THE TREATMENT OF MENTALLY ILL IN THE INTERNATIONAL HUMAN RIGHTS INSTRUMENTS

AN STUDY ON THE EVOLUTION OF THE LEGAL TREATMENT OF MENTALLY ILL

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ABSTRACT

This work is the result of a research on the evolution of the legal treatment received by mentally ill in the international human rights instruments. Especially focused on a comparisson between the European Convention on Human Rights (ECHR) and the Convention for the Rights of Persons with Disabilities (CRPD).

The initial idea was to determine the consequences of deinstitutionalisation on the human rights field. But, when deeply studying article 5 of the ECHR, which permits forced detention, the author realised the contradiction of this provision with the deinstitutionalisation process and with human rights standards overall. Therefore, it was decided to focus on the study of the legal treatment of mentally ill through the study of their forced institutionalisation and forced treatment through history. However, during the study, the author finds out that the human rights instruments had not prohibited this practices until recently (CRPD), rather have regulated and legitimated them (ECHR). Autonomy and capability arise as two key elements in order to finish with disempowerment practices and give the rights back to mentally ill in an equalitarian ground.

The contributions of this project are twofold. First, is demonstrated that human rights are not free from contextual influences and they evolve through time parallell to society's attitudes and awareness. Secondly, the benefits of applying the CRPD provisions to mentally ill are exposed. But it will be necessary to abolish existing mental health laws and article 5 of the ECHR in order to comply with the CRPD.

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INTRODUCTION

1. HISTORICAL OVERVIEW

The history of separation and segregation of groups of people that "deviate" from the norm is and had been common since centuries. As detailed in Foucault's thesis "History of madness"[1]: since there is documentation mentally ill had been segregated.

On the fifteenth century, on the historical period called Renaissance, any "deviant" was sent out to the limits of the cities or in galleys or boats to other destinies, on the "ship of the fools".

Later on in the seventeenth century, came the times of the "Grand refermement." Those considered "deviants" were locked up in places of confinement created all over Europe. Confinement worked as a social mechanism. It allows society to expel the "asocial".[2] At the beginning, either prostitutes, profaners, libertarians, the vagrants, the "mad" and any other group acting "different" from the stipulated behaviour was closed together on these institutions were they were assigned a work. It was not just a social method to organise society, but it also seeks being economical productive.

After that period came the "modern experience" of madness. When the psychiatric hospitals or lunatic asylums substitute the houses of confinement. They still detained the ones labelled "mad" but with a new aim to "cure" and experiment. They became the object of interest of science. But they stop being productive and became a burden for the State.

On the fifty's, the elevate costs of the institutions, the advance on psychotropic medicines and the response to the human rights abuses that were taken place in the institutions trigger the deinstitutionalisation movement. It can be defined as "the replacement of long-stay psychiatric hospitals with smaller, less isolated community-based alternatives for the care of mentally-ill people".[3]

[1] Foucault , 2006.
[2] Foucault , 2006, p. 18.
[3] Lamb & Bachrach, 2001, p.1039

On the fifty's in the US[4]and in 1978 in Italy[5], - the first European country to begin the movement with the "Basaglia Law"[6], - started the process. It was aimed at eliminating psychiatric hospitals to develop a community-based psychiatric system.

Even though few countries had nearly totally eliminated the obsolete psychiatric hospitals, i.e. New Zealand, most of them still make use of the same or similar institutions. It is the so-called "re-institutionalisation" movement or relocation to different institutions. A consequence of that process might be the alarming data about the rise of mentally ill inmates in jails in the western world.[7] Maybe also the increase of homeless who were users of psychiatric services[8].

However, the latter facts are difficult to proof because of a lack of data on diagnosis of mental illness some decades ago, because of the continuous increase of disorders categorised as psychiatric conditions and also because of other external factors that could influence the situation: the toughening of the criminal codes or the restrictive conditions on prisons that are often the cause of the development of a mental disorder on inmates after being incarcerate. In other cases where a disorder might have existed previously of the entrance in prison, it might have been unobserved during the whole criminal process. All these variables make it difficult to know wether the deinstitutionalisation process together with the lack of an effective instauration of the community services is the cause of the situation in prisons or not.

To clear the causes of this situation is not the object of study of this thesis. But is necessary to have an overview on the old centurial practice of division and segregation of mentally ill to better understand the contemporary context of the situation and the aim of the thesis.

[4] Lamb, 1993, p. 587
[5] Russo & Carelli, 2009.
[6] However, on 2011 Italy was the target focus of human rights activists when several still running psychiatric institutions were discovered to treat their patients in inhumane ways. For more information: http://www.repubblica.it/salute/medicina/2011/03/16/news/viaggio_negli_ospedali_psichiatrici_giudiziari_italiani-13671732/
[7] Lamb & Bachrach, 2001, p.1042.
[8]Idem, p.1040 - 1041

2. THE AIM OF THE THESIS

The situation of human rights abuses that had suffered the ones labelled as "mentally ill" through history is still perpetuated nowadays all over the world. Even at the western world and at the most socially developed states, cases concerning the treatment of mentally ill arise from now and on in the media.[9] Hundreds or thousands remain concealed. But nearly most of them suffer the consequences of stigma, exclusion and discrimination that the condition of a mental diagnosis entitles.

There is an interesting indivisibility between the human rights, the law and the psychiatry. Those labelled as mentally ill are usually carrying legal consequences, like incapacitation, forced institutionalisation or the denial of responsibility on the criminal system.

The psychiatry and its methods of treatment had often legitimate coercive and forced treatment or detention. These methods had also been historically used to "suppress" dissident political opinions. And mentally ill had been a targeted group for experimental psychiatry and medicine in certain periods of history. Mental health laws had often regulate such practices.

Forced involuntary institutionalisation and the legal consequences like incapacitation tend to leave the individuals powerless and without "voice" to stand up for their rights. It is usually when a situation of deprivation of liberty and/or deprivation of capacity takes place when human rights abuses and violations happen.

