Involuntary Placement and Treatment of Persons with Psychosocial Needs

by Nino Karanadze

Human Rights M.A. THESIS

PROFESSOR: Bárd, Petra Dóra

Central European University

1051 Budapest, Nador utca 9.

Hungary

ACKNOWLEDGMENTS

This paper would not be possible without the guidance and mentoring from my advisor Dr. Petra Bárd. Thank you for helping me make sense of my project and encouraging me to find my voice.

Many thanks to my CEU family, to my classmates and professors, who have become my role models and shaped my academic journey.

I must express gratitude to all the people I have interviewed for my research, and to those who have offered their advices and shared their experiences. Your help was immense.

Special thanks to my family and friends, for your continuous love and support. Thank you for being with me throughout this emotional and intellectual roller-coaster and making me feel like I can do anything.

Contents

Executive Summary 1
Chapter 1: Introduction 2
Chapter 2: The Mental Health debate 5
Chapter 2.1: Chapter summary and concluding remarks 9
Chapter 3: Council of Europe Standard and the ECHR Case Law 11
Chapter 3.1: Involuntary placement and concept of "unsound mind" in ECHR case law 14
Chapter 3.2: ECHR case law and COE standards concerning involuntary treatment 22
Chapter 3.3: ECHR case law concerning involuntary treatment 27
Chapter 3.4: Chapter summary and concluding remarks 29
Chapter 4: Involuntary treatment and placement in Georgia 31
Chapter 4.1: Chapter summary and concluding remarks 40
Chapter 5: Involuntary treatment and Placement in Sweden 41
Chapter 5.1: Assessment process and procedures 45
Chapter 5.2: Chapter summary and concluding remarks 48
Chapter 6: Analysis 50
Concluding Remarks 61
Bibliography 63

Executive Summary

This thesis examines a controversial and sensitive issue of involuntary treatment and placement of persons with psychosocial needs under the framework of Council of Europe and the ECtHR standards as well as Georgian and Swedish national jurisdictions. The thesis sets out to analyze which interests should prevail in the context of involuntary hospitalization and/or treatment: the state legitimate interest or the person's autonomy and right personal integrity.

The paper argues that the national legislations need to see involuntary placement and treatment as separate measures and the standards should differ accordingly. The fact that person is dangerous due to their mental health condition could be legitimate grounds for placement, however, long term involuntary treatment under any circumstances is unjustified, since it inherently violates personal autonomy and the principle of informed consent which is fundamental to medical world. The actions aimed at restoring person's autonomy and stabilizing the critical situation at hand are justifiable as immediate emergency measures, and should be terminated at the point when the patient autonomy is restored. Otherwise, subjecting a person to the compulsory treatment is unreasonably paternalistic.

Chapter 1: Introduction

The famous image of Philippe Pinel singlehandedly breaking the iron shackles in Bicerte Hospital, at the suburbs of Paris, has become a symbol of modern, more humane metal health care. This action could be considered as a birth of psychiatry, as we know it, which fostered the liberation of the psychiatric patients from the chains of "generic segregation" and moved the conversation regarding mental health into general field of medicine. However, since that time, asylums have soon turned into large scale custodial institutions, and even after the process of deinstitutionalization and advances in the field of psychiatry (both in terms of medical advances and changes in legal systems as well as social attitudes and awareness), the field of psychiatry and mental health care has yet to move away from restrains and compulsory treatment of individuals. This paper will analyze involuntary treatment, as one of the last, and definitely not the least, chains to be broken towards the end of the process Pinel started in the beginning of the 19th century. [1]

Among the persons with disabilities, persons with psychosocial needs represent the most vulnerable group, as they are more likely to be subject to coerced treatment and limitations of their rights and freedoms. Often, such persons are treated as patients, who are stripped of decision-making power regarding one of the most private and confidential aspects of life, such as one's health. Instead, the decision-makers are doctors (who tend to assess the situation in strictly technical/medical terms, often underestimating other relevant social factors), relatives, designated individuals and state, even. Can this type of intervention be justified? And if yes, what could be legitimate state interest that justifies such interference.

[1] Agnetti, "The Consumer Movement and Compulsory Treatment."

In the 21st century, where the principle of informed consent is considered to be fundamental in the medical sphere, the persons with psychosocial needs are frequently subject to involuntary treatment and admission. To this day, in some jurisdictions, mental health laws do not distinguish involuntary placement and treatment, and hospitalization necessarily involves consequent medical intervention.

Considering the human rights' and ethical risks associated with compulsory hospitalization and involuntary medical intervention, the issue needs to be evaluated in the context of person's right to health, and needs to be justified with strong argumentation and legitimacy. In relation to the treatment and placement decisions, while it is true that the assessment of state legitimate aim, such as the protection of others (safety and security argument) and the patient's health interests, is an important consideration, this paper will argue that the individual personal autonomy and the right to informed consent should prevail. In that regard, this paper analyzes the person's subjection to treatment and involuntary placement in the context of number of rights and freedoms, such as right to health (including informed consent), right to liberty, personal integrity and autonomy.

The objective of this paper is to evaluate the scope of the rights of persons with psychosocial needs according to different international standards (such as COE and the case law of the European Court of Human Rights) and analyze whether persons with mental diagnosis can be justifiably subject to involuntary treatment and hospitalization. The research question the paper sets out to answer is the following: When making decisions regarding involuntary placement and/or involuntary treatment which interests should prevail: the state legitimate interest or the person's autonomy and the right personal integrity.

It is important to discuss what legitimate interest the state has in the context of involuntary treatment and hospitalization, which rights are potentially under risk in such cases and how the balancing takes place in different situations. In that regard, this paper will discuss the scope of rights and freedoms of the persons with psychosocial needs under the framework of Council of Europe as well as how Georgian and Swedish national jurisdictions understand this issue; In each jurisdiction this paper will analyze how the beneficiaries of the mental health laws are involved in their health related decision-making process. It needs to be emphasized that this paper does not address the situation where the compulsory treatment is understood in the context of criminal law, meaning that due to their mental health situation, the perpetrator is subjected to compulsory hospitalization and the consequent treatment, instead of going to prison.

It is important to evaluate not only the legal framework on the international level, but also the implementation of international standards on the domestic level, as well as the national legal environment and practice. In order to discuss these issues, I will scrutinize relevant international standards, documents regarding guidelines for implementation, state practice, analysis of international and national case law, research documents and interviews from persons involved with psychiatric institutions, as well as state reports and shadow reports (NGO reports), legal acts, statistics and other official primary and secondary sources.

Chapter 2: The Mental Health debate

Mental health concerns us all. In fact, according to the European Parliament Resolution (2006), in Europe, one in four people experience at least one major episode of critical mental health situation throughout their lives. Mental health related issues affect everyone whether directly or indirectly, as mental health conditions have serious social and economic repercussions not only for the persons with psychosocial needs but also those who are indirectly affected by it (relatives, friends and family, fellow citizens). Human psyche is complex. What makes the situations particularly difficult is the lack of information and the need for constant "systemic research". Much work needs to be put towards developing relevant discussion points and producing necessary information in order to gain appropriate knowledge and promote adequate approaches and perspectives to tackle complex mental health issues in order to secure mental health, as a precondition to overall health of the persons. The Resolution points out that measures taken towards prevention and/or timely treatment of mental health problems represents an actual state interest, among other things, considering that "healthy" citizens contribute to the well-being of the society overall.[2]

The EU Parliament Resolution stresses on the importance of "dignity and humanity" in the context of providing support and mental health care to the persons with mental health issues. In that regard, the document emphasizes on the instrumental concept of user empowerment, underlining that the persons concerned should be consulted on their own health related matters and their opinion should be taken into consideration. Moreover, according to the resolution, it is the responsibility of health care professionals to provide all the necessary information to the

[2] European Parliament, "Improving the Mental Health of the Population - towards a Strategy on Mental Health for the EU - P6_TA(2006)0341."

patients regarding the safe methods to withdraw from the treatment, if they wish to do so.[3] The Parliament Resolution condemns the use of force in the treatment process. It criticizes the compulsory medication, classifying it as "counterproductive", and calls for applying the medical intervention only after obtaining free and informed consent from the patients themselves and in the absence of it, from the relevant authorities "only as a last resort". The Resolution also discusses the existing stigma (including among medical professionals) and misconceptions, which, by their very nature, undermine anti-discrimination practices at hand. Therefore, in the opinion of the EU parliament, tackling stigma must "be at the heart of any future strategy".[4]

In her paper, Angetti refers to the debate regarding the issue of involuntary/compulsory treatment of patients with Schizoprenia, conducted by the National Empowerment Center, the US based organization assisting individuals and patient oriented groups in the process of advocacy and lobbying for changes in the mental health system.[5] Major proponent of compulsory, involuntary treatment was E. Fuller Torrey, American psychiatrist specialized in Schizophrenia and long term contributor to the journal of the American Psychiatric Association (APA). According to Torey, there is a significant danger of no-intervention and the consequences simply cannot be overlooked. Torrey pointed out number of compelling arguments in favor of involuntary/compulsory treatment. He argued that psychosocial disability needs to be understood in the light of practical, social and medical issues. From medical (biological) perspective, mental disorders are closely linked with "impaired awareness", which will likely cause social problems for the individual, bringing practical considerations, such as public safety in the center of the debate. According to the research cited by Torrey, persons with mental diagnosis (history of

[3] Ibid., para 32.
[4] Ibid., paras 32-35.
[5] National Empowerment Center

mental illness) are responsible for 4.3% of all cases of homicide.[6] However, in their paper Gert Helgesson and Manne Sjostrant refer to the contrary statistical data pointing to the fact that in most cases persons with psychosocial needs are not violent and, hence, do not pose threat to the society.[7] Lastly, Torrey affirmed that forced treatment leads to favorable medical results, since it increases submission rates to medication or other measures. As Agnetti points out, the baseline of Torry's argument is that patients could be subjected to hospitalization and treatment involuntarily at first, however in most cases they will continue the treatment in voluntary terms, after they see the improvements in their mental health and the overall positive results. On the other side of the argument stood Judi Chamberlin, human rights activist from survivors' movement. Chamberline referred to the research which suggests that involuntary treatment does not lead to more favorable results, and, in fact, those who would otherwise voluntary agree to be treated in the hospital, are reluctant to be admitted exactly because they are scared of the controlled and involuntary treatment they will potentially be subjected to. As a concluding argument Chamberline quoted C.S. Lewis: "but those who torment us for our own good will torment us without end for they do so with the approval of their own conscience. ... To be "cured" against one's will and cured of states which we may not regard as disease is to be put on a level with those who have not yet reached the age of reason". [8] According to Agnetti, this debate is a clear indication of clash/disparities between the strictly medical based model supported by Torrey and social-survivor centered approach advocated by Chamberline.[9]

In her paper Consumer Movement and Compulsory Treatment: Professional Outlook, Germana Agnetti refers to the success story proved by Mosher's Soteria Houses, where young, trained

[6] Ibid., Agnetti
[7] Sjöstrand and Helgesson, "Coercive Treatment and Autonomy in Psychiatry."
[8] The full debate can be found at National Empowerment Center's Website at http://www.power2u.org/debate.html
[9] Ibid, Agnetti

professional staff with acute listening skills and a sense of awareness, empathy and understanding, are contributing to creating therapeutically beneficial environment for the patients with recent diagnosis of Schizophrenia. Soteria project proved the importance of the surrounding environment, and delivered astounding results, showing that the patient's psychotic episodes can be overcome with little or no involvement of medication. Instead, Soteria Houses' staff concentrated on fostering meaningful, personal relationships with the patients, based on support and understanding.[10] The expert in mental health issues, with whom I spoke for the purposes of this paper, also shares this view. According to her, non-medical interventions and more "social, spiritual environment", where the patients with mental health issues will be able to release the stress factor which has contributed to their critical episode is much more beneficial than involuntary medical treatment.

