39–44 (2017).

[126] *Shtukaturov v. Russia*, op. cit., paras. 126–129.

[127] *Bureš v. the Czech Republic*, no. 37679/08, judgment of 18 October 2012.

[128] *Selmouni v. France* [GC], no. 25803/94, judgment of 28 July 1999.

[129] *Assenov v. Bulgaria,* no. 24760/94, judgment of 28 October 1998.

[130] Gosney, P., Bartlett, P. (2020). The UK Government should withdraw from the Convention on the Rights of Persons with Disabilities. *The British Journal of Psychiatry*, 216, 296–300, 296.

[131] Fennell and Khaliq (2011), op. cit., 666.

[132] Bartlett (2012b), op. cit., 839.

[133] Flynn, E., & Arstein-Kerslake, A. (2017). State intervention in the lives of people with disabilities: The case for a disability-neutral framework. *International Journal of Law in Context*, 13(1), 39–57; McSherry, B., & Keyzer, P. (2009). *Sex offenders and preventive detention: Politics, policy and practice*. The Federation Press; Yannoulidis, S. (2002). Negotiating dangerousness: Charting a course between psychiatry and law. *Psychiatry, Psychology and Law*, 9(2), 151–162; Zuckerberg, J. (2010). Mental health law and its discontents: A reappraisal of the Canadian experience. In B. McSherry, & P. Weller (Eds.). Rethinking rights-based mental health laws (pp. 300). Hart Publishing.

[134] Guidelines on Article 14, *op. cit.*

[135] Flynn, E. (2016), op. cit., 84.

[136] Bartlett (2012a), op. cit., 774.

[137] Kanter, A. S. (2014). *The Development of Disability Rights under International Law: From Charity to Human Rights*. Routledge, 145.

[138] Van der Wolf, M. (2016). Legal Control on Social Control of Sex Offenders in the Community: A European Comparative and Human Rights Perspective. *Erasmus Law Review*, 2, 39–54.

[139] Szwed, M. (2020). The notion of 'a person of unsound mind' under Article 5 § 1 (e) of the European Convention on Human Rights, *Netherlands Quarterly of Human Rights*, 38(4), 283–301, 289.

[140] Kanter (2014), op. cit., 148.

[141] Fennell and Khaliq (2011), op. cit., 666; Bartlett (2012b), op. cit., 839.

[142] *Bergmann v. Germany*, no. 23279/14, judgment of 7 January 2016.

[143] *Blüihdorn v. Germany*, no. 62054/12, judgment of 18 February 2016; *Klinkenbuss v. Germany*, no. 53157/11, judgment of 25 February 2016.

retrospectively placed in preventive detention.[144] Because he did not fulfil the criteria for involuntary hospitalisation, the domestic courts argued that his serious criminal acts were a manifestation of a personality disorder which made him a danger to society. The European Court had to rely on a very tenuous connection between the applicant's alleged personality disorder and his earlier criminal acts to justify his detention as that of a person of unsound mind, because no other justification was applicable to his situation.[145] As Judge Pinto de Albuquerque's dissent forcefully argued, this was a very questionable approach, because it significantly expanded the meaning of person of "unsound mind", and the justifications so far accepted under this heading, essentially allowing the detention of someone "because of nothing more than a prediction of dangerousness".[146]

The Court did not refer to the CRPD in these cases; if it had done so, that would have made it even more difficult to justify its position. The decisions nevertheless provide an important argument for the debate on the interpretation of the CRPD: they show that seemingly disability-neutral measures based on detention are indeed disproportionately used against persons with disabilities. In the case of the European Court, they can only be used against persons with disabilities, however tenuous the connection between dangerousness and disability is. This underlines the CRPD Committee's reservation towards disability-neutral preventive detention measures, and strengthens the argument that even if not connected to disability, measures based on dangerousness are not acceptable under the CRPD.[147]

4. The reasons for divergence between the European Court and the CRPD Committee

On first impression, the fact that the ECHR and the CRPD in the area of mental health law are interpreted differently is hardly surprising. These are two different instruments, differently worded, and potential conflicts between human rights treaties are not uncommon in international law.[148] The respective treaty bodies have different roles: while the European Court issues binding decisions in contentious cases,[149] the CRPD Committee is not a court, it delivers concluding observations on state reports and issues general comments, and its decisions on individual communications are not binding.[150] The judges of the European Court rarely have expertise in the field of disability rights and mental health law, which might explain their caution in interfering with medical decisions; by contrast, members of the CRPD Committee are disability rights specialists, but have less international law experience.[151]