Thus, the human rights instruments should be especially involved on the protection of this vulnerable group. In order to avoid the continuity of certain degrading traditional practices and to empower this group of people. However, human rights law is a human creation, thus it is not free from the influence of societal and cultural prejudices and values. Some beliefs or "patrons" are so deeply-rooted on society that even international human rights instruments hardly overcome them.

This situation brings the author to wonder how the mentally ill has been treated on the human rights history. Thus, the aim of this thesis is to study the treatment of the mentally ill in the international human rights documents at different moments of history.

[9] Cfr. Supra footnote 6, p.2

We will do so analysing the treatment of mentally ill on two significant human rights documents from two different moments in history: the European Convention on Human Rights (ECHR) drafted on 1950 and the Convention for the Rights of Persons with Disabilities (CRPD) from 2008.

Each historical period shows the manner in which "unreason" was perceived at that moment. This perception is a reflection of the social structures of the different periods and is closely related with the dynamics of the dominant powers and their legitimisation of certain beliefs, while the ones "deviating" from the dominant belief are consign to oblivion. The dominant groups are the ones enacting the laws. Thus, the laws reflect the manner in which society perceive the mentally disordered at any moment of history. This thesis aims to proof that also human rights law is evolving on time parallel to society's evolution. Therefore, it is not free from the social prejudices and values that dominate the perception towards mentally ill.

The first part of the thesis is dedicated to the general questions that rise controversy on the field of mental health. A general overview on the problematic of the contextualisation and definition of mental illness is exposed.

In order to evaluate how far the international human rights documents promote mental health or, contrary, relegate it to a secondary or implicit element of the "right to health", the thesis will overview how the different instruments had referred to this question. This general evaluation reflect whether international human rights treaties prefer a disperse or a consolidate treatment of the "right to mental health". The description and the differences on the two legal approaches are also exposed.

On the second part, the work focuses its attention on the legal treatment of mentally ill given in the ECHR.

The ECHR is a document drafted at the beginning of the history of human rights, on 1950 and at the rise of the deinstitutionalisation movement.

Even though the scope of the ECHR is limited to the parties of the Council of Europe (CoE), the author finds very interesting to analyse the regulation on this document. Because it is still the only human rights document providing for such an enforcing mechanism as a Court were individual complaints can be held, the European Court for

Human Rights (EctHR). Consequently, the jurisprudence of the Court and of the former European Commission on Human Rights (Commission)[10] is used to support the study.
Through the evaluation of the jurisprudence of the Court in relation to mentally ill, the main human rights concerns related to this group will be identified.
Later, the study will specially centre its attention on article 5.1.e) from the ECHR. It is one of the articles with more case law on the EctHR.
The author seeks to proof that it is a discriminative and obsolete provision and that reflects the stigma lying on mentally ill . The methodology to do so will be the analysis of several case-law, the use of other provisions to set equality and discriminatory standards and the use of studies and surveys from other authors to support the theory of the author. The prevailing logic will surround the arguments.

On the third and last part, the recent CRPD from 2008 will be studied.
First of all, are exposed the different approaches to mental illness and disability: the social and the medical model. These points are very significant in order to understand the different construction of the two documents that are being analysed. It is exposed at this point because of the relevant role played by the social model in the overall text of the CRPD.
Following, it is evaluated how and whether its innovative provisions and the social model it proclaims can be used to benefit mentally ill. The articles and values of the CRPD of our interest are assessed and analysed.
The success or failure of its implementation will be also briefly studied through the evaluation of the content of the initial reports submitted by the State parties.
Finally, the treatments on the ECHR and on the CRPD will be compared.

[10] The European Comission on Human Rights held an important role on assisting the EctHR from 1953 to 1998. Its role was to decide if an application was admissible to the Court. It would examine it, try to settle it in a friendly manner. Otherwise would issue a report to the Court with the facts and their opinion on wether a violation or not had occurred. More information available at: http://www.unhcr.org/refworld/publisher/COECOMMHR.html

PART 1.

CONTEXTUALISATION

1. WHAT IS A MENTAL ILLNESS? CONTROVERSIES AND LACK OF DEFINITION

It is of significance for the purpose of this thesis to dedicate a chapter to explain the controversies and conflicts that this definition entitles. For the determination of an appropriate one for this work it is necessary to expose an overview of the legal, clinical and social approaches of the definition.

Firstly, the thesis will briefly explain the importance of having clear a meaning of a term. Afterwards, it will explain the lack of a definition from a legal approach. Thirdly, we will briefly explore on the causes of this gap, which lay on a lack of agreement of the terms on the medical world. Thus, we will have a look at the medical definition of mental illness and its controversies. On the following, we will briefly make an in-put on the social definition of mental illness and its relation with the CPRD.
Finally, and due to what had been exposed, the thesis will specify which meaning of the term is going to use for the rest of the work.

1.1 Importance of a clear meaning of the term mental illness.

The content of meaning that will be given to a particular term, - mental illness in this case, - is often a value judgement.[11] But language is not neutral.[12]Quoting Fein[13]: "Not only do the words we use to describe events and express ideas reveal something about our present attitudes, but repeated often enough, words also affect the way we look at things and thus help to determine future attitudes". The language reflects values and behaviours. Further, it creates "labels". Margaret A. Somerville suggests that [14]"on a neutral situation, where no label has been attached, an independent observer may classify or treat a patient differently from the way he would had the patient already been

[11] Somerville, 1985, p.188.
[12] Fein, 1982, p. 863 – 864.
[13] Idem.
[14] Somerville, 1985, p. 188

labelled." Hence, once a label is attached, it leads to a differentiate treatment. A differentiate treatment can lead to discrimination, which is on itself a human right violation. Notwithstanding it have huge psychological and social consequences, which can lead to legal consequences. Thus, naming is not a simple act. It is a "power" issue. Consequently, is seems safer to have always a clear idea of what a term means in order to avoid mistaken definitions.