Agnetti finds it important to specify the different approaches and perspectives coming from psychiatric field professionals and persons with mental diagnosis (so-called "consumers"). The main challenge is that priorities differ. Healthcare professionals are concentrated on relief of medical symptoms and prevention of future complications. Consumers, on the other hand, understand the issue from the perspective of individual decision-making (principles of autonomy and self-determination) and the importance of subjective experiences. When traditionally in the medical field "subjective experience" is understood solely as a competence of the healthcare professional (doctor's expert- interpretation), pro-consumer groups take "experience as a grounds for individual empowerment".

Agnetti asserts that some consumer oriented groups and organizations are proposing advance psychiatric directives. The purpose of the directives, as a legal instrument, will be providing feasible alternative to compulsion. This will increase patient participation, since the person will

[10] "Schizophrenia Treatment Without Antipsychotic Drugs and the Legacy of Loren Mosher."

be able to assign/name the decision makers in case of potential psychotic episode which will jeopardize their awareness.[11]

Other viable attainable alternative Agnetti notes is Berlin Runaway House. Established in 1996, after 10 years of advocacy and lobbying from consumer groups, House acts as anti-psychiatric institution where the staff mainly act as facilitators. The House staff does not necessarily have psychiatric degree or qualifications, what is more important is their personal characteristics, such as empathy, experience and ability to manage the stressful situations. In fact, half of the staff are survivors of psychiatry themselves. In this respect, because of the shared struggle, they provide valuable knowledge and experience to the residents. The "patients" stay in the residence for up to six months and receive support without any kind of medical treatment. The cited statistics suggest that longer the residents stay in the House, the more likely it is that they move away in their own accommodation. [12]

Chapter 2.1: Chapter summary and concluding remarks

Chapter 2 presents the relevance of involuntary treatment and placement of persons with psychosocial needs and noted that the mental health issues affect everyone, whether directly or indirectly, therefore it is in the interest of the state to promote mental health and well-being of its citizens. What makes the issue particularly difficult to tackle is lack on information and continuous need for systemic research. In the context of treatment and placement decisions, EU Parliament resolution emphasizes on the used empowerment and condemns compulsory medical

[11] Idid., Agnetti.
[12] Iris Holling, "The Berlin Runaway-House - Three Years of Antipsychiatric Practice."

intervention. According to the Resolution, persons with psychosocial needs have to be consulted prior to any kind of medical treatment and their wishes need to be taken into consideration.

Arguments for and against involuntary treatment and placement are as follows. According to the proponents of compulsory/involuntary treatment, patients with mental health issues suffer from "impaired awareness" which could be clouding their judgment and therefore, in practical terms their subjection to involuntary treatment is justified in order to avoid safety and security concerns. Moreover, persons might first involuntarily undergo mental health related medical intervention, however soon after they themselves see the satisfactory results and improvements in health, they will voluntarily continue the treatment. Central to this line of reasoning is "dangerousness criteria" and the proponents cite statistical data according to which there is an increased risk of violence if the mental health condition is not treated properly in a timely manner. On the other hand, those who are against compulsory placement and treatment take more social-survivor centered approach, as opposed to strictly medical standpoint. According to them, compulsion is counterproductive and those patients who would otherwise consent to treatment refuse to do so because of the involuntary controlled environment, where the subjective experiences are not taken into account. The opponents refer to the success stories such as Berlin Runaway House and Soteria project, where even critical "psychotic episodes" are handled without medical intervention, in a "social-spiritual environment".

Chapter 3: Council of Europe Standard and the ECHR Case Law

A sensitive and controversial issue of involuntary treatment and placement of persons with psychosocial needs to be discussed under the framework of number of relevant fundamental rights. With regards to involuntary treatment the most obvious linkage is prohibition of torture and ill treatment, as well as the protection of the right to privacy, involuntary placement/hospitalization needs to be understood in the context of right to liberty. [13]

The EU law, which is the complementary legislation for the member states, does not directly deal the issues of involuntary treatment and placement, however under the framework of the EU legislation, the most relevant discussion will be based on Charter of Fundamental Rights, more specifically: Right to integrity of the person (Article 3), which concerns both the physical and mental integrity and stresses on the free and informed consent; [14] Prohibition of torture and inhumane treatment (Article 4); Right to liberty and security (Article 6); Respect for private and family life (Article 7); Prohibition of discrimination of grounds including disability (Article 21); Recognizing and respecting measures to ensure the independence and social integration of persons with disabilities (Article 21); Access to healthcare and high level health protection (Article 35). [15]

Further guidance comes from European Parliament resolutions. In particular, resolution of September 6, 2006 concerning the improving of mental health of the population, states that persons with mental health issues ought to be treated with dignity and respect and that they should be empowered to participate in the decision making process with respect to the treatment

[13] FRA – European Union Agency for Fundamental Rights, "Involuntary Placement and Involuntary Treatment of Persons with Mental Health Problems."
[14] Charter of Fundamental Rights of the European Union. (2000/C 364/01). Article 3.
[15] Ibid., FRA

options available to them (para 32). As described in the previous chapter, the resolution also takes a stance that necessary information and guidance should be provided to those who wish to withdraw their consent and terminate the course of treatment. The document makes an important point that compulsory (involuntary) treatment, as well as use of force is counterproductive, it should be limited and used only as a "last resort" measure, under the scrutiny of the relevant authorities, as defined by the law. Resolution also addresses the issue of stigma and its effects on the well-being of persons with mental health issues. Interestingly, paragraph 35 takes a view that existence of stigma is also relevant in the community of the mental health professionals.[16] Green Paper on "improving mental health of the population" states that discrimination and stigmatization as well as disrespect of rights and dignities of "mentally ill" is still prevalent and is fundamentally contrary to European values.[17]

Although European Convention of Human Rights does not explicitly mention health related legal standards, European Court of Human Rights in its practice has dealt with number of cases, which contributed to the development of the extensive case law regarding health related matters. Moreover, ECtHR cases also frequently cite relevant international documents, such as recommendations regarding health field by the Committee of Ministers, European Social Charter (see Molka v Poland) and Oviedo convention in Glass v UK, which concerned the administration of opiate-based painkiller -diamorphine after the boy with severe mental and physical disabilities (and severe respiratory problems) was believed to enter critical terminal state. Administration of the medication was done without applicant's mother's free and informed consent. Moreover, the attending doctors signed "do not resuscitate" form contrary to his mother's wishes. According to

[16] Ibid., European Parliament, "Improving the Mental Health of the Population - towards a Strategy on Mental Health for the EU.
[17] "Green Paper - Improving the Mental Health of the Population - Towards a Strategy on Mental Health for the European Union."

the Court, the UK regulation setting guidelines to resolve the conflict between the patient's family members and doctors was not contradictory to the Oviedo Convention, since the healthcare professionals were acting in the best interest of the patient and believed that their actions would lead to positive results. Instead, the ECtHR evaluated, whether the medical decision to administer the medication contrary to the mother's wishes (and against her expressed, free and informed consent) should be considered by the national court. The ECtHR found the violation of Article 8 of the European Convention of Human Rights, because of the missing final decision-making power of the court;[18] As a general standard, the convention puts negative and positive obligation on the state in terms of safeguarding rights and freedoms in the health related sector. To fulfill the negative obligation, states need to refrain from unjustifiable interfering in the person's right to health. Positive obligation includes the obligation of the state to ensure the protection of the health of individuals. Relevant articles for the protection of right to health in the scope of the convention are Article 2 (Right to life), Article 3 (freedom from Torture and Inhumane Treatment), especially important is Article 8 (Right to Respect for Private Life) for the cases dealing with physical and psychological integrity of the person), Article 5 (unlawful deprivation of liberty) and Article 14 (non-discrimination- health is one of the protected grounds for discrimination). [19]

[18] Glass v. United Kingdom, App. no. 61827/00, ECtHR 2004.
[19] ECtHR, Thematic Report

Chapter 3.1: Involuntary placement and concept of "unsound mind" in ECHR case law

The European Convention of Human Rights does allow deprivation of liberty on grounds of "unsound mind". Such wording can be found in Article 5 (Right to Liberty) of the convention: (e) "the lawful detention of […] persons of unsound mind […]." Exhaustive body of case law regarding deprivation of liberty of persons with mental health problems provides a comprehensive overview of how ECHR understands the above mentioned concept.

In landmark case of Rakevich v. Russia, where, for the first time, Russian psychiatric system was subject to scrutiny from European Court of Human rights, the court found violation of Article 5, paragraphs 1 and 4 of the convention. The applicant, Tamara Rakevich, was involuntarily placed in a psychiatric hospital, after her acquaintance, with whom Rakevich had a disagreement over a text of bible, called an ambulance. Rakevich was diagnosed with paranoid schizophrenia, however neither the applicant nor her lawyer had access to the medical assessment documents provided by the panel of doctors. The European court discussed the concept of "unsound mind" and noted that due to evolving medical as well as social attitudes, there is no precise definition of the concept (para 26). Moreover, the court provided the criteria according to which the hospitalization/placement decision can be made according to Article 5.1 (3): a) the patient suffers from a true mental disorder and this is proven by an objective medical diagnosis, b) the disorder in its nature calls for involuntary confinement, c) the disorder is present throughout the period of confinement. The court, eventually found a violation due to the lack of procedural grantees, namely the fact that the local district court took unreasonably long time (39 days) to hear the case and produce detention order and the applicant was unable to "seek judicial review of the detention". The ECHR ordered the respondent state to pay 3,000 Euros for non-pecuniary

damages, "distress, anxiety and frustration" suffered by Tamara Rakevich during her detention (para 52).[20] According to, Yuri Savenko, a chairman of "Russian Association of independent Psychiatrists", the circumstances of this case are rather typical in the region. In fact, aside from involuntary confinement being the usual, the local courts take minutes to decide on individual cases and often these decisions are simply formal affirmation of earlier decisions made by healthcare professionals, the process takes place in absence of the person concerned or his/her legal representative and consequently, the patient's needs and rights are simply neglected. [21] In other words the court decisions are blanket decisions mirroring the conclusions made by psychiatrists. As Savenko puts it: "health is understood assomething purely biological, and a patient's rights are irrelevant".

In the Rakevich case, the ECHR relied on Winterwerp v. The Netherlands, where the court discussed in detail the meaning of the "unsound mind". Interestingly, the court recalled that the societal attitudes and perceptions towards mental illnesses tend to change, as well as the psychiatric studies in researching the issues of mental health is continuously progressing, resulting in "flexibility in treatment" (para 37).[22]

Analysis suggests that the court takes into account number of factors, including type, duration and the effects of a mental health issue and how the measure (involuntary placement, in this case) is being implemented. In Stanev v. Bulgaria, the court dealt with the following issue: the applicant, native of Ruse, Bulgaria, who was diagnosed with Schizoprenia, was regarded to be 90% disabled, however he was not in need of special assistance. Because of his diagnosis, Stanev family members neglected him and he was assigned guardian by the state. The guardian was a

[20] Rakevich v. Russia, App. no. 58973/00, ECtHR 2003.
[21] Savenko, "Rakevich v. Russia"
[22] Winterwerp v. The Netherlands, App. no. 6301/73, ECHR, 1979.

person previously not know to Stanev. In 2000, Stanev was deprived of legal capacity under the ruling of the Regional Court. The applicant was no way involved in the court process determining his legal status. As Stanev was deprived of his legal capacity and placed under the guardianship, he was practically and legally unable to make any decisions regarding his life and his health, in particular. As a result, in 2002, without his prior knowledge or consent, Mr. Stanev was picked by an ambulance and was taken to the psychiatric institutions. Not only Stanev did not consent to the decision to be admitted in the psychiatric unit, he was actively against leaving his residence. He was not given appropriate information regarding the duration of this stay in the unit or the purpose of his admission. The court found the violation of Article 3 and the Article 6 of the ECHR. The circumstances he was living in, while he was being detained was found "degrading", hence the violation of Article 3. As for the Article 6, the Court found that the Bulgarian legislation did not provide Stanev with mechanisms/measures to appeal against his legal status and restore his legal capacity. The court did not find it necessary to consider Article 8 claims, regarding the deprivation of legal capacity. Dissenting opinions of the two judges provide an interesting argumentation. According to Judge Kalaydjieva, the main issue of this case was "legal capacity" and arbitrary interference in the private life of the individual. Hence, Kalaydjieva noted that she would have found the violation of Article 8. [23] In fact, had Mr. Stanev been able to exercise his legal capacity and not be dependent on the goodwill of his guardian, he would be able to refuse to give consent to be taken to the psychiatric unit and he would also seek for legal remedies, for being subject to involuntarily placement and treatment. It is important that according to the court any measure, which is based on the decision not taking into account the opinion of the interested person needs to be assessed with "great scrutiny", since such instances may give rise to situations where the rights of the persons are disregarded and abused (para 153)

[23] Stanev v. Bulgaria, App. no. 36760/06, ECtHR 2012.