Nevertheless, in the area of mental health law the CRPD and the ECHR overlap. To avoid the fragmentation of international law[152] and to help states understand what their obligations are, it is desirable to harmonise the interpretation of human rights treaties.[153] The International Court of Justice has endorsed the systemic integration of overlapping treaties[154] to achieve "the unity and indivisibility of human rights treaties".[155] The Vienna Convention on the Law of Treaties (hereinafter VCLT), which contains the rules on interpretation of international treaties, also supports the position that the CRPD is a relevant norm for the European Court: according to article 31(3), when interpreting international treaties, "any relevant rules of international law applicable in the relations between the parties" should be taken into account.[156] The CRPD is such a relevant rule in the areas where it overlaps with the ECHR.[157] Moreover, as a newer treaty, it should take precedence over the ECHR, because States Parties to the ECHR are also parties to the CRPD. According to article 30(3) of the VCLT, in the case of treaties "relating to the same subject matter", "the earlier treaty applies only to the extent that its provisions are compatible with those of the later treaty".[158] The ECHR itself contains a provision, Article 53, according to which the ECHR should not be interpreted in a way limiting or derogating rights provided by another treaty. Lastly, when interpreting the ECHR, the European Court has a long tradition of taking into account other international treaties which provide specific rules in certain areas. It is therefore a legitimate question to ask what caused the eventual divergence between the position of the European Court on involuntary mental health treatment and that of the CRPD Committee. Understanding the causes helps to outline what opportunities there are to close the gap between the two instruments.

The European Court has never accepted the CRPD Committee's categorical rule of prohibiting involuntary hospitalisation. A rejection of categorical rules, and reliance on proportionality assessments is a core feature of the Court's jurisprudence.[159] The interference with a patient's liberty or personal integrity must be balanced against their dangerousness to others or their protection from self-harm. Cases where restrictions are justified might be very exceptional, but because they exist,

[144] *Ilnseher v. Germany* [GC], no. 10211/12, judgment of 4 December 2018.

[145] *Id.*, para. 169.

[146] *Id.*, no. 10211/12, judgment of 4 December 2018, Dissenting opinion of Judge Pinto de Albuquerque joined by Judge Dedov, para. 30.

[147] Nilsson (2014), op. cit., 463.

[148] Fennell and Khaliq (2011), op. cit., 670.

[149] Lewis and Campbell (2017), op. cit., 49.

[150] Scheinin, M. (2017), The Art and Science of Interpretation in Human Rights Law. In B. A. Andreassen, H. O. Sano, & S. McInerney-Lankford (Eds.), *Research Methods in Human Rights: A Handbook*. Edward Elgar (17–37), 22.

[151] I am grateful to the anonymous reviewer for raising this point.

[152] Fitzmaurice, M. (2013). Interpretation of human rights treaties. In D. Shelton (Ed.). *The Oxford Handbook of international human rights law*. Oxford University Press (739–771).

[153] Greenwood, C. (2015). Unity and diversity in international law. In E. Bjorge, & M. Andenas (Eds.), *A farewell to fragmentation: Reassertion and convergence in international law*. Cambridge University Press (37–55).

[154] Popa, L. E. (2018). The holistic interpretation of treaties at the international court of justice. *Nordic Journal of International Law*, 87(3), 249–343, 343.

[155] Gowland-Debbas, V. (2013). The role of the international court of justice in the development of the contemporary law of treaties. In C. J. Tams, & J. Sloan (Eds.), *The development of international law by the international court of justice*. Oxford University Press (24–52), 47.

[156] Vienna Convention on the Law of Treaties (VCLT), 1155 U.N.T.S. 331, 23 May 1969, article 31(3).

[157] Flynn, E. (2016), op. cit., 91.

[158] VCLT, *op. cit.*, Article 30(3).