The condition of "mentally ill" creates a label and a stigma that can have notorious impacts on the rights of the person suffering it. As a consequence of the grossly abuses committed against the individuals named as mentally ill, last decades the need to define the term and frame its scope has increased. Especially because of the interference on their lives that such a diagnosis implies. Mainly on establishing their capacity status and to set their responsibility during criminal process. However, there is no one single definition of mental illness universally accepted. Its definition is still a confusing and controversial issue that varies across jurisdictions and professions[15]. Quoting B.Wilson[16]: "Definitions of mental illness are notoriously difficult to draft. If they are framed too narrowly they deny services to people. If they are too broad they may result in unnecessary intervention."

1.2 Legal definitions of mental illness

There is an absence of an established definition of the construct of mental disorder on the science of psychopathology. Hence, it is very hard for lawyers, legislators, judges and other professionals of the law to overcome this obstacle when there is a need to interpret and apply the law that affects this group of people. Continuous attempts to draw the borderlines of mental illness had been made in the psychiatry at an international level and multiple classifications and definitions had been given at national levels. Mostly all countries had specifically defined in law "mental illness", some more or less broadly.[17]

[15] Karras, McCarron, Grey & Ardasinskyi, 2006.
[16] Wilson, 1995, p. 312.
[17] i.e. Under UK's Mental Health Act 2007 mental disorder is defined in a short way open to interpretation and link to disability: "mental disorder" means any disorder or disability of the mind. i.e. Under the Mental Heal Act 1990 from Australia (NSW) a long and specific defintion is used: "mental illness" is defined as a condition characterised by the presence of symptoms such as delusions,

From a human rights legal approach, neither the EctHR has dare to give a definition of the term: "This term – ("unsound minds"[18]) - is not one that can be given a definitive interpretation: it is a term whose meaning is continually evolving as research in psychiatry progresses, an increasing flexibility in treatment is developing and society's attitude to mental illness changes, in particular so that a greater understanding of the problems of mental patients is becoming more wide-spread (...)".[19] On the other hand, it is common for the EctHR and the Commission to avoid discussing and defining conflictive substantive terms.[20]

The only classification found at an international level from a human rights international organisation is the one given on the "Report on the situation of the mentally ill" from 1977 by the Parliamentary Assembly of the Council of Europe. It classifies mental disorders in three categories[21]: a) Brain disorders b) Mental deficiency c) psychogenic disorders. Whose causes are not clearly traceable to a physical cause or to structural damage of the brain. This latter one include the major psychoses.
This classification is based on medical concepts and not on social ones. It substantiates again the interrelation between medical, legal and human rights issues.

If we would search mental illness or mental disorder on any legal dictionary, we will find some uncertain definition like the following one: "a psychiatric disorder; a clinically significant disease, illness or disability of the mind."[22] All of them medical-based concepts.

To conclude, the legal definitions are relying on the clinical ones and are also much linked to the notion of "disability". The problem is that there is neither a universal consensus on the clinical definition and scope of mental illness.

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hallucinations, serious disorder of thought form, a severe disturbance of mood, or sustained or repeated irrational behaviour, which seriously impairs, either temporarily or permanently, the mental functioning of a person. A "mentally ill person" is someone who suffers a mental illness where, owing to that illness, there are reasonable grounds for believing that care, treatment or control of the person is necessary, for their own or others' protection. This determination must take into account the person's continuing condition, including the effects of any likely deterioration in their condition.

[18] This is the term used in the European Convention of Human Rights to identify major mental disorders or other severe disorders. Rise critics by tiself and prospects of being perjurative and not the adequate one. The thesis develops further on this point on p. 24.

[19] *Winterwerp vs the Netherlands*, Application nº 6301/73, Judgement October 1979, §37.

[20] Donar algun exemple més.

[21] Tabone & Voogd, 1977, p.6.

[22] Duhaime.org, Legal Dictionary, availabe at http://www.duhaime.org/LegalDictionary/M/MentalDisorder.aspx (last consulted on 6 June 2012)

1.3 Clinical definitions

On a psychopathologic point of view, proposals and compelling critiques for the existing proposals are continuously being developed. Widiger[23] refers to, i.e. Bergner 1997, Dammann 1997, Lilienfeld & Marino 1995, Nathan & Langenbucher 1999 and Wakefield 1999, among others.

Continuous attempts to categorise and divide into groups the "mental illness" depending on its physiological causes are documented since the beginning of the interest of science on any "deviant behaviour".

Nowadays, in the psychiatric world the most popular manual for categorising and describing the types of mental diagnosis is the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association (APA) to diagnose "mental disorders". The DSM[24] contains descriptions, symptoms and other criteria for diagnosing mental disorders, no treatment information, which provide a worldwide common language among professionals who treat patients with these disorders. A definition of "mental disorder" has neither been set in here. The DSM classifies the "mental disorders" using a categorical system according to their predominant features. Sixteen "mental disorders" were categorized when writing this thesis.[25]

The DSM is using the term "disorder" instead of "disease" because it is a more general term that implies "a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability; and which reflects a psychological and/or biological dysfunction on the individual."[26] An illness or disease is a narrower term that implies the need to know the

[23] Widiger & Sankis, 2000, p. 378.
[24] At the time of this theis the DSM-IV was the manual in use, while the DSM-V was being drafted and expected for 2013. More information available at the American Psychiatry Association, available at http://www.dsm5.org/about/Pages/Timeline.aspx (consulted 6 June 2012).
[25] Adjustment disorder, anxiety disorder, dissociative disorder, eating disorder, impulse-control disorder, mood disoder, personality disorder, psychotic disorder, sexual disorder, sexual disorder of gender identity, sexual disorder of paraphilias, sexual disorder of sexual dysfunction, sleep disorder, sleep disorder of dyssmonias, sleep disorder of parasomnias and somatoform disorder.
[26] The Virtual Psychology Classroom, 29 November 2011, available at http://allpsych.com/disorders/dsm.htm (consulted 6 June 2012)

aetiology of the medical diagnostic.[27] But the DSM decides to use the term "mental disorder" because its generality was used to gain a broader acceptability and not felt too much medical oriented, as the objective of the DSM is to categorise the disorders, not to find its causes.