In D.D. v Lithuania, the applicant was suffering from "episodic paranoid schizophrenia", and in certain instances she would lose control over her actions. Her mental diagnosis progressed as she found out that she was adopted. As her mental diagnosis worsened, she was placed in the institution for persons with mental disabilities, upon the request of her father. According to the facts of the case, her father refused to care for her, as they had a conflict. Upon admission in the psychiatric institution, she not only was deprived of her liberty, but also was subjected to involuntary medical treatment. Physicians administered her medication without prior free and informed consent. Not only that she did not give consent to the procedure, she deliberately objected to the medical treatment and her admission/stay in the institution, however her pleas were left unheard. After losing her legal capacity, she lost her right to take part in the decision making process regarding her health and life. Nonetheless, the court found no violation of Article 5, since, according to the court, her deprivation of liberty was not arbitrary. [24] In this case, the court did not distinguish between involuntary admission (deprivation of liberty) and compulsory medical treatment. This is problematic and will be discussed in greater detail in the following chapters.

In X v. Finland, the court took a different stand. The ECtHR found the violation of Article 8 of the Convention, because of the involuntary medical treatment during the applicants stay in the psychiatric unit. The European court still did not find involuntary confinement in the psychiatric care institutions problematic, however, it ruled that the necessary safeguards were missing. According to the facts of the case, the healthcare professionals/doctors who were primary decision makers in the process of extending her institutionalization period, were working in the same psychiatric unit, therefore, there was no appropriate system of checks and balances.

[24] D.D v. Lithuania, App. no, 13569/06, ECtHR 2012.

Moreover, the applicant did not have effective possibilities to seek the legal remedy and appeal her case in the court, since, according to the domestic legislation, the procedure could only be initiated by the institution.[25]

In the case of Herczegfalvy v. Austria, the applicant was detained in the psychiatric institution for offenders with mental diagnosis. Applicant was alleging the violation of Article 8, because of the interference with his communication to his family members, as well as Article 3 for the coercive medical intervention and compulsory feeding. The court asserted that it is the competence of healthcare professionals to decide on the measures which will be more medically beneficial to the patient. Rights protected under Article 3 are of fundamental nature, however the court ruled that Article 3 did not apply and the "medical necessity" was justifiable interest. As for the interference with the communication, the court found the violation of Article 8.[26]

Another set of cases the court dealt with concerns the necessity to control and supervise the person due to the fears that he/she will cause harm to themselves or others. The court addressed this issue in Hutchinson Reid v. the UK. The court referred to its previous case law and stated that the person may be subject to compulsory confinement, not only when there is a need for treatment in the medical sense (in other words where the medical intervention can alleviate the persons mental health condition, but also when he/she is in need of the supervision to avert the risk of self-harm or harm to others (para 52)). In that line, the court concluded that the applicant's detention was justified in terms of Article 5, due to the finding that upon release

[25] X. v. Finland, App. no. 34806/04, ECtHR 2012.
[26] Herczegfalvy v. Austria, App. no. 10533/83, ECtH 1992.

would likely impose risk due to his "mental disorder manifesting itself in abnormally aggressive behavior" (para 53).[27]

The court has also dealt with the principle of necessity to inform the patient the reasons of detention, as set out in Article 5. In Van der Leer v. the Netherlands, ECHR reasoned that the term "arrest" as understood by Article 5 (2) also applies beyond the concept/measures of the criminal law cases, in other words Article 5 covers both situations, where the person is arrested on criminal charges and detained for other reasons, as is the case for persons with psychosocial needs. The person concerned cannot effectively enjoy the right to have his/her case speedily decided without having access to the necessary information covering the reasons as to why the deprivation of liberty is justified. In that regard, the court found the violation of Article 5 (2), reasoning that the information regarding her status in the facility (specifically the fact that the patient was not allowed to voluntarily leave the premises of the institution) was communicated to the applicant 10 days late (paras 27-31). It is interesting to note that the patient entered the facility voluntarily and her status was changed without informing her.[28]

In terms of reviewing the lawfulness of detention, in order to fulfill the conditions set in Article 5, para 4 of the ECHR, number one guarantee must be speedy review by the competent judicial authority. The court discussed this issue in the number of cases, including Kolanis v. the UK, where the applicant was not able to have the court review his case for over a year (para 82). Subsequently, the court found the violation of Article 5 (4).[29] The similar guarantees are set in the CPT Committee standards, according to which a person, who is involuntarily placed in the

[27] Hutchison Reid v. The United Kingdom, App. no. 50272/99, ECtHR 2003.
[28] Van Der Leer v. The Netherlands, App. no 11509/85, ECtHR 1990.
[29] Kolanis v. The United Kingdom, App. no. 517/02, ECtHR 2005.

facility upon the decision of a non-judicial body must have an access to the court and the lawfulness of the placement should be speedily decided by the competent authority. [30]

In addition to reviewing the ECHR case law, it is important to discuss other CoE safeguards in the context of involuntary placement of persons with mental diagnosis. For the purposes of this paper, I will discuss the Convention on Human Rights and Biomedicine (Oviedo Convention) and Recommendation Rec(2004)10 of the Committee of Ministers.

More detailed guidance can be found in CoE Committee of Ministers Rec(2004)10. The principles elaborated in the document confirm the standard set by ECHR case law and are based on the interpretation of the Convention and its relevant articles (Article 5 in particular). By setting a threshold for involuntary placement and treatment decisions, it promotes an unified approach to be followed by CoE Member States. [31]

Article 17 of the Rec(2004)10 specifies 5 criteria for the involuntary placement decisions:

a) the person has a mental diagnosis (note that person may be put under involuntary placement to establish whether he/she has mental disorder); b) person's mental condition poses considerable risk to his/her health or to others; c) placement has beneficial, "therapeutic purpose"; d) there are no less restrictive alternatives available; e) the wishes of the interested person has been taken into consideration. It is important to note that in order for the involuntary placement to be justified all 5 criteria must be met and the placement should be terminated if any one of the listed above no longer applies.

The principle of least restrictive alternatives is further elaborated in Article 8, according to which the persons with mental disorders have the rights to be placed in the least restrictive environment

[30] Council of Europe, CPT (2010), para 53.
[31] Ibid., FRA report

and the methods of treatment should be "least intrusive", considering their health or safety needs, as well as needs of others. [32]

Once the admissibility criteria is covered, the next question is who should have the competence and expertise to make decisions regarding involuntary placement. According to the Rec(2004)10, the relevant organ to make placement decisions should be the court or other competent body, taking into consideration the wishes of the interested person (through the representative, if the situation calls for it) and basing its decision on the medical examination conducted by the doctor with appropriate experience and credentials. The placement decision should be appropriately documented and reviewed. Article 25 sets out the review procedure. Article states that the interested person must be able to appeal the placement/treatment decision and its continued application (lawfulness of the measure) to the court and have the case reviewed speedily.

[32] Article 8 of the Rec(2004)10

Chapter 3.2: ECHR case law and COE standards concerning involuntary treatment

It is important to analyze the existing link between involuntary placement and treatment. In fact, the need for treatment and the therapeutic purpose of the procedure is used as a justification for compulsory placement. The similar line of reasoning is used in Article 17 of CoE Recommendation Rec(2004)10. However, in the case law of ECHR it can be observed that the court establishes the standard where the therapeutic purpose is not necessarily the precondition for placement and the person may be involuntarily confined "not only when the person needs […] treatment to cure or alleviate the condition, but also when the person needs control and supervision..".[33]

Before analyzing the Council of Europe approach to this issue, it is important to provide a brief overview of CRPD standards. Article 15 of convention clearly states that "no one shall be subject to medical or scientific experimentation" without their free (and informed) consent. Article also addresses inhumane and degrading treatment and asserts that national legislations, aiming at prevention and combating inhumane and degrading treatment should consider persons with disabilities on equal basis with other citizens.[34] It is noteworthy for that forced or involuntary treatment and placement has been omitted in the text of the article as the result of the negotiations. Considering this, the Art. 15 needs to be understood together with Articles 17 ("Protecting the integrity of the person") and 25 ("Health) of the Convention. Article 25 explicitly discusses right to health. The opening sentence of the article emphasizes on the principle of non-discrimination in the context of accessing highest standards of health. Most importantly, paragraph d. of Article 25 makes it a requirement for the medical personnel (health

[33] Hutchison Reid v. The United Kingdom, App. no. 50272/99, ECtHR 2003.
[34] See CRPD, Article 15

professionals) to provide similar quality care to persons with disabilities, which necessarily is based on "free and informed consent". [35]

Committee has stated in number of reports that involuntary psychiatric treatment is in violation of Article 17 (the right to equal recognition before the law and an infringement of the rights to personal integrity), Article 15 (freedom from torture) Article 16 (freedom from violence, exploitation and abuse) and Article 12 (legal capacity). According to General Comment equal recognition of persons with disabilities necessarily includes respecting individual's liberty and security. Committee finds deprivation of legal capacity, involuntary hospitalization and treatment as ongoing problem. Committee calls on signatory states to condemn such practices which are direct violation of Articles 12 and 14 of the CRPD (para 40). [36] It is important to note that legal capacity enjoyed by the persons with disabilities should be respected even during the critical situations. Committee reaffirms the importance of free and informed consent with regards to measures/treatment affecting individual's mental and physical integrity and points to the fact that, as research suggests, forced/compulsory treatment is largely ineffective and causes psychological pressure and trauma for the patients (para 42).[37]

For the purposes of this paper, it is relevant to discuss chapter two of the Oviedo Convention which consists of articles related to the notion of consent, based on the patients "autonomy" and "right to self-determination". Article 5 of the convention sets the standard that any health related intervention may be carried out after the patient has been given all the necessary information regarding the nature of the intervention as well as its side effects and he/she has given free and informed consent to the procedure. Informed consent is a legal standard in the health field, which affirms the doctrine of shared decision-making authority between medical professionals and the

[35] See CRPD, Article 25
[36] UN CRPD, General comment N1
[37] Ibid.

patient. The doctrine is based on the principle of self-determination (personal autonomy), where patient acts as a "final arbiter" when determining what happens to his/her body. Physicians have legal responsibility to provide appropriate and comprehensive information to their patients, in order for them to make free and informed decisions regarding their health. [38] It is important to note that the patient can withdraw/refuse the consent at any point in time. [39]