[159] Eissen, M.-A. (1993). The Principle of Proportionality in the Case-Law of the European Court of Human Rights. In: R. St J. Macdonald, F. Matscher, & H. Petzold (Eds.), *The European System for the Protection of Human Rights*, Martinus Nijhoff (1993).

every situation requires a careful consideration of which category they belong to.

The CRPD Committee sharply differs in this regard. It adopts categorical rules prohibiting exclusion even in these exceptional circumstances, and does not accept individual justifications for exceptions to the rule. The CRPD Committee has been frequently criticised for its seemingly unreasonable positions, not taking account of such exceptions.[160] However, these arguments criticise the Committee for the wrong reasons. The Committee must be aware of possible difficult cases. It does not provide a clear answer regarding how to deal with these cases by alternative means.[161] It nevertheless does not consider these considerations sufficient to change the categorical rule. One reason is that even if exceptional situations might exist, they are difficult to convincingly identify. In other words, if the CRPD Committee permitted the continued existence of involuntary hospitalisation and treatment, it could not ensure that it was not used unjustly against a large number of persons with psychosocial disability.[162]

On the other hand, the European Court almost always prefers to assess the individual circumstances of each case. For the Court, the existence of exceptional cases is a reason to avoid categorical rules, therefore it does not prohibit involuntary hospitalisation as such. This rests on the assumption that medical professionals can categorise individuals with reasonable precision, courts can meaningfully review these decisions, and the role of an international court is merely to oversee that the domestic bodies justify their position.[163]

The two bodies thus mainly differ with regard to their faith in medical and judicial decision-making: the European Court trusts national authorities to be able to convincingly identify persons who are a threat to society,[164] and accepts the marginalisation of these persons.[165] The European Court is also ignoring the polycentric impact of its decisions – the consequences for those persons who might be affected by it but are not parties to the proceedings before it.[166] It is not moved by arguments about the consequences of permitting restrictions based on dangerousness- and capacity-based classifications for persons with disabilities at large. It is merely acting as a forum of remedy for those individuals who were directly harmed by the domestic policies and were fortunate to be able to complain to an international court. In contrast, the CRPD Committee is adopting positions that have a large-scale positive benefit for all persons with disabilities.[167] The CRPD Committee is thus acting as an advocate for the whole community of persons with disabilities.

5. Towards a potential harmonisation of the two sets of norms

The CRPD and the ECHR are currently interpreted differently. However, their text is not an obstacle to harmonizing the interpretation of the two instruments. Article 5(1)e) of the ECHR permits involuntary hospitalisation, but currently does not require it to be available.[168] Psychiatric treatment only provided with consent would comply with both instruments.

For the sake of completeness, it should be mentioned that the CRPD's interpretation can also change in the future: with the change of the CRPD Committee's composition, the treaty's text is flexible enough to permit some form of involuntary hospitalisation. I do not wish to argue that this would be desirable, I am only mentioning this possibility.

Currently, neither treaty body shows willingness to adopt their counterpart's position. Full convergence is therefore unlikely until European countries successfully implement the CRPD through legislative reform, and can show that the abolition of involuntary treatment does not lead to adverse consequences in practice. This would presumably include finding alternative means to prevent harm to self and others, without resorting to deprivation of liberty, which would allay the European Court's concerns articulated by Judge Sajó in *Hiller*.

Notwithstanding the possibility of legislative reform on the national level, the CRPD is still a binding international treaty. It can be instrumental in highlighting the shortcomings of current mental health systems, motivating the European Court to take its own standards more seriously.

The social model of disability underpinning the CRPD has a lot to offer in this respect.[169] As expressed in Article 1 of the CRPD, disability is a result of an interaction between the person's impairment and various societal barriers.[170] In the context of mental health laws, taking this paradigm seriously would allow for a closer scrutiny of involuntary hospitalisation orders which are based on the review of the person's mental illness, without taking into account the person's support network and social environment. Unfortunately, such formalistic reviews are all too common across Europe.[171] Situations like this appear before the European Court, but it has so far failed to stress the social dimension of psychosocial disability as an important consideration for its own standards. Assessing the person's social environment has indeed often been missing from cases that come before the European Court, and the Court is not considering this issue as carefully as it could.[172] A promising past

[160] Neuman, G. L. (18 June 2017), Submission to the Committee on the Rights of Persons with Disabilities Regarding Draft General Comment on Article 5, Equality and Non-Discrimination, UN OHCHR; Dawson, J. (2015), *op. cit.*;, Freeman, M. C. et al. (2015), *op. cit.*

[161] Stein, M. A., Mahomed, F., Patel, V., & Sunkel, C. (Eds.)(2021), *Mental Health, Legal Capacity, and Human Rights*. Cambridge University Press, 5.