Many critics had been laid on the way the DSM classifies "mental disorders" and on its use. On the following we will enumerate some of them:

Its lack of biological assessment, validity and reliability. Being the Rosenhan experiment a great example of the failure of psychiatry to diagnose[28].

Because of its categorical system that forgets the dimensional approach. The dimensional approach takes more in account the temporal and social context on the diagnosis. But just 3 from the 886 pages of the DSM-IV take in account dimensional measures[29]. Some dimensional assessments are being considered on the creation of the future DSM-5.[30]

Its use of arbitrarily divisions between normality and abnormality to define a disorder has also been criticised. Widiger[31] strongly critics some of the criteria used on the DSM that make it difficult or impossible to distinguish between just a maladaptive behaviour in living or a true psychopathology. It seems that "normality" is the base criteria to define a dysfunction, but "normality" is a subjective and relative term changing on time and culture. Thus, it is an inherently value judgment on the basis of what is an adequate, common or optimal functioning.

At this point, another of the critiques of the term "disoerder" used in the DSM is the westernisation of the concept on an American bias approach. The concept of disorder "emerge in a particular place (North America), in a particular era (the second half of the twentieth century), in a particular cultural milieu (the encounter of the neneokraepelinian and neoempiricist-psychiatrists) and in reply to particular challenges"[32]. So it is a cultural relative term.

[27] Aragona, 2009.
[28] Further development of the Rosenhan experiment on the thesis p. 42.
[29] Read, 2006 (a), p. 54.
[30] There is a division on the clinical field on the dicotomy: categorical / dimensional approach to classify mental illness/disorders.
[31] Widiger & Sankis, 2000.
[32] Aragona, 2009, p.12.

Moreover, Widiger refers in his article to Follette 1996 and Rogler 1997 [33] who claim that an increasing number on the diagnosis on each DSM edition might be either a political consequent and not a scientific one, an excuse for American health insurances to higher their rates and a consequence of the power of the pharmacological industry. And/ or either an intent to psychiatrise society.

The question whether mental "disease", "illness" or "disorder" are scientific biomedical terms or sociopolitical terms is not the issue of this thesis. But it is important to keep this point on mind to understand the complexity of the ethical and human rights issues arising from the legal consequences of targeting someone with one of these terms. Terms which, as stated, are not even clearly identified for the psychiatric world on a medical basis and are very controversial.

1.4 Social definition of mental illness and its link to disability

The legal definitions tend to use the medical dimension of "mental illness". On the other hand, the definitions are often also link to disability and some of them even directly relate mental illness to disability.

However, the term "psychiatric disability" is a narrower term than mental illness.[34] Not everyone with a mental illness will consider themselves, or be considered, disabled.
Nevertheless, it is of importance to consider briefly in here the social model of disability, and in extension of some mental illness.[35] This model understands the source of disability not the impairment itself, but the social and economical barriers that discriminate and exclude those suffering from the impairment. So, when the "responses of society towards impairment" are ones that fail to provide appropriate services and to ensure the needs of this people on its social construction model, this group of people will be considered disable.[36]So, the disability will depend on their social inclusion and their ability to adapt, not on the impairment.

[33] Widiger & Sankis, 2000, p.379.
[34] Karras, McCarron, Grey & Ardasinskyi, 2006.
[35] Further developed in pp. 60 – 61.
[36] Karras, McCarron, Grey & Ardasinskyi, 2006.

The social definition is "at the heart" of this thesis. It allows us to relax upon the medical definition problem and to define the scope of mental illness depending on their inclusion and adaptability to society.
A further chapter is dedicated to the relation between mental illness and disability and the way how the CPRD gives a new approach to the protection of this group through a social model.[37]

1.5 Working definition of mental illness for this thesis

This document is not a medical thesis and the writer's skills on medical issues are limited, so the thesis is going to use the words "illness", "disorder", "disease" and "psychiatric condition" as synonyms on the following. These terms are going to be used here in a not medical but a legal approach to describe "persons who, because of their mental health, are not capable of functioning in society in a manner that does not attract legal consequences"[38]. Those whose mental condition or they being "labelled" with a certain mental condition carries legal consequences and/or change their criminal status are the object of the thesis. Because these are the situations when human rights can be and had been easily denied or abused on the name of "cure" or "protection of public interests".

Anyway, we need to difference intellectual disability, defined "as an impoverishment in intellectual competency as a result of either an innate fault in the individual's development potentiality, or an arrested development" [39]from other mental disorders. The latter is an updated definition to the one given by the Parliamentary Assembly of the Council of Europe on its report on the situation of mentally ill.[40]

The thesis will not analyse the treatment of the so called "intellectual retarded". But mental disorder will be interpreted in a broad way. However, not mention to specific disorders will be done, in order not to mislead them and to raise confusion.

[37] Further information, p. 51.
[38] Wachenfeld, 1992 (a), p. 5.
[39] Tabone & Voogd, 1977, p.6
[40] Idem.

1. 6 Conclusion

The lack of universal definitions and strict interpretations on the above-mentioned terms leads to mix, confuse and assimilate mental illness, mental disorder, mental disability, intellectual disability and psychiatric disorders as one solely term, decontextualising them. It should be further studied if this lack of ability to define and specify the mentally ill "group" of people is actually decreasing its protection on the law. Or by contrary if the flexibility of the concept can be positive to protect a wider group of people.