According to Article 6, in cases where an individual does not have capacity to consent (in case of mental disability), the authorization to the medical procedure should come from the authorized person or the relevant organ, as established by the law, however, even in such cases the patient's wants should be taken into consideration as much as possible. Separate article (Article 7) deals with persons who have "mental disorder of a serious nature", according to which medical practitioners may proceed with the treatment aiming at treating the diagnosis without first obtaining consent only if the patient's health will likely be "seriously harmed" in absence of the intervention.[40] Article 9, dealing with "previously expressed wishes", states that when the patient is not in the position to communicate wishes regarding his/her treatment options, his/her previously expressed wishes "shall be taken into account. [41] In essence, Article 9 is highly important as it provides international written statement for "advance care directives", specifying that the patient's wishes may be taken into consideration in cases where the patient is not capable to make decisions and/or communicate the decisions regarding treatment.[42] However, there is some vagueness in the article. It is not specified exactly in which ways should the wishes of the patient be communicated or how the doctors should recognize those wishes. It is also questionable whether the statement is legally binding, the text itself does not offer specific

[38] Karanadze, Nino. Law and Bioethics final paper, Winter 2017.
[39] Oviedo Convention, Article 5.
[40] Ibid., Article 7.
[41] Ibid., Article 9
[42] Stefania Negri, Jochen Taupitz, and Amina Salkic, *Advance Care Decision Making in Germany and Italy*.

guidance. However, the Explanatory Report does provide some clarification. According to the report, Article 9 provides an exception to the general rule of consent on the one hand, and, on the other hand, it provides protection to persons with mental disability, "by limiting the instances on intervention without prior consent". Before the practitioners proceeds with the treatment, two conditions must be met: a) person must have an mental disorder; b) the medical procedure/intervention is necessary to the treatment of the disorder (refusing consent may not be taken into consideration when the procedure is necessary to treat the mental condition and in absence of such treatment will cause serious harm to the patient's health or to safety of others); The report notes that in those countries where the persons with mental diagnosis may be involuntarily placed in detention, there are laws allowing medical interventions to treat "serious somatic illnesses in a psychotic patient", per medical practitioner's discretion.[43]

Analysis shows that Oviedo Convention does not strictly prohibit administering medical treatment without consent in cases of persons with mental diagnosis. The Convention "authorizes but strictly regulates the use of involuntary measures in psychiatry"[44], allowing obtaining the consent not from the person who is directly involved in the matter, but from the legal representative or person prescribed by the law[45]. This understanding/legal norm contradict standards set in the CRPD, such as the legal capacity for all persons with disabilities and the application of free and informed consent to persons with mental disabilities.

Committee of Ministers Recommendation Rec(2004)10 develops further guidelines. Article 18 sets the criteria for involuntary treatment, specifying that all of the following needs to be in place in order for the person to be subjected to compulsory treatment: a) a person has mental diagnosis;

[43] Explanatory Report to the Convention on Human Rights and Biomedicine
[44] Parliamentary Assembly, "PACE - Recommendation 2091 (2016) - The Case against a Council of Europe Legal Instrument on Involuntary Measures in Psychiatry."
[45] Oviedo Convention, Article 6.

b) there is a significant risk of self-harm or harm to others, including health related concerns; c) treatment option is least intrusive; d) the person concerned is consulted. And Article 19 provides concrete conditions which need to be satisfied during compulsory treatment. In particular, the adequately documented treatment plan needs to be a in a written form and address the specific medical symptoms, taken into consideration the overall health of the patient. Most importantly, the treatment plan should eventually allow the person concerned to follow the procedures most acceptable to them. [46] Article 22 deals with the person's right to information, and states that the person who is subjected to involuntary placement and/or treatment should speedily receive information (both verbally and in a written form) regarding the reasons for the detention and/or treatment and the criteria upon which the measures will be terminated. [47]

Recommendation 2091(2016) further elaborates that any legal doctrine that is based on/includes the link between the "involuntary measures and disability" is of discriminatory nature and therefore is by default in violation of the Convention of Persons with Disabilities. It can be assumed, that according to the CoE document, having a "mental disability" as one of the criteria, among others, is discriminatory.[48]

Lastly, it is important to discuss the standard set by the Committee for the Prevention of Torture. First of all, according to the Committee, the persons concerned (in this case the patients with mental diagnosis) should be put in the position where they will be able to give free and informed consent to the medical intervention. This means that they should be provided with full, adequate and accurate information regarding their diagnosis, the treatment options and the potential side effects. Second of all, the committee distinguishes compulsory placement and treatment, in other words, subjecting a person to involuntary confinement does not necessarily mean that the

[46] Article 19 and 18 of the REC(2004)10
[47] Article 22 of the REC(2004)10
[48] COE Recommendation 2091(2016)

treatment is also authorized, meaning that every (competent) patient no matter the voluntariness (or lack of it) of their admission, should be put in the environment where they can exercise their right to informed consent. Any derogation from this standard, should be exceptional and be strictly regulated by the law. [49]

Chapter 3.3: ECHR case law concerning involuntary treatment

In the context of ECHR the case law is concentrated on two fundamental rights: the right to freedom from cruel, inhuman or degrading treatment (Article 3) and the right to respect for private life (Article 8).

The most prominent case with regards to prohibition of torture is Herczegfalvy v. Austria, where the applicant was given drugs (neuroleptics) and chained to a bed without consent. The court reasoned that it is the discretion of the medical professionals to decide on the treatment method, however the measures of therapeutic treatment need to be assessed in line with Article 3 of the convention. The patient is in the "position of inferiority and vigilance", and therefore there needs to comprehensive oversight, nevertheless the court was satisfied that the medical necessity was established and the doctors were justified in using compulsory methods of treatment in order to cure or alleviate the condition.

In Kudla v. Poland, that court ruled that "elements of suffering and humiliation" may be part of the conventional treatment or punishment plan/procedure and in order for the measures to qualify for Article 3 claims, the stress and humiliation must go beyond that of conventional treatment.[50]

[49] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)
[50] Kudla v. Poland, No. 30210/96, ECtHR 2000, para 92.

More common are the cases that fall under the Article 8 of the Convention. In Y.F. v Turkey that court stated that involuntary intervention in the person's body, no matter how minor, constitutes at interference in the most intimate aspect of the person's life. [51] And if the interference is not justified, as required by the law, there will be a violation. In this context, involuntary treatment will be allowed if all of the following conditions are met: a) in accordance with the national law: the court found violation in Shopov v. Bulgaria, reasoning that the applicant did not have a possibility to utilize the right to a regular court review, which is the contrary to the domestic law of Bulgaria; b) necessary in a democratic society; c) existence of the legitimate aim: in most cases the legitimate aim is protection of others and the patients' health related concerns;

In Storck v. Germany, where the applicant was administrated medication by force, after she refused treatment, the court found violation of Article 8. In her submission, the applicant argued that being "treated as a mentally insane person […] has ruined her health and life permanently".[52] The court noted that the applicant was in the vulnerable position, and the state failed its positive obligation to protect her "physical and mental integrity" and ensure the protection of her right to private life. [53]

[51] Y. F. v. Turkey, No. 24209/94, ECtHR 2003, para 33.
[52] Storck v. Germany, No. 61603/00, ECtHR 2005, para 139.
[53] Idid., para. 150.

Chapter 3.4: Chapter summary and concluding remarks

This chapter analyzes the issue of involuntary treatment and involuntary placement in the context of different COE standards and refers to the extensive ECtHR case law in order to clarify how the European Convention of Human Rights can be relevant to the mental health related matters. While the text of the convention does not explicitly set health standards, according to the case law, involuntary treatment is covered under Articles 3 and 8 (freedom from torture and ill-treatment and right to privacy) and involuntary hospitalization is relevant to Article 5 (right to liberty). In that regard, it is important to discuss the concept of "unsound mind", as grounds for deprivation of liberty under Article 5 of the ECHR. Analysis shows that the European Court is primarily concerned with the procedural guarantees, such as speedy review by the competent judicial authority and the necessity to inform the person the reasons of detention as well as the type, duration and the effects of the measures in place. The court looks at whether the persons with psychosocial needs, who are subject to involuntary placement, have access to legal remedies and the necessary checks and balances are available to them. In terms of treatment decisions the most common cases concern Article 8, since, according to the court, involuntary intervention to the person's physical self (no matter how minor the medical intervention is) constitutes interference to person's private life. Article 3 cases are more difficult, and the court looks at whether the medical necessity is established and the comprehensive checks and balances are in place, emphasizing that the person concerned is in the position of inferiority.

Furthermore, the chapter discusses Committee of Ministers' Recommendation Rec(2004)10, specifying criteria for involuntary placement and involuntary treatment (note that the separate criteria are applied to the two). Another important legal document the chapter addresses is the report by the Committee for the Prevention of Torture, according to which hospitalization and

treatment needs to be distinguished and the person's subjection to involuntary placement should not considered the start of the treatment. The Committee also emphasizes on the importance of free and informed consent in the context of healthcare and notes that all the necessary information needs to be provided to the patients in order for them to make informed decisions. Moreover, according to the Recommendation 2091(2016), any piece of legislation which includes the link between involuntary measures and disability is discriminatory by nature.

Lastly, the chapter refers to the General Comment by the Committee on the Rights of Persons with Disabilities, in light of which, the equal recognition necessarily includes respecting person's individual liberty and integrity and, thus, involuntary measures are in violation of Articles 12 and 14 of the CRPD.

Chapter 4: Involuntary treatment and placement in Georgia

On December 26th of the year 2013, Georgian parliament ratified the UN Convention of the Rights of Persons with Disabilities.[54] By ratifying the convention, Georgia expressed the willingness to establish/implements its policies regarding the rights of persons with disabilities according to the highest standard established by the CRPD. [55] For the state, ratifying the convention means, taking the responsibility to fulfil the obligation set by CRPD standards, which creates new challenges for Georgia – to review the national standards of the protection of the rights of persons with disabilities and systemically change the situation in accordance with CRPD[56]. Persons with mental diagnosis in Georgia represent one of the most vulnerable and unprotected group, as they are often subject to systemic and disproportional limitations.

In Georgia, the implementation process of Article 12 started based on the decision of the Constitutional Court, which asserted that the existing legal capacity model in the country was contrary to the basic principles of human rights protected by the Georgia constitution. Constitutional Court found the legal capacity norms in the existing legal system unconstitutional and obliged the Georgian Parliament to adopt a new legislature regulating the legal capacity within 6 months. [57]

Besides voluntary stationary assistance, existing legislation in Georgia calls for person's involuntary admission to the psychiatric unit for treatment purposes. Consequently, as per according to the law, under the court order, if person, due to mental health problems, might cause

[54] Georgian Parliament decree, 2013.
[55] Human Rights Education and Monitoring Center, "Understanding Georgias' Legal capacity reform and its implementation", p. 5.
[56] Ibid: Karanadze
[57] Georgian Constitutional Court decision N2/4/532,533. October 8, 2014. Note: writing originate from Coursework (Mental Disability Law and Advocacy).

danger to others or create substantial danger of material harm (for himself/herself or others), he/she will have to undergo involuntary treatment. Furthermore, in such cases, there is no need for patients, person's legal representatives and/or relatives consent and this case will be dealt with solely under the state decision.

Compulsory treatment and placement in Georgia is regulated by the Law on Psychiatric Care, which came into force in 2006. The aim of the legal document (as stated in the Article 1) is providing psychiatric continuous psychiatric care and protection of the rights and freedoms, as well as dignity of the persons with "psychiatric problems".

During involuntary admission in Georgia, persons do not have a right to refuse treatment, since the law addresses involuntary psychiatric help, which automatically includes the treatment component. Contrary to abovementioned regulations, during voluntary admission, individual has the right to refuse treatment, if she/he is over 18. However, the attending doctor, without the consent of the beneficiary and his/her relatives, can decide that the individual's situation at the moment falls under the criteria of involuntary treatment and act accordingly, by changing the patient's status to "involuntary".