[162] Fennell, P. (2012). Institutionalising the community: the codification of clinical authority and the limitations of rights based approaches. In: B. McSherry, & P. Weller (Eds.), *Rethinking Rights-Based Mental Health Laws*, Hart (13–50).

[163] Fennell and Khaliq (2011), op. cit., 665.

[164] *Id.*

[165] Wachenfeld, M. (1992). *The Human Rights of the Mentally Ill in Europe.* Danish Centre for Human Rights, 128.

[166] On the polycentric nature of human rights adjudication see: De Schutter, O. (2005). Reasonable Accommodations and Positive Obligations in the ECHR. In: A. Lawson, & C. Gooding (Eds.), *Disability Rights in Europe: From Theory to Practice*, Hart (35–63).

[167] O'Cinneide, C. (2009), Extracting Protection for the Rights of Persons with Disabilities from Human Rights Frameworks: Established Limits and New Possibilities. In O. M. Arnardóttir, & Quinn, G. (Eds.), *The UN Convention on the Rights of Persons with Disabilities: European and Scandinavian Perspectives*, Martinus Nijhoff (163–198), 164.

[168] Bartlett (2012b), op. cit., 836.

[169] Stein et al. (2021), op. cit., 1.

[170] Lawson, A., & Beckett, A. E. (2021). The social and human rights models of disability: towards a complementarity thesis. *The International Journal of Human Rights*, 25(2), 348–379.

[171] Reid (2015), op. cit., 832.

[172] Bartlett (2013), op. cit., 354.

attempt shows that it is possible for the Court to engage with this issue more in detail.[173] A case currently pending before the Court is raising this same point, providing the Court with an opportunity to address it directly.[174]

The CRPD can also be used to conceptualise alternatives to involuntary hospitalisation and coercive psychiatric practices.[175] A large number of situations can be imagined where the authorities' default approach to a mental health crisis is hospitalisation, without exploring whether less restrictive alternatives might be available or should be available.[176] Even if these hospitalisations can be justified in medical terms, and thus accepted by the European Court on this basis, the CRPD Committee's insistence on alternatives can help patients contesting the necessity of these interventions if they can point to other forms of treatment or care measures which are or should be available to them.

The CRPD can also be instrumental in stressing the importance of legal capacity in opposing involuntary treatment. The European Court is commonly faced with situations when persons subject to involuntary hospitalisation are treated against their will, without their mental capacity proven to be limited or even put in doubt. Applicants can rely on the CRPD to argue for their capacity to be taken into account in such situations. The European Court has already done this implicitly in the above cited *Plesó* judgment, and made an important distinction between the formal status of restricted legal capacity and the person's actual mental capacity in *Sýkora* and *Shtukaturov*. Building on *Plesó* and taking the CRPD seriously has the potential to separate detention from treatment, or at least tighten the criteria for treatment in the case of persons who have clearly intact capacity.[177]

Article 17 of the CRPD, the right to personal integrity, has a lot of unexplored potential in this regard. During the drafting negotiations, it was the key article for restricting involuntary treatment, but its eventual wording is very truncated.[178] Its content is currently unclear, and it has received little attention from commentators and the CRPD Committee.[179] If the obligations following from it were clarified, it could provide new impetus for discussions on the justifications for involuntary treatment. *X. v. Finland* and *Plesó* already applied the concept of personal integrity. If the CRPD Committee provided more substance to Article 17 and how it affects patients' rights, the European Court could also explore further its application under the ECHR.

In contrast, the right to equality did not prove to be successful in influencing the European Court, contrary to some expectations.[180] The Court did not consider disability-specific measures such as involuntary hospitalisation as raising an issue under Article 14, the right to be free from discrimination.