2. MENTAL HEALTH AS A HUMAN RIGHT.

This chapter is dedicated to assess if mental health is recognised as a human right. Also to check if it is dealt as an independent human right or contrary if it is included in the "right to health". In order to discover so, we need to know the content of the right to health.

First, we will have a brief overview on the importance to recognise the "right to mental health" as a human right. Immediately afterwards, a discussion about the advantages and/or disadvantages of treating mental health separately from the general "right to health" or not, the so-called consolidate or disperse treatment, will take place. On the third subchapter, the author has assessed the international human rights documents protecting and giving some guidelines on the protection and promotion of the "right to health", searching for special emphasis on the "right to a mental health" in order to evaluate if the treatment given at the international human rights level is more consistent with a dispersed treatment or with a consolidate one. When analysing those documents and to support the analyse outcomes' a brief view on international health definitions will be necessary.

2.1 The importance of a right to mental health as a human right.

The "right to health" is widely accepted as it is explicitly embedded in several regional and international human rights instruments. However, its core content is not clearly specify and when it is, is not universally accepted. Consequently, disagreement persists whether mental health is an inherent part of the general "health" term, whether it is a separate element or merely an aspirational or rethorical claim.

Independently if the existence of a right to mental health is recognised "inside" the right to health or on itself; the importance to frame mental health as a human right, rather than a mere moral claim, is that its recognition "entitle" the right-holder and create obligations for the duty-bearer. Thus, States would possess binding obligations to respect, protect and fulfil a "right to mental health".

2.2 Dispersed treatment or consolidate treatment of mental health.

An ongoing discussion among human rights and law professionals is taking place concerning the advantages and/or disadvantages on the inclusion of mental health in the general term "health" and its need of consolidate or separate treatment in the legal system.

On one side, the so-called dispersed treatment englobes those who agree that mental health does not need to be mentioned explicitly and does not need separate legislation regulating it because it is an element of the general term "health". On this line, the supporters agree that the explicit mention and separate treatment of mental health in the law emphasise the segregation of mental health issues and persons with mental disorders. "It has the potential to reinforce stigma and prejudice against persons with such disorders"[41]. If separating mental health from the general meaning of "health" the latter is reduced to "physical health". The argument pose by the dispersers is that separating mental health from physical health is neither helping to improve general health standards nor to increase protection of mentally ill, contrary is raising discrimination.

[41] WHO, 2003, p. 10

On the other side, the consolidate treatment, consists on treating mental health issues separate from general health issues. The supporters on this line agrees that separate recognition and treatment of mental health gives good opportunities to rise public awareness of mental disorders and to educate policy makers and the general public about human rights issues, stigma and discrimination concerning this group of people.[42]

An overview to the European national legislations shows that most of them have enacted special mental health acts, save Spain, Greece and Italy.[43]

It has not been proven that one approach has better results than the other. A combined approach is claimed to be the more likely to address the complex needs of this group of people. Therefore, a combined approach will include mental health issues indifferently inside other issues, but at the same time will complement them with some specific mental health legislation.[44]

2.3 The international legal framework on the protection of the right to health and to mental health.

A considerable number of international and regional human rights instruments firmly mention the right to health in their provisions as one of the main human rights. On this section, it has been evaluated if these documents give special emphasis on the right to mental health, on the line of a consolidate treatment or not.

The first organisation which states explicitly the "right to health" was the World Health Organization (WHO) on its Constitution of 1946. The preamble establishes the "highest attainable standard of health" as a fundamental right of everyone and defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.[45]"

None of the following International Covenants, treaties or protocols, save the Protocol of San Salvador (OAS 1988)[46], define again the right to health. Both documents had

[42] WHO, 2003, p.10
[43] Salize, Dreßing & Peitz, 2002 (b), p. 20.
[44] WHO, 2003, p.10
[45] WHO, 2006, p.1
[46] Article 10 Protocol of San Salvador : "Right to health 1. Everyone shall have the right to health, understood to mean the enjoyment of the highest level of physical, mental and social well-being.(...)"

specifically mentioned mental health as one of the elements composing the right to health, and necessary to achieve a "complete state of health."[47]

On article 12 of the International Covenant on Economic, Social and Cultural Rights (UN 1966)[48], on article 10 of the Protocol of San Salvador[49], on article 16 of the African Charter on Human and People's Rights (OAU 1981)[50]and on the principle 8 of the Programme of Action of the ICPD (UN 1994)[51] mental health is especially emphasised. Always as an element conforming the core content of the right to health, next to physical health and sometimes also next to the social well-being. It has not been mentioned in any of them as an independent right.

The other human rights documents that embed the right to health: article 10 of the Declaration on Social Progress and Development (UN 1969), article 11 of the European Social Charter (CoE 1961), article 11 of the American Declaration of the Rights and Duties of the Man (OAS 1948) and the Cairo Declaration on Human Rights in Islam (OIC 1990), implicitly in article 17, do not mention mental health. Two hypotheses arise from this option: either mental health is without doubt considered to form part of the right to health; hence no mention to it is necessary. Either the documents want to avoid the discussion about the content of the right to health and leave the concept open to interpretation to the jurisdictional bodies.

It is also of significance to remark that the Universal Declaration of Human Rights does not mention directly a right to health. Even though its article 25 states: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care (...)." Neither the ECHR does directly grant protection to the right to health. Because the State Parties could not agree upon a limited right which could be considered appropriate for enforcement by

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This is a very interesting article. It defines health and gives special emphasis on the education of population about health, recognising the lack of knowledge about it. Moreover, it offers a special protection in f.) to those highest risk groups where, even though not explicitilty mentioned, mental health sufferers could be included.

[47] This is the term used in the Preamble of the WHO Constitution to understand what is a "healthy state." However, this affirmation has received huge critiques and has been mainly denied by the other international organisations.

[48] Article 12 ICESCR: "The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. (...)"