The CRPD Committee directly, without any exceptions, negatively assesses any legislation or practice which allows violations of freedom solely based on disability. [58] According to the Committee, deprivation of liberty, on grounds of disability, even if the justification is the potential danger to self or others contradicts the Convention. Moreover, such practice is found to be arbitrary and discriminatory in nature, since there are instances when other people (those who do not have psychosocial needs) might also create dangerous situations, potentially harming themselves and/or others, and, yet, they are not subjected to the same limitations. [59]Right to

[58] Gvishiani, Lela. "Forced Treatment, as rights violating practice."
[59] Ibid PACE.

health, besides access to health system, also calls for equal access to health. This, together with other issues, includes the right of persons with disabilities to have access to information regarding their health and to make decisions regarding the starting or stopping the medical treatment.

In Georgia, the main legal acts, regulating the right to health of persons with disabilities are "Law on Psychiatric Help" and "Law on Health Protection". The later asserts that it is one of the most fundamental principles of the state, to provide equal and universal medical help. "Law of Georgia on Psychiatric Assistance" calls for two types of services for persons with disability: ambulatory and stationary. Law states that psychiatric help promotes social integrations and is the combination of procedures/activities, including testing, treatment, and prevention). According to the law, stationary treatment can be voluntary or involuntary. Voluntary treatment is a decision based on individual's directly expressed wishes. About one year ago, however, with regards to persons with mental disabilities deprived of their legal capacity, voluntary treatment had different interpretation, namely: when consent for the medical treatment was given by the guardian of the person with psychosocial needs, such treatment was regarded as voluntary, even though the person directly does not express his/her will nor is involved in the decision-making in any other way. According to the law, voluntary treatment and hospitalization of the person deprived of legal capacity was concerned with legal representative's request or his/her informed consent. Abovementioned was still considered as voluntary stationary assistance, even though person with psychosocial needs is not the decision-maker himself/herself.

Involuntary stationary procedures are established by the law, which asserts that individuals who have mental diagnosis, do not have the ability to make rational decisions and psychiatric help is not possible without admissions to the stationary unit. Moreover voluntary treatment can

transform into involuntary treatment, when, as described above, under special circumstances, the doctor makes the decision to administer the treatment without the consent. [60]

Systemic problem for the national legislation is a legal framework, according to which involuntary admission and involuntary treatment are not distinguished. Georgian law regarding psychiatric help evaluates admission and treatment as separate procedures, however, both are understood under involuntary psychiatric assistance, which includes hospitalization as well as treatment. In other words, during involuntary admission, individuals/patients lose their rights to refuse medical intervention/psychiatric assistance.[61]

National legislative regulations accommodate involuntary admission of the patient in the psychiatric unit or prisoner from penitentiary system for the purposes of medical treatment. Involuntary admission and coercive treatment hinder individual's right to informed consent, which includes person's hospitalization and consequent treatment based on persons' expressed will. Such coercive measures practiced in Georgian psychiatric system, which disregard individual integrity (among other rights) of persons with mental diagnosis contradict CRPD standards.

Law of Georgia on Psychiatric Assistance establishes patient's right to be subjected to humane treatment. [62] The law also reinforces the admitted patient's rights, including the right to be protected from degrading treatment.[63] However, as an exception, which is established by

[60] EMC: implementation Guidline p. 52
[61] Law of Georgia on Psychiatric Assistance Article 5, para 1, „b", „e";
"Georgian psychiatric institutions. Problems, Needs, and Recommendations ", Human Rights Center, 2013, p. 19. Original Source: EMC Unpublished Report.
[62] Law of Georgia on Psychiatric Assistance Article 5, Para. A
[63] Law of Georgia on Psychiatric Assistance Article 15

paragraph 3 of the same Article, the doctor has the right/ability to restrict the right on the grounds of protection of security. [64]

The abovementioned legal standard allows to interfere with the person's dignity for the safety reasons which is completely contrary to the Convention and the international legal acts. Infringement of dignity, as an absolute and fundamental right, cannot be permitted and cannot be justified for the reasons of proctection of safety. Thus, in order for the norm to be in accordance with the objectives of the CRPD, it is important for the regulations to exclude the risks/limitations to person's dignity.

It is also problematic that the law considers persons medical diagnosis as an independent factor, which means that persons mental disability status can become basis for their involuntary placement and treatment. This is in direct contradiction of the CRPD standard, which asserts that person's disability status can be ground for infringing their liberty. This issues also is relevant in the context of psycho-social rehabilitation, when the law allows subjecting the person, who is undergoing psycho-social rehabilitation, to involuntary treatment as defined by the provisions covering involuntary care. [65]

It is important to emphasize that, as described above, the involuntary placement in the institution is already considered to be the beginning of the treatment, therefore the existing legislation does not distinguish involuntary placement and compulsory treatment and does not assign separate criteria. This is contrary to CPT standard. Committee for the Prevention of Torture states that patients should be placed in the position where they are able to exercise free and informed consent (which necessarily implies that the patients should be provided relevant information and

[64] Law of Georgia on Psychiatric Assistance Article 15
[65] Law Of Georgia on Psychiatric Care, Article 21

their wishes should be reflected in the treatment decisions). The fact that person is involuntarily confined in the hospital, cannot be the legitimate grounds for the beginning of the treatment, prior to obtaining consent. Therefore, any "adequate patient", voluntary or involuntarily placed in the care, should have the right to refuse any kind of health related intervention or treatment. [66]

Number of research projects conducted under the monitoring process of the psychiatric units affirm the improved conditions in terms of ill-treatment of the patients, however it needs to be noted that there are still number of significant problems in this regard. In several closed institutions there are instances of ill-treatment, in particular, the use of force and coercion in cases of involuntary treatment. Moreover, there are cases of isolation, when beneficiaries/patients are not allowed to have telephone communications with their family members, those individuals using wheelchair do not have physical access to it, in other words, there is a problem with physical accessibility. In some institutions that are cases of use of labor of beneficiaries.[67] Article 15 of the Law of Georgian of Psychiatric care asserts that patients admitted to the inpatient care have a right to access all form of unsupervised communication (sending/receiving letters and parcels, telephone calls, etc), however this right can be limited under the authority of the attending doctor on grounds of security and safety. [68]

Limiting physical movement/physical accessibility is a well-proven method in the psychiatric institutions. In direct contradiction and disregard of the law, the usage of this method was

[66] 8th General report on the CPT's activities covering the period 1 January to December 1997; 31 August 1998; pr 41
[67] "Georgian psychiatric institutions. Problems, Needs, and Recommendations ", Human Rights Center, 2013, pp: 10-12
[68] Georgian comprehensive report, CRPD

reported in number of psychiatric units. However the instances are not officially disclosed, since some institutions do not physically have official records.[69]

According to Ombudsman 2016 report, beneficiaries of the psychiatric institutions, persons with mental disabilities, receive psychiatric and general medical assistance without informed consent. The institutional regulations do not establish the requirement of obtaining the free and informed consent before providing medical assistance. Medical card (medical history) does not contain signed document of informed consent, therefore, it is difficult to establish whether the treatment the beneficiary receives is voluntary or not. According to the psychiatric unit staff, beneficiaries often refuse medication prescribed to them by the psychiatrist, which results in the worsening of their prognosis. However, the medical records does not contain such information, such as signed form of withdrawal from medical treatment.

According to the beneficiaries interviewed during the monitoring process, they have very limited information regarding their mental health and treatment, and sometimes they cannot even name the medication prescribed to them. Treatment of beneficiaries in the psychiatric unit is mainly limited to medication. All institutions have separate space for psycho-social rehabilitation, as per according to Article 5 of the Law of Georgia on Psychiatric Care, however material and professional resources for such services (psychological intervention and psycho-social rehabilitation) is severely limited. The majority of the interviewed beneficiaries denied involvement in activities that foster psycho-social rehabilitation. [70]

Under Article 18 of the Law of Georgia on Psychiatric care, patients who are involuntarily treated have the right to have their case heard by the commission of psychiatrists in 48 hours

[69] "Georgian psychiatric institutions. Problems, Needs, and Recommendations ", Human Rights Center, 2013, pp: 13-14. Note: Original Source – EMC, Unpublished report
[70] Obudsman, Special Report. pp: 72-79.

after the admission. If the commission finds involuntary treatment unjustifiable, the patient needs to be discharged right away. According to Article 21 of Administrative Procedure Code of Georgia, the commission expert opinion should be followed by the court ruling, which discusses individual cases. The decisions will be rendered after 24 hours of submission of the case by the psychiatric unit administration. The involuntary treatment, after the initial court ruling, cannot last more than six months, however psychiatric unit administration can re-apply for the extension. Appeal procedure is set in Article 21, patient, his/her relative, attorney, and/or psychiatric unit administration can appeal the court judgment within 48 hours. Article 22 asserts that any kind of medical intervention must come after obtaining free and informed consent. However, if an individual is under 18 or is deemed to be mentally incapable, the consent is given by the family member or legal representative. [71]

Since signing and ratifying CRPD Georgia has submitted one comprehensive report regarding the implementation of the standards, in accordance with Article 35 of the Convention. Paragraph 62 of the report refers to the 2014 decision of the Constitutional Court (Kemoklidze and Kharadze v. the Parliament of Georgia), according to which established legal norms and regulation infringing on the legal capacity of persons with disabilities were found unconstitutional. Accordingly, in 2015 the parliament of Georgia amended over 200 statutory norms, reinforcing the full legal capacity and aligning domestic legislation with standards set by the CRPD. Consequently, there were changes in the Civil Code and the notion/concept of "legally incapable person" was replaced with ""a person with psychosocial needs" (para 62). According to the amended Civil Code of Georgia (Article 1508), guardians of the persons who were previously regarded as deprived of legal capacity need to apply to the court and, based on individual assessment, the court decided adequate level of support needed for each individual on

[71] Ibid, Georgian Comprehensive Report

case by case basis (para 69). According to CRPD General Comment N1, Legal capacity guarantees should include protection from undue influence and persons will and choice should be respected, including right to take risks and right to make mistakes.[72] This statement applies to the supported decision making, however, I believe, that is also relevant to person's right to take risks in their health related matters. This point will be further elaborated in the analysis chapter.

Analysis of the Georgian national legislation shows that health related matters, such as obtaining consent before administering treatment is based on person's perceived "mental capacity". Even though, Georgia has ratified CRPD and, consequently, amended the legislation after finding legal norms, depriving legal capacity to persons with disabilities, unconstitutional, practical implementation still follows the old model, where the person who otherwise should have all the rights and freedoms guaranteed on equal basis with others, is stripped away from decision making power regarding his/her own health. Another important factor is that besides the court, expert decisions on the person's fate (in this case, their treatment and placement) is decided not by the multidisciplinary group, which is considered to be the practice set by the international norms (as described above), instead the responsibility lies with the psychiatrist only. Professionals representing other disciplines, for example social workers, are missing from the decision making panel. This shows that person's evaluation is strictly through medical lances, the social dimensions are disregarded, which excludes the possibility of analyzing (and considering) person's social needs and other relevant factors.

[72] General Comment N1, para 29

Chapter 4.1: Chapter summary and concluding remarks

This chapter analyzes the existing legislation and practice in Georgia in terms of involuntary placement and treatment of persons with psychosocial needs. The main legal documents concerning the right to health of persons with disabilities in Georgia are "Law on Psychiatric Help" and "Law on Health Protection". Systemic problem for the national legislation is a fact that involuntary admission and involuntary treatment are not distinguished. In other words, during involuntary admission, individuals/patients are consequently subjected to involuntary medical intervention. Under the court order, if a person, because of the mental health issues, causes danger to others or create substantial danger of material harm (for himself/herself or others), they will have to undergo involuntary treatment. Moreover, if the person is voluntarily hospitalized, at any point in time the attending doctor can decide that the situation calls for involuntary treatment and can change the person's status accordingly.