The European Court shifted from an explicit endorsement of the CRPD to its explicit rejection in the area of mental health law. However, the CRPD's standards in this area go beyond merely outlawing involuntary hospitalisation. By taking certain elements of the CRPD seriously, the European Court could significantly improve its own standards, to the benefit of mental health patients who are victims of the overuse of hospitalisation and enjoy little protection from formal court reviews.

6. Conclusion

The CRPD's adoption presents a clear challenge for global mental health law, which has not been fully endorsed by the European Court of Human Rights. The Court was initially open to apply the CRPD as a relevant instrument for its standards on the rights of persons with disabilities, but it has not adopted the CRPD Committee's positions on involuntary hospitalisation, involuntary treatment, the role of capacity in treatment decisions, the permissibility of certain psychiatric practices, and dangerousness as a basis for detention. After initial attempts to find common ground with the CRPD Committee, the Court explicitly rejected the abolishment of involuntary hospitalisation in *Rooman v. Belgium*, taking a position irreconcilable with the CRPD.

This article argues that such a conflict is primarily not caused by the Court's lack of understanding of disability or the CRPD's vision, even if that might be a factor. The Court and the CRPD Committee simply see their roles as international bodies differently, and are emphasising different types of risks. The CRPD Committee wishes to prohibit involuntary treatment, even in difficult circumstances, among other reasons because law could offer little protection against its overuse by medical professionals. The European Court is commonly faced with examples of unjustified use of involuntary treatment, but it is of the opinion that prohibiting the practice in its entirety would endanger the life and health of persons currently protected by it. It has dealt with cases of deaths caused by too little restraint, as opposed to too much restraint, which is the CRPD Committee's main concern.

Until states find a solution for alternative forms of care for all persons with psychosocial disability, including those in the most serious conditions, it is unlikely that the interpretation gap between the two treaty bodies can be closed. However, that does not mean that the CRPD is irrelevant for the European Court in this area. Doctrines underlying the CRPD, such as the social model of disability, the recognition of capacity, less restrictive alternatives, and the right to personal integrity, can be key to exposing failures of the current mental health systems to prevent unnecessary hospitalisation. This can lead to highlighting how the European Court's current standards are unable to protect patients in psychiatric hospitals from interferences with their rights. The CRPD can put new fire into the ECHR's existing standards, and achieve a higher level of protection from arbitrary decisions.

Vice versa, the ECHR is far from irrelevant for the CRPD. The European Court's acceptance of the CRPD can provide considerable authority to the CRPD Committee. Developments in the European Court's case law could signal what norms under the CRPD are unconvincing, and need to be clarified by the CRPD Committee. They can also provide evidence of the negative consequences of some approaches, as the example of detention on the basis of dangerousness delinked from disability shows.

These developments would lead to reducing involuntary hospitalisation instead of eliminating it. This does not reach the CRPD Committee's position of prohibiting the practice. Nevertheless, they would decrease the discrepancy between the two instruments, and also create a

[173] The case of *Mitev v. Bulgaria,* no. 42758/07, decision of 29 June 2010, considered the question of placement in an institution not only from the perspective of Article 5, the right to liberty, but also under Article 8, the right to private life, assessing the connection between institutionalisation and the applicant's social environment. The European Court's Grand Chamber held a hearing in the case, which shows that they considered the issue carefully. Unfortunately, the applicant's death did not permit the Court to continue the examination of the case, it was struck out of the list.

[174] *Benitóné Martinez Fernandez* v. Hungary, no. 30814/22, currently pending before the First Section of the European Court, raises a detailed complaint regarding the relevance of the applicant's social environment for the justification of involuntary hospitalisation.

[175] Flynn, E. (2016), op. cit., 100.

[176] Bartlett (2012b), op. cit., 842.

[177] Szmukler, G., Daw, R., & Callard, F. (2014). Mental health law and the UN Convention on the rights of persons with disabilities. *International Journal of Law and Psychiatry*, 37(3), 245–252.

[178] Bartlett (2012a), op. cit., 756.

[179] McSherry, B. (2008), Protecting the Integrity of the Person: Developing Limitations on Involuntary Treatment. *Law in Social Context*, 26 (2), 111–124.

[180] Flynn, E. (2016), op. cit., 78.

better starting position for considering the abandonment of involuntary hospitalisation in practice.

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Declaration of competing interest

None.