[49] Cfr. Supra footnote 44, p. 16

[50] Article 16 African Charter of Human and People Rights: "Every individual shall have the right to enjoy the best attainable state of physical and mental health.(...)"

[51]Programme of Action of the ICPD: "CHAPTER II-PRINCIPLES: principle 8: Everyone has the right to the enjoymnet of the highest attainable standard of physical and mental health. (...)"

the EctHR.[52] Therefore, there is not an available robust corpus of jurisprudence that we could use to specify the content of the right to health at an international level. Regardless of some mentions done to it in reference to article 8 ECHR.

To summarise, the international human rights documents use a disperse treatment of mental health, because this is either referred as part of the right to health or it is either totally ignored. None of the above-mentioned documents specifically mention a right to mental health.

On the other side, even though they are not binding Conventions, a set of resolutions and recommendations exist which especially protect and promote the rights of persons with mental illness and declare mental health as an independent right. The best known in this context, - without taking in account the recent CRPD[53],- are: the Recommendation R(83)2 "The legal protection of persons suffering from a mental disorder placed as involuntary patients" from 1983[54], the "Parliamentary Assembly of the CE Recommendation no1235 on psychiatry and human rights" from 1994,[55] the "United Nation's General Assembly Resolution 46(119) Principles of the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care" from 1991[56]and the "Recommendation of the Committee of Ministers of the Council of Europe no(2004)10 of the Committee of Ministers of the Council of Europe" from 2004[57].

Are also very significant the "Declaration of Human Rights and Mental Health" by the World Federation and Mental Health on 1989[58]and the 10 basic principles established by the World Health Organisation (WHO) in 1996 about "Mental Health care law"[59].

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[52] Nielsen, 2001, p.32.
[53] Further Part 3 of the thesis is dedicated to it.
[54]Council of Europe, Committe of Ministers Recommendation, 22 February 1983, available at https://wcd.coe.int/com.instranet.InstraServlet?command=com.instranet.CmdBlobGet&InstranetImage=602308&SecMode=1&DocId=678490&Usage=2 (consulted 7 June 2012).
[55] Council of Europe, Parliamentary Assembly Recommendation, 12 April 1994, available at http://assembly.coe.int/Main.asp?link=/Documents/AdoptedText/ta94/EREC1235.htm (consulted 7 June 2012)
[56] United Nations, General Assebly Resolution, 17 December 1991, available at http://www.un.org/documents/ga/res/46/a46r119.htm (consulted 7 June 2012).
[57] Council of Europe, Committe of Mibnisters, 22 Setember 2004, available at https://wcd.coe.int/ViewDoc.jsp?id=775685&Site=CM (consulted 7 June 2012).
[58] World Federation on Mental Health, October 1989, http://www.wfmh.org/PDF/DeclarationHR&MH.pdf (consulted 7 June 2012).

Though they non-binding character, these documents are creating standards that serve as guidelines to protect mentally ill. Their existence is, on the opinion of the author, enough proof to affirm the existence of a notorious awareness about the need to protect the rights of mentally ill. Mentally ill people are undoubtedly recognised as a group on need of protection due to a feature that makes them more vulnerable: a mental disorder. The recognition of the existence of such characteristic automatically activates the recognition of certain rights. These rights would not have logical sense to exist if the basic characteristic that "entitles" this people of the latter rights (the mental disorder) is not subject of improvement on itself. Thus, a basic human right to mental health, either mentioned inside the right to health or either separated, must exist in order to entitle the ones suffering from a mental disorder of the special protection that they have the right to. The right to mental health is the basic right from where grow the rest of the special rights related to the condition of having a psychiatric diagnosis.

If any doubts about the existence of a right to mental health still exist, the General Comment nº 14[60] adopts the definition of the ICESCR that clearly mentions both physical and mental health as part of the right to health. Also the Special Rapporteur's Mental Health Report by Paul Hunt[61], explicitly mentions mental health as a component of the right to health.

We can conclude that the right to health includes the right to mental health. However, what is the exact content and scope of the right and which exact obligations it imposes to the State is another unsolved issue.

Is the right to mental health a positive right? The definitions of the right to health developed by General Comment Nº14, the Special Rapporteur's Mental Health Report (Paul Hunt), the CRPD and the developing jurisprudence on the right to health[62] set a precedent defining a broad right to health.

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[59] World Health Organisation, 1996, available at http://www.who.int/mental_health/media/en/75.pdf (consulted 7 June 2012).
[60] United Nations, Committe on Economic and Social and Cultural Rights, 11 August 2000, available at http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En (consulted 7 June 2012).
[61] Paul Hunt, 2005.
[62] The Inter-American comission of human rights have especifically recognised the right to health and some of the obligations that it entailed, like i.e. the access and availability of health services for mentally disabled in *Victorio Rosario Congo v Ecuador*, informe 12/97, case 11.427, Judgement march 1997.

On this line, high standards of obligations are set for the State, including the provision of community based preventive mental health services, treatment facilities and rehabilitation services. It would also require governments to assure that mental health services are available, accessible, and acceptable and of appropriate quality, following the norms established in the General Comment.[63]

2.4 Conclusion

From the above mentions we can abstract the existence of a human right to mental health, as an element conforming the right to health, even though not as an independent right. But it is very difficult to delimite exactly which is the content of this right to health. Quoting Brigit Toebes[64]: "the problem with the right to health is not so much a lack of codification, bur rather an absence of a consistent implementation practice (...), as well as a lack of conceptual clarity." These problems are interrelated, as one, in turn, supports the continuity of the other one and vice verse. Therefore, the inconsistence with the content of the right to health makes it very difficult for the right to mental health to be universally recognised, and even more to be implemented. Even though nowadays we can consider the existence of such a right, the international human rights legislation and jurisprudence is still reticent to directly claim a right to mental health and its implementation. If the basic right to mental health can not be clearly claimed, the provisions protecting the mentally ill against human rights abuses can not achieve their maximum efficiency.