It is also highly problematic that Georgian mental health legislation considers diagnosis as a separate, independent factor, meaning that mental disability status alone can become basis for person's subjection to involuntary hospitalization and consequent treatment. Furthermore, according to the number of Ombudsman and NGOs reports, persons, placed in psychiatric institutions, undergo medical intervention without free and informed consent. Studies conducted with the users of psychiatric services suggest that the beneficiaries are not provided with appropriate information regarding their health status and often their wishes are not taken into consideration. As shown by the analysis of existing national legislation and practice, such coercive/involuntary measures in Georgian mental health system, which violate right to private life, individual autonomy and integrity of persons with psychosocial needs contradict international standards described in previous chapters.

Chapter 5: Involuntary treatment and Placement in Sweden

In Sweden, the majority of psychiatric treatment and rehabilitation options as well as specific support procedures for the persons with mental disorder are provided on voluntary bases, taking into account the concept of free and informed consent. The principle of self-determination and voluntarism is considered to be the basis for the mental health legislation in the country, including the Social Services Act[73]. However, according to the Swedish mental health study, despite legislative progress, nearly 3000 persons are subjected to involuntary treatment, on a daily basis, under the Compulsory Psychiatric Care Act and the Forensic Psychiatric Care Act. [74] Compulsory Psychiatric Care Act provides legal framework for "civil commitment", the provision specifies issues related to treatment and there is no separate provision for placement. [75] Involuntary care has a long history in the country and remains prevalent to this day, bolstering the perception that the society needs to take responsibility to care for those who are perceived not able/willing to do so on their own, despite the person concerned refusing the treatment. According to Khellin, his conception is problematic, since, such paternalistic "state solidarity" expressed in the wish to "help" others, can infringe the fundamental human rights of the person involved. Swedish legislation has been reviewed and revised several times in the last forty years. Previously, the mental health care was unified under the general legislative act covering all health related issues. The new legal framework was elaborated as a way of increasing protecting mechanism and introducing more comprehensive legal rights to the person with psychosocial needs.[76] However, current legislative framework dates back to 1992, and it is not surprising that

[73] SFS:2001:453.
[74] Bolling et al., "Swedish Mental Health Study", p. 18.
[75] Ibic., p. 20.
[76] Kjellin et al. "Compulsory psychiatric care in Sweden".

ideas given in the legal documents, concerning care of the persons with psychosocial issues, reflect the knowledge contemporary of the period.

Bases for all health care related legal framework is the Health Care Act of Sweden. The document provides general guidelines, specifying that it is the duty of the medical professionals to provide adequate care under the equal and accessible environment, taking into consideration person's integrity and the right to self-determination. Health Care supplements Compulsory Psychiatric Care Act and Forensic Psychiatric Care Act.

Compulsory Psychiatric Care Act in its wording provides strict guidelines regarding involuntary treatment and placement, however different NGO and News Media reports, as well as statements from the CoE Commissioner for Human Rights suggest that the implementation of the Act is problematic and even though not many cases end up in courts, the instances of coercive treatment, including "electro-shock therapy without consent" are still prevalent. [77] According to disability movement in the country, the existing practices/system of psychiatric care tend to be insufficient, leading to the compulsory treatment and hospitalization, covered under the Compulsory Care Act. It needs to be noted that there is a separate legal document ("Forensic Psychiatric Care Act") for persons who have committed a criminal act and suffer from a severe psychiatric condition. If the patient "disturbing behavior" constitutes danger to other patients, they may be put in isolation, under the authority of the Chief Physician for the period of maximum 8 hours. If the isolation lasts more than 8 hours, the National Board of Health needs to be notified (when the time exceeds 8 hours). This is contrary to the CoE Recommendations, according to which keeping the patient in isolation and subjecting them to restraints should be minimized and recorded.

[77] Bolling et al., "Swedish Mental Health Study".

Laws covered by these two acts allow interference with person's right to physical and mental integrity (protected by CRPD Article 17, also partly covered by Article 8 of the ECHR) as well as the principle of obtaining free and informed consent before conducting a medical procedure (CRPD Article 25 and in extreme cases Art. 3 of the ECHR). However, Swedish mental health acts strictly regulate interference with abovementioned rights and set out rules for the application of the specific measures, including the appeal procedures and speedy court review. Since 2008, there is a new, additional, mental health act in Sweden regulating outpatient psychiatric involuntary care, provided that the patients follow certain agreed upon rules. According to Bollinger and others, Compulsory Outpatient Care was a result of the government recommendation to the parliament, aiming at providing care for those persons who do not need to be received treatment on the inpatient basis and are not able/willing to receive such care voluntarily. In order for such treatment plan to be successful, there needs to be close cooperation with the medical personnel and the representatives of the social services. Such cooperation should allow information sharing between social services and the medical team, in order to provide adequate care to the patient. However, outpatient care framework can only be initiated after the patient has already undergone the treatment in the facility. The Chief Physician submits an appeal to the administrative court, explaining that the need for the patient to stay in the hospital is no longer sufficient and the patient agrees on the specific conditions upon which they will receive outpatient care. [78]

Further guidelines can also be found in the Social Services Act, according to which the principle of proportionality must be in place and correct balance must be struck between the benefit the patient will get from the treatment (alleviate or cure the condition) and the potential infringement to their self-determination and integrity. Legal guidelines also emphasize on the importance of

[78] Ibid.

individualized approach and providing information to the patient in a way that they proceed with the treatment voluntarily. According to the report on Swedish mental health care, the patient's participation in the care planning process is noted in the legislation, however it is not clearly identified in what way (if any) can the patients influence the decisions concerning involuntary treatment. [79]

Compulsory Psychiatric Care Act requires concrete written plan, which is based on the holistic understand of care considering persons "medical, social and psychological needs", and sets out the aim and duration of the treatment. Even through, the beginning of the treatment process is considered to be according to the decision to subject the person to involuntary confinement, the written plan should cover not only the inpatient treatment phase, but also the period after the hospitalization (in other words, "continued care"). The responsibility of overseeing the concrete treatment care lies with the Chief Psychiatrist or Chief Physician, who needs to make sure that the attending doctor, with relevant specialization and credentials, develops and implements the plan. The final responsible person needs to make sure not only that the treatment procedures are adequate, but also that they are conducted according to the law, and the patient's rights and freedoms are respected. [80]

In order for the person to be subjected to involuntary treatment, the following criteria must be satisfied: the person must have an "absolute need" for treatment and psychiatric care can only be provided in the facility ("inpatient psychiatric care") or the person requires special conditions, but does not necessarily need to be placed in the facility ("outpatient care"). When reviewing the patients "absolute need" for treatment, danger to others and overall safety concerns are also assessed. While, danger and safety of others is one of the factors influencing the decision on the

[79] Ibid.
[80] Ibid., p21

compulsory treatment, it is not a determining factor. To compare, Council of Ministers Rec(2004)10 considers dangerousness a much more important factor than Swedish legislation.

Chapter 5.1: Assessment process and procedures

According to the Compulsory Psychiatric Care Act, the responsibility to make the placement decision lies with the Chief Physician of the institution the person will be placed. Involuntary treatment is based on the treatment certificate provided by a licensed medical practitioner after the examination procedure. Obtaining the special certificate is the first step, in the two step process/assessment, followed by the decision of the second doctor, different from the first one, to start the involuntary care. It is the discretion of the physician to call the law enforcement personnel, namely the police, if the person, soon to become a patient, refuses the treatment. Involuntary treatment is eventually authorized by the administrative court, and it needed, the court has independent psychiatrist who will review the decision concerning the patient's treatment in the facility. The administrative court also reviews and assesses the decisions regarding continuing involuntary treatment, after the initial period is over, if the goals of the care plan have not been met and the Chief Physician/Psychiatrist applies for such an extension.

According to the Article 6 of the Compulsory Care Act, the decision concerning the person subjection to involuntary care should be made within 24 hours of the person entering the facility. If the patients is aggressive and refuses to remain in the institution during this period (which is also the critical period) the institution reserves the right to call the police and use force to detain the patient. This time is enough for the physician to analyze the patient's medical condition, as well as obtain relevant additional information needed for the assessment. The initial cycle of the patient's involuntary treatment is the period of 4 weeks. Considering the needs of the patient and

if the aims of the care plan are not met within this initial period, the Chief Physician applies to the administrative court and the care can be prolonged for the period maximum of 6 months. The court order is also need when the patient's status changes from inpatient to outpatient care, as decided by the attending medical professional.

It is important to emphasize that the person's status as a voluntary patient can change and they can be subjected to involuntary care, if the relevant requirements are met (meaning that the person refuses to consent the treatment) and the person represents a danger to self and others. Such instances are treated as a new case, and the treatment certificate is issued within 24 hours, afterwards, again, within 24 hours after the treatment status has been changed by the attending Chief Physician, the administrative court renders its final decision.

According to the Act, during the involuntary care, if the patient wishes to leave the institution and is being aggressive, creating danger and safety concerns for themselves and others, if other measures are insufficient, use of force may be authorized in order to "uphold order or to satisfy the facility security requirements". [81] If the danger is imminent, the Chief Physician is sanctioned to use restraints for a limited period of time, however the medical profession has to be present during the period the patient is constrained.

Compulsory Psychiatric Care Act also specifies procedural guidelines, including the right to appeal to the court against the treatment decision, including having the treatment discontinued. The court will consider the case within eight days after the submission and will also hear the opinion of the Chief Physician. The court decision is final and is not subject to be appealed by the physician. The court appoints the counsel to the person concerned lies. The Act does not specify "right to free counsel", right to free legal aid is covered by Legal Aid Act and, therefore, is available to the patients as well. However, it is problematic that the patient has to initiate legal

[81] SFS: 1991:1128

aid procedures and considering that the patient (because of involuntary placement), in practice, may have limited access to information.

UN Committee against Torture report assessing mental health issues in Sweden discusses involuntary measures in Sweden, including procedures such as physical restraints and subjecting the patients to isolation. The main problem, according to the report, is that there is no sufficient data regarding the care of persons with mental diagnosis residing in the psychiatric hospitals/institutions. [82] The report also stressed the importance of reviewing coercive practices and limiting their application as a measure of last resort for a strictly defined short period of time.

The lack of data makes the monitoring and evaluation process even more difficult for the national and international bodies overseeing the implementation of the domestic and international law. Considering that persons with psychosocial needs, especially those who are subjected to compulsory care, constitute especially vulnerable group, they are more likely to be dependent on the institute personnel while they are being treated involuntarily and, in practice, have limited chances to question or appeal against the measures/procedures, it is highly important for the state to ensure that the relevant domestic and international regulatory bodies are provided with adequate oversee mechanisms to safeguard the fundamental rights of the patients involved. The lack of data significantly hinders this systemic control mechanism and the "oversee process".

[82] UN 2008:76

Chapter 5.2: Chapter summary and concluding remarks

The legal framework regulating mental health care in Sweden consists of three supplementary legal acts: Health Care Act, Compulsory Psychiatric Care Act and Forensic Psychiatric Care Act; criminal cases where perpetrators suffer from a severe mental health condition are regulated under the separate Forensic Psychiatric Care Act. According to the general guidelines provided in the abovementioned three legal documents, the medical professionals are obliged to provide an adequate health care under the equal and accessible environment, respecting person's integrity and autonomy. Differently from Georgian legal system, Swedish legislation allows compulsory outpatient mental healthcare, in cases where the beneficiaries do not need to be subject to hospitalization and refuse and aren't able to receive treatment voluntarily.

According to the Swedish Social Services Act a correct balance must be struck between the benefit the patient will get from the involuntary treatment and the potential risks to patient's rights to self-determination and integrity. However, even though not many cases end up in national courts, media and NGOs reports suggest that the coercive measures are prevalent. In that regard, it is highly problematic that there is no sufficient statistical data regarding the mental health care of persons residing in the psychiatric hospitals/institutions.

Similarly to Georgian standards, according to Swedish legislation the patient who is voluntarily placed in the hospital can be subject to involuntary medical intervention, if the situation falls under the "involuntary criteria". However, in Sweden there are much more sufficient procedural guarantees, such instances are treated as new cases and require separate court order.

One important peculiarity of the Swedish mental health legislation is that the primary criteria for involuntary medical intervention is "absolute need" for treatment. While, danger and safety

concerns are among the criteria influencing compulsory treatment decisions, they are not the decisive ones. To compare, the dangerousness factor is much more important consideration according to Georgian legislation and international standards such as Rec(2004)10.

Chapter 6: Analysis

For the purposes of analyzing the issue of involuntary treatment and placement of persons with psychosocial needs, it is important to discuss the Convention on the Right of Persons with Disabilities in greater detail. The convention, which was adopted in December 2006 and entered into force in May 2008, is crucially important international document in protecting the rights of the persons with disabilities. By introducing new legal standards and approaches, CRPD alters the definition/understanding of disability and establishes the principles of human rights in the context of disability[83]. The Convention, as a product of international negotiations and strong lobbying from disability advocacy groups, generated massive support and become the century's first most comprehensive treaty. CRPD moved away from presenting persons with disabilities as objects of medical and legal beneficence and established the beneficiaries of the treaty as subjects of international law, whose rights and freedoms ought to be respected and protected.[84]

In terms of issues related to the right to health CRPD establishes the following legal obligations on the signatory states. The preamble reaffirms the fundamental principles of universality and interdependence of all human rights. It is important to note that in some states, including Georgia, involuntary admission and involuntary treatment are not distinguished. Therefore, for the purposes of the paper, Article 14 concerning "Liberty and Security" of persons with disabilities becomes relevant point of discussion. Article asserts that signatory parties take the responsibility to ensure that deprivation of liberty does not constitute discriminatory practice (arbitrary or unlawful practice) and mere existence of disability is not grounds for deprivation of liberty.[85] Article 15 of the Convention reaffirms that no one should be involved in medical or

[83] Karanadze, Nino. Final paper for Mental Disability Law and Advocacy class, Fall 2016-2017
[84] "Convention on the Rights of Persons with Disabilities (CRPD)."
[85] See CRPD Article 14

scientific experimentation without free and expressed consent. Article also addresses inhumane and degrading treatment and asserts that national legislations, aiming at prevention and combating inhumane and degrading treatment should consider persons with disabilities on equal basis with other citizens.[86]

Article 12 CRPD discusses the right of persons with disabilities to equal recognition as persons under the law and establishes the concept of legal capacity. It is important legal capacity is not the same as mental capacity. In fact, based on the interpretation of Article 12, new formula of legal capacity includes individual will and preferences, unique decision-making abilities, supports, accommodation and equal legal recognition. The content of the Article 12 is based on (is a reflection of) the basic principles of the CRPD, such as personal dignity, autonomous decision-making, equal and effective participation in the social life, protection and respect of the particularities of the persons with disabilities.[87] In its general comment, The Committee on the Rights of Persons with Disabilities explains the importance of the "support system model" which is based on the principles of human rights and asserts that "substituted decision-making" is unacceptable[88]. Center to supported decision-making is the trust and is much more holistic and radically different to guardianship decision-making. The Committee emphasizes the universal and inherent nature of "legal personality". Enjoying legal capacity on equal basis with others is important in the context of mental health. Moreover, legal capacity includes two concepts: being a rights holder and being able to exercise the rights. According to Article 12, paragraph 3, states are obliged to provide supports where needed to help individuals exercise their legal capacity. Types of support include: decision-making supporters, peer support, communication assistance, interpreters, plain language, alternative formats, independent advocates. States must provide

[86] CRPD, Article 15.
[87] General Comment N1, The Committee on the Rights of Persons with Disabilities/C/GC/1, para. 4.
[88] Ibid: para 3.

safeguards to protect against exploitation. Adequate safeguards include: regular review by the competent independent and impartial authority or judicial body and guidance about how decisions are made. Government also has responsibility to ensure that the accommodation is provided (para 4, reference to Articles 5 and 2).[89]

In its General Comment N1, CRPD Committee asserted that persons with disabilities enjoys full legal capacity. The Report notes that even though, historically legal capacity has been arbitrarily and unjustifiably limited/denied to specific groups such as ethnic minority communities and women (as a result of marriage, for example), persons with disabilities still remain as most vulnerable group, whose legal capacity is prejudicially denied throughout the different legal systems. CRPD affirms the "right to equal recognition before the law", which consequently implies that the notion of legal capacity is fundamental and inherent to all persons, including the persons with disabilities. The notion of legal capacity and equal recognition under the law is relevant in all aspects of person's life, especially with regards to decisions related to health. In fact, denial of legal capacity, directly effects person's other fundamental rights and freedoms, including health related decisions (decisions regarding treatment and hospitalization (para 8).

According to General Comment equal recognition of persons with disabilities necessarily includes respecting individual's liberty and security. Committee finds deprivation of legal capacity, involuntary hospitalization and treatment as ongoing problem. Committee calls on signatory states to condemn such practices which are direct violation of Articles 12 and 14 of the CRPD (para 40). [90]

[89] Mental Disability and Advocacy, class notes, class three "legal capacity". Professor Oliver Lewis.
Note: writings cited under footnotes 86, 87, 88 originate from previous coursework (Mental Disability Law and Advocay).
[90] Ibid., General comment N1.

Article 25 explicitly discusses right to health. The opening sentence of the article emphasizes on the principle of non-discrimination in the context of accessing highest standards of health. [91]

Informed consent precludes two distinctive aspects of decision-making: disclosure of information and consent. Information provided by the healthcare professional should be understandable (non-technical) and sufficient for the patient to make intelligent choice/informed decision regarding their health. Disclosed information should cover diagnosis and the potential risks and benefits of treatment, as well as viable alternatives. Awareness and the state of mind becomes relevant to the "consent" aspect. Consent is a way patient gives the attending doctor the right to act, and practically protects the individual from unjustified invasion in their bodily integrity. Anglo-American legal tradition, on numerous occasions strongly condemned the concept (and its practical implication) of involuntary medical treatment, in fact proceeding with treatment without prior consent constitutes battery and makes doctor legally liable. There are several notable exceptions to obtaining informed consent, pre-treatment: a) in cases of emergency, where because of the circumstances of the situation (such as timing, for example), the doctor proceeds before obtaining consent, b) patient's submission to the procedure is voluntary, c) so-called "therapeutic privilege", when disclosing the information (regarding the prognosis) potentially might cause substantial psychological stress, which might negatively affect the success of the procedure. Even though the doctrine of informed consent is of critical importance in the medical field, in its practical implementation the notion is limited when it comes to patients with mental diagnosis. The state acts under the concept of "parens patriae", presumed to be acting in the best interest of the individual, "protecting the one who cannot protect himself/herself.

[91] CRPD, Article 25.

Refusing right to informed consent (and consequent involuntary treatment) for persons with mental diagnosis finds its roots in 1256 Henry de Bracton first legal treatise in the English common law tradition. "A madman could not make an agreement nor do any business because he did not understand what he was doing". This understanding in also affirmed in the Dexter v. Hall US. Supreme Court decision, where the court stated law does not recognize the mind of the person with mental diagnosis, "non compos mentis".[92]

Torture Prevention Committee sets the standard, according to which, patients, as a rule, should be in the position to give free and informed consent to the medical treatment. Individual's involuntary admission in the psychiatric unit should not be the basis for treatment without his/her consent. Consequently, every competent patient, voluntary or involuntary, should have the possibility to refuse treatment or any kind of medical intervention. Exceptions to this fundamental principle should be set in law and include only clear and exhaustive, special circumstances.[93]

European Network for (ex)-Users and Survivors of Psychiatry (ENUSP) shadow report on EU[94], as well as public statement made by ENUSP's Olga Kalina, survivor of psychiatry living in Georgia, also condemn forced treatment as violation of human rights/principles and UN CRPD standards ("direct contradiction with the spirit of CRPD") and call on the states to ensure that persons with psychosocial disabilities are treated on equal basis with others, and are guaranteed fundamental rights and freedoms, such as freedom from involuntary treatment and forced institutionalization.

[92] Solomon, "Informed Consent for Mental Patients - Given the Reallity of Institutional Life, Is Such a Thing Possible."
[93] EMC, "Guidelines on the Implementation of the UN Convention on the Rights of Persons with Disabilities (UNCRPD)."
[94] ENUSP, Shadow Report.

In order to advance the substantive equality for persons with psychosocial needs, it is imperative the law and practice is based on the new paradigm for protecting autonomy. The fundamental question which needs to be answered is: "What principles and considerations should be applied when considering placing limitations on the ability of persons with disabilities to make their own choices?"[95] The state has primary responsibility to protect the persons autonomy in all aspects of life, including decisions entailing health, especially whether to accept or refuse medical interventions.

Yet, the person's with psychosocial disabilities face substantial or total restrictions in making their own decisions. They often encounter others who perceive them as unable to take charge of their own lives, as people who need to be 'fixed', or protected against their own selves. Such perceptions significantly limit or fully restrict the scope of their decision making, and contribute to the risk of "stereotyping, objectification, negative attitudes and other forms of exclusion which people with disabilities disproportionately face; and which increase powerlessness and vulnerability to abuse, neglect and exploitation".[96]

In this regard, the important questions are how to balance the right to autonomy and the duty to protect, where people's decision-making abilities are limited, or where they are lacking needed supports, and/or where they are vulnerable to abuse and neglect? How do we manage this balance in a way that does not discriminate on the basis of disability? Before we are able to answer these questions, we first need to discuss what is meant by the patient autonomy and why it is relevant in the context of the rights of persons with psychosocial needs.

First of all, it needs to be emphasized that the notion of patient autonomy, person's right to decide on matters that exclusively concern them, is central to the healthcare system (especially in

[95] Law Commission of Ontaria
[96] Michael Bach and Lana Kerzner, "A New Paradigm for Protecting Autonomy and the Right to Legal Capacity."

the Western world). It is noteworthy, that there are known exceptions to this principle. The patient's autonomy can be limited in specific cases for example when there is a risk of spreading airborne communicable diseases or in cases when parents are primary decision-makers for their children. In practice, mental health is also another area whether exceptions to the patient's autonomy is applicable. In other words, the will of the patient concerned is not always awarded significant (decision-making) weight and involuntary, compulsive inpatients treatment is relatively common. According to Sjostrand and Helgesson, the main points of discussion in the context of the involuntary mental healthcare can be grouped under three arguments: a) the societal interests as manifested by the state interest b) the patient's health care needs, understood to be the patient's health related interest c) the patient autonomy [97].

For the purpose of providing clear analysis and roadmap of involuntary treatment and placement, it is important to discuss these three arguments in detail.

Interest of society becomes relevant in the discussion of mental health issues when the state is assessing whether not treating a persons with psychosocial needs will create a substantial risk for the society. The following question will be asked: is the person potentially dangerous to his/her surroundings? The principle that some persons need to be treated, even against their will, in order to ensure public safety and security and minimize the risk of "dangerousness", does seem to have certain public support and finds its place in law. As discussed in the previous chapter, the interest of society and the "dangerousness criteria" is particularly relevant in the context of Georgian legislation, compared to the Swedish one.

[97] Sjöstrand and Helgesson, "Coercive Treatment and Autonomy in Psychiatry."