To consider if the right to mental health should be consolidate as an independent right, or rather included in the right to health, goes beyond the purpose of this thesis. However, and until nowadays, the tendency in the international human rights field is to include it as part of the right to health. Contrary, the national governments tend to provide consolidate mental health legislation.

The ECtHR jurisprudence does not recognise directly the right to health as it is not one of the rights set in the ECHR, but several references to it has been done when referring to article 8 of the ECHR. Some relevant cases are: *Moldovan v Russia*, Application nº 55723/00, Judgement of 9 June 2005; *Taskin and others v Turkey*, Application nº 46117/99, Judgement of 10 November 2004, *Novoseletskiy v Ukraine*, Application nº 47148/99, Judgement February 2005.

[63] Gable & Gostin, 2009, p.257.

[64] Toebes, 1999, p.665.

PART 2

ANALYSE OF THE TREATMENT OF MENTALLY ILL ON THE EUROPEAN CONVENTION ON HUMAN RIGHTS AND ITS BODIES.

1. HUMAN RIGHTS ISSUES. Violations and abuses concerning the mentally ill.

On this chapter we will overview the human rights abuses and violations on mentally ill through the case-law of the EctHR.

The author has chosen to use the EctHR because it has been recognised as having particular significance in the development of the European Union Law, and its requirements and the case-law of the EctHR are considered part of the general principles of EU law which the Court of Justice of the EU (CJEU) applies to ensure the application and respect of the Treaties.[65] Furthermore, The ECHR is the only human rights treaty with such an enforcement mechanism as an international court where individual complaints can be held.

1.1 Limitation on the rights of the mentally ill.

Human rights provide a framework mainly for the relation between the individual and his government, but also to a lesser extent between the individual and the international community and other human beings. Some of these rights are non-derogable, like the right not to be tortured, therefore it can not be denied under any circumstances. But other rights are derogable, so they can be restricted or completely suppressed, under some circumstances. Usually in behalf of public's interests. The interest of public safety is actually the most used justification to limit individual rights.[66]

Mentally ill is one of the few targeted groups some of whose rights can be diminished or denied just because of their condition. They are also a group whose individuals interests' are put at the stake on behalf of collective interests, and the latter had often weight more than the individual rights of the ill.

[65] Schutter, 2011, p. 9.
[66] i.e under article 8, 9, 10 and 11 of the ECHR.

The implementation and slowly consolidation of the right to health has raised lot of awareness about the vulnerability of mentally ill, while creating a set of standards and guidelines to protect them. However, and quoting the Special Rapporteur on the right to health, Paul Hunt, mental health is still "among the most grossly neglected elements of the right to health."[67]We can deduce from this quote that mentally ill are among the subjects suffering most abuses and violations of human rights.

1.2 Mentally ill human rights abuses' claimed to the European Court of Human Rights.

Studying the case-law of the EctHR the author finds that the following provisions of the Convention are, by order, the ones relating mentally ill's violation of rights which had been more times brought up to the Court.

To find it out the author has tip in the advanced searcher of the database of the EctHR (Hudoc) [68]the mentioned articles and some of the key words relating to this group: "unsound mind" and/or "mentally ill" and/or "mental health". Further, the research has been complemented with some of the compilations of comments of the case-law on the ECHR.[69]

Deprivation of liberty

First of all, the claims which have been more times dealt with in the Court are on relation to violation of article 5 ECHR,[70] about security and personal liberty. Especially on art.5.1e) concerning deprivation of liberty of persons of "unsound mind" and art.5.4. concerning the right to review the detention.

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[67] Paul Hunt, 2005.

[68] Available at: http://cmiskp.echr.coe.int/tkp197/search.asp?skin=hudoc-en

[69] Murdoch, 2006.
White, Jacobs & Ovey, 2010.

[70] Relevant cases are: *Ashingade v United Kingdom*, Application no. 8225/78, Judgement May 1985; *Aerts v Belgium*, nº 61/1997/845/1051, Judgement July 1998; *Nielsen v Denmark*, Application no. 10929/84, Judgement November 1998; *Winterwerp v Netherlands*, Application no. 6301/73, Judgement November 1981; *C.B. v Romania*, Application nº April 2010, Judgement April 2010.

Civil rights

Followed by few cases, the Court has faced with claims on violation of art.6 ECHR[71], about the denial of civil rights. To our concern the more controversial civil rights are the status of mental capacity and the access to Court on article 6.1) and the presumption of innocence on article 6.2).

Privacy and family life

Some case law concerning mentally ill also exist referring article 8.1) ECHR, about privacy and family life.[72] On behalf of this article, the jurisprudence had referred to the scope and content of the right to health in several occasions.[73]

Prohibition of torture and inhuman and degrading treatment

There are also significant case-law related to mentally ill on violations of article 3 ECHR, on the prohibition of torture and inhuman and degrading treatment. Mainly referring to the conditions of detention and imprisonment of mentally ill.[74]

Forced medication

Forced medication of mentally ill is another controversial issue.[75] However, no right of non-forced treatment exist in the ECHR, so there is no direct case-law on the issue. The Court had referred to it few times on behalf of article 8[76], but there is not a clear set of jurisprudence. The Court is reluctant to condemn or disagree with action taken by health professionals.[77]

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[71] Relevant cases are: *Shtukaturov v Russia,* Application no. 44009/05, Judgement March 2008; *H.F v. Slovakia,* Application nº 45797/00, Judgement February 2006; *Nenov v Bulgaria,* Application nº 33738/02, Judgement October 2009

[72] Relevant cases are: *Shopov v Bulgaria,* Application nº 11373/04, Judgement December 2010; *Shtukaturov v Russia,* Application no. 44009/05, Judgement March 2008; *Berková v Slovakia,* Application no. 67149/01), March 2009.