Sjostrand and Helgesson notes that there are specific cases where "coercive measures" can be justifiable used against certain dangerous persons in order to protect people and ensure public safety. However, the main point of discussion here is whether inpatient treatment and hospitalization are adequate measures in such cases. According to the authors, the answer is no. The line of reasoning is the following: if the persons suffers from a mental condition and due to his/her conditions poses a threat to the community and the person has the capacity to understand his mental health issue and decide he wants to forgo the treatment, the patient autonomy should be respected and the treatment decisions should be up to the person concerned. In such cases, the coercive treatment as a measure to combat dangerousness is not a prerogative of health care professionals. Sjostrand and Helgesson refers to the Madrid Declaration prepared by the World Psychiatric Association, according to which "the medical treatment must always serve the best interest of the patient", meaning that when it comes to the interventions to the person's health, any other interests (including the interest of the society) should be secondary and based on "strong supporting arguments". On the other hand, it could be suggested that it is according to the "dangerously ill person's interest" not to be a threat to others, and if he/she is unable to fully comprehend the complexity of their situation, it is in their own best interest to be subject to treatment and hospitalization. However, even if this were the case, according to Sjostrand and Helgesson, the main reasoning behind the treatment decision is primarily the fact that the person has the mental health issue, not the dangerousness, per se.

It is also important to discuss whether involuntary treatment can be justifiable from the position of the person's own health interest (which is also the second point in Sjostrand's discussion). However, the problematic issue in this context is the difficulty to define what can be the actual interest of the person concerned. On the one hand, the treatment and hospitalization decisions can be considered reasonable from the position of the person's own health interest if actual physical/mental harm can occur without the medical intervention. [98]However, if we compare the situation of involuntary treatment of persons with psychosocial needs with the cases of Conscientious Objection in health care or when patients with serious somatic illnesses refuse the treatment and the doctor respects patient's wishes (informed decision to refuse treatment), even though it might lead to fatal consequences. In such situations, patients other legitimate wishes override health related interests. For example, when cancer patient refuses life prolonging treatment and decides to spend the remaining time in the company of the loved ones. It would be considered completely unethical to coerce the cancer patient into treatment. According to this line of reasoning, it can be concluded that when in conflict, patient autonomy overrides health reasons. According to the authors for the sake of consistency, involuntary/coercive treatment in the context of mental health should also be outlawed if the only justification is health interest. However, it needs to be noted that difficulty in such situations lies in the assumption that the mental health issue might jeopardize the patient's "autonomous capacity". This is particularly important because self-awareness and being able to comprehend the situation at hand is a critical aspect in the context of autonomy. Therefore, if autonomy is missing, measures aimed at restoring patient autonomy could be considered legitimate, in other words guiding principle in such cases is "presumed will of the patient". This notion is relevant

[98] Ibid.

both in a physical and mental health care. Most patients find comfort in knowing that if there is an extreme situation and/or an accident, doctors would not wait for them to be conscience and give consent and start the medical intervention based on the presumed autonomous will of the patient's "healthy self". Such type of "soft paternalism" also applies to the cases of mental health. It would be reasonable to suggest that according to the patient's autonomous self-interest, even if the person opposes treatment at the time, the adequate treatment should be administered to the person concerned. The necessary precondition in such cases of subjecting the patient to the "soft paternalism" is that the person cannot comprehend their own diagnosis and prognosis.[99] Helgesson and Sjostrand points out that though there are some cases when the persons with severe mental health issues cannot fully comprehend the complexity of their diagnosis and thus are not able to make rational health related decisions, statistics suggest that on average persons with psychosocial needs are able to make autonomous health related decisions, similarly to those patients with somatic problems. Following this line of reasoning, it is unclear as to why persons with mental health issues are treated differently. If the person is diagnosed with schizophrenia, is well aware that the voice they hear is imaginary and refuses to undergo the medical treatment, then such a person with a mental health issue is, arguably, in an analogues position to someone with an unwanted somatic health problem. [100]

According to one of survivors of psychiatry, with whom I had an interview while researching implementation of mental health legislation in Georgia, a lot of people experience such critical, "psychotic" situations in life, but once you get a diagnosis, you become a label. And that is all psychiatrists see. However, there is also a double standard. Often, it is not only the clinical symptoms, but the social status of the person, "if you are wealthy, popular or both nobody will

[99] Ibid.
[100] Ibid.

try to lock you up". My interviewee gave up on taking narcoleptics, after undergoing treatment (first involuntarily after being hospitalized against her will and then voluntarily), because the medication "made [her] numb" and negatively affected her overall physical health, nearly causing her kidney failure and liver disease. She also vaguely remembers the time she spent in the medical institution, where she was being held against her will. She was not given any information regarding her status or the treatment plan, the living conditions were "unimaginable… it is difficult to describe." [101]

[101] Name is intentionally omitted.

Concluding Remarks

This paper argues that involuntary treatment, as well as involuntary hospitalization, includes significant risks to human rights and therefore it is important to distinguish involuntary hospitalization and involuntary treatment to minimize those risks.

First of all, when discussing involuntary treatment and placement of persons with psychosocial needs, it is important that national jurisdictions distinguish independent grounds separately for hospitalization and treatment. Involuntary placement is relevant in the context of deprivation of liberty, for which the state needs to have legitimate aim. Moreover, in order to ensure the proportionality, there need to be specific conditions, such as real danger to person's life and/or property, set in law. In addition, it is important that the persons are protected under the procedural guarantees and have access to legal remedies including the right to appeal in front of competent judicial authority in a timely manner. In such cases, where the state has demonstrated existence of an imminent threat and presented a legitimate interest of safety and security which prevails individual's liberty considerations, involuntary placement is justified and the interference to the individual liberty of the persons with psychosocial needs stands the balancing test, provided that all the procedural guarantees are in place,

In terms of involuntary placement is it more difficult to identify the state interest which would prevail over person's fundamental right to physical integrity and autonomy. I find it hard to imagine a case scenario, where the involuntary treatment/long term medical intervention can be considered an adequate and proportional measure to the state legitimate aim. If, in such cases, as discussed in previous chapters, the state interest is public safety and the protection of others, involuntary long term treatment is not a justifiable measure to achieve the abovementioned aim.

In fact, as Sjostrand and Helgesson point out, coercive treatment as means to combat dangerousness is beyond the prerogative of health care professionals. However, in pre-defined critical situations, providing initial emergency intervention[102] in order to put the patient in the position where/when they are able to exercise their self-determination and autonomy is justifiable. Ideally, such interventions do not have to be strictly medical, and can take the social/spiritual dimension, where the patients can release the stressor and consequently can learn how to manage it.

[102] Note that emergency intervention should be terminated the moment the personal autonomy is restored.

Bibliography

Agnetti, Germana. “The Consumer Movement and Compulsory Treatment: A Professional Outlook.” *International Journal of Mental Health* 37, no. 4 (December 1, 2008): 33–45. https://doi.org/10.2753/IMH0020-7411370403.

“Convention on the Rights of Persons with Disabilities (CRPD).” Accessed March 31, 2017. https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html.

European Parliament. “Improving the Mental Health of the Population - towards a Strategy on Mental Health for the EU - P6_TA(2006)0341.” europarl portal. Accessed November 10, 2017. http://www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//TEXT+TA+P6-TA-2006-0341+0+DOC+XML+V0//EN.

European Union Law. “Green Paper - Improving the Mental Health of the Population - Towards a Strategy on Mental Health for the European Union.” Accessed October 29, 2017. http://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX:52005DC0484.

FRA – European Union Agency for Fundamental Rights. “Involuntary Placement and Involuntary Treatment of Persons with Mental Health Problems.” http://fra.europa.eu/en/publication/2012/involuntary-placement-and-involuntary-treatment-persons-mental-health-problems.

Iris Holling. “The Berlin Runaway-House - Three Years of Antipsychiatric Practice.” Accessed March 30, 2017. http://www.peter-lehmann-publishing.com/articles/others/iris_eng.htm.

Michael Bach, and Lana Kerzner. “A New Paradigm for Protecting Autonomy and the Right to Legal Capacity.” *LCO-CDO* (blog). Accessed November 30, 2017. http://www.lco-cdo.org/en/our-current-projects/the-law-and-persons-with-disabilities/disabilities-call-for-

papers-january-2010/commissioned-papers-the-law-and-persons-with-disabilities/a-new-paradigm-for-protecting-autonomy-and-the-right-to-legal-capacity/.

Parliamentary Assembly. "PACE - Recommendation 2091 (2016) - The Case against a Council of Europe Legal Instrument on Involuntary Measures in Psychiatry." Accessed November 10, 2017. http://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-en.asp?fileid=22757&lang=en.

"Schizophrenia Treatment Without Antipsychotic Drugs and the Legacy of Loren Mosher." Accessed November 29, 2017. /.

Sjöstrand, Manne, and Gert Helgesson. "Coercive Treatment and Autonomy in Psychiatry." *Bioethics* 22, no. 2 (February 2008): 113–20. https://doi.org/10.1111/j.1467-8519.2007.00610.x.

Solomon, Trudy. "Informed Consent for Mental Patients - Given the Reallity of Institutional Life, Is Such a Thing Possible." *Human Rights* 8 (1980 1979): 31.

Stefania Negri, Jochen Taupitz, and Amina Salkic. *Advance Care Decision Making in Germany and Italy*. Accessed November 29, 2017. http://www.springer.com/la/book/9783642405549.

Savenko, Yuri. "Rakevich v. Russia". *Transitions Online,* (November, 2013).

Human Rights Education and Monitoring Center, "Understanding Georgias' Legal capacity reform and its implementation". Accessed September 20, 2017.

8th General report on the CPT's activities covering the period 1 January to December 1997; 31 August 1998; pr 41 Available at: http://www.cpt.coe.int/en/annual/rep-08.htm

Kjellin et al. "Compulsory psychiatric care in Sweden – Development 1979-2002 and area variation". *International Journal of Law and Psychiatry*. 31(2008) 51-59.

Gvishiani Lela, "Forced Treatment, as rights violating practice". *Human Rights Education and Monitoring Center- EMC.*

Cases:

Kudla v. Poland, No. 30210/96, ECtHR 2000.

Y. F. v. Turkey, No. 24209/94, ECtHR 2003.

Storck v. Germany, No. 61603/00, ECtHR 2005.

Glass v. United Kingdom, App. no. 61827/00, ECtHR 2004.

Rakevich v. Russia, App. no. 58973/00, ECtHR 2003.

Winterwerp v. The Netherlands, App. no. 6301/73, ECHR, 1979

Stanev v. Bulgaria, App. no. 36760/06, ECtHR 2012.

D.D v. Lithuania, App. no, 13569/06, ECtHR 2012.

X. v. Finland, App. no. 34806/04, ECtHR 2012.

Herczegfalvy v. Austria, App. no. 10533/83, ECtH 1992.

Hutchison Reid v. The United Kingdom, App. no. 50272/99, ECtHR 2003.

Van Der Leer v. The Netherlands, App. no 11509/85, ECtHR 1990.

Kolanis v. The United Kingdom, App. no. 517/02, ECtHR 2005

Legal Acts and other sources

Charter of Fundamental Rights of the European Union. (2000/C 364/01).

"Green Paper - Improving the Mental Health of the Population - Towards a Strategy on Mental Health for the European Union."

Convention on the Rights of Persons with Disabilities.

UN CRPD General comment N1.

The Convention for the Protection of Human Rights and Dignity of the Human Being – Oviedo Convention.

Explanatory Report to the Convention on Human Rights and Biomedicine.

COE Recommendation 2091(2016).

European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)

Georgian Parliament decree, 2013

Georgian Constitutional Court decision N2/4/532,533. October 8, 2014.

Law of Georgia on Psychiatric Assistance.

Georgian comprehensive state report to CRPD.

Ombudsman of Georgia: Special Report.

SFS:2001:453 Swedish Compulsory Psychiatric Care Act.

UN Committee against Torture 2008:76

EMC, “Guidelines on the Implementation of the UN Convention on the Rights of Persons with Disabilities (UNCRPD).”

ENUSP Shadow Report.

Law Commission of Ontaria.

Previous coursework materials from Law and Bioethics and Mental Health Law and Disability Classes.