[73] Relevant cases are: *Moldovan v Russia,* Application nº 55723/00, Judgement of 9 June 2005; *Taskin and others v Turkey,* Application nº 46117/99, Judgement of 10 November 2004, *Novoseletskiy v Ukraine,* Application nº 47148/99, Judgement February 2005; *Lopez Ostra v Spain,* Application nº 16798/90, Judgement 9 December 1994.

[74] Relevant cases are: *Soering v the United Kingdom,* Application nº 14038/88, Judgement July 1989; *Romanov v Russia,* Application nº. 63993/00, Judgement October 2005; *Peers v Greece,* Application no. 28524/95, Judgement June 1999; *Rupa v Romania,* Application nº 58478/00, Judgement December 2008; *Filip v Romania,* Application nº 41124/02, Judgement December 2006.

[75] Furhter information in p. 44

[76] Relevant case: *Storck v Germany,* Application no. 61603/00, Judgement June 2005.

[77] Murdoch, 2006, p.295.

The author thinks that its mention is significant because the last chapter was dedicated to the right to mental health and because it is intrinsically linked with involuntary detentions. A right to mental health does not mean an obligation to have mental health. The rights are individual entitlements but not obligations to be entitled to. One's body is the last resort of the human being and its interference is directly link to the core of human dignity. "Human dignity is the fundamental value" and cornerstone of all human rights.[78] No interference with human dignity should take place against one's will. As far as other's rights are not neglected. A proportionate and balanced solution should be found.

On this line, the 2004 Recommendation Rec(2004)10 of the Committee of Ministers concerning "the protection of the human rights and dignity of persons with mental disorder" provides a guidance on the area of involuntary treatment. For the first time, before forcing treatment and/or institutionalisation of the patient, apart from taking in consideration that the person has a mental disorder, that his condition represents a significant risk of serious harm to his health or others' and that no less intrusive means for appropriate care exists; his opinion has to be taken into consideration.[79] This is an advancement on the recognition of autonomy of mentally ill.

Right to treatment

On the other hand, a right to treatment is neither included in any of the Convention provisions. Article 5.1.e), though authorizing the detention of persons of unsound mind, does not require that the State at least tries to provide treatment.[80] By dealing with the detention of this group and not with their treatment, the Convention deals with the social function of protecting society and not with the therapeutical and individual function to rise a higher attainable standard of life and health for everyone. It seems contradictory that the most significant regional document in Europe protecting human rights authorizes governments to detain mentally ill but does not set on them an obligation to give them a proper treatment (when the person will seek one). The Convention bodies have support this restrictive view with their decisions.[81]

[78] *Federation of Human Rights League (FIDH) v France*, Decision on the merits, 3 November 2004, § 30.
[79] Recommendation Rec (2004)10, article 18.
[80] Wachenfield, 1992 (b), p. 260.
[81] i.e., *Dhoest v Belgium*, Application nº 10448/ 83, may 1987.

On the Guzzardi Judgement the Court for the first time opened the option of the "need of treatment."[82] Moreover, the Commission has pointed several times that detention under article 5.1.e) is not intended to be of a punitive nature and as guaranteed by art.5.4 is intended to be under review to avoid its perpetuation when the illness is ended. If treatment is not provided, the chances of improving the mental state of a detainee decrease. Thus, the detention can be unjustifiably longed. Moreover, if treatment is denied, the purpose of the Convention that consists on protecting individuals´ rights next to society´s rights will be violated. Withoutstanding that forced treatment can constitute in itself a human rights abuse.

Discrimination

Finally, it is interesting to notice that no case-law in the EctHR exist dealing with discrimination in relation to mental status. Neither had the jurisprudence of the EctHR linked the above-mentioned abuses and violations to discrimination against mentally ill.[83]

1.3 Conclusion

Mentally ill is a targeted group for human rights violations. The main concerns brought up to the EctHR are concerning their deprivation of liberty in relation to article 5.

A strengthen of the non-discrimination jurisprudence could help to improve the situation of mentally ill.[84] Though is deduced from the lack of jurisprudence on discrimination relating to a mental status that the Court does not seem to relate those violations to a failure on article 14. The EctHR also avoids tackling directly other controversial issues like "forced treatment" and "the right to a treatment," which the ECHR itself does not regulate.

[82] *Guzzardi v Italy*, Application no. 7367/76, Judgement 6 November 1980.
[83] Further developed in pp. 45 - 51.
[84] Wachenfield, 1992 (a), p.18.

2. THE TREATMENT OF MENTALLY ILL IN THE EUROPEAN CONVENTION OF HUMAN RIGHTS. ANALYSIS OF ARTICLE 5.1.e)

Just a minority of persons suffering from mental illness in Europe, around 10% of them, will be at some point subject to article 5.1.e).[85] Anyway, the author has chosen this provision because it tackles mentally disordered as one of the subjects able to be deprived of their liberty. Deprivation of liberty is one of the most restrictive measures that a State can take and usually a situation where other human rights abuses take place. Moreover, the author will try to proof that such a provision is a legitimate discrimination towards mentally ill.

First of all, it will be assessed the content of article 5. Followed by an analysis of the term "unsound mind" used in the provision. Thirdly, an extensive subchapter is dedicated to the safeguards provided by the ECHR in order to avoid an arbitrary detention. The author has been very critical with the validity of the protection of the safeguards established by the EctHR. The criterion of "dangerousness" is especially studied because of the discrimination that it might entitle. Also the role of medicine in the whole process had deserved special attention. During the whole analysis has been used case-law of the EctHR and the Commission, other studies and surveys which support the theory of the author and also other human rights standards.

2.1 Deprivation of liberty in the ECHR and its bodies.

Liberty is one of the most precious rights of the human being. Most human rights abuses and violations take place when there is a deprivation of liberty. Article 5 of the ECHR regulates the right to liberty and security, as follows: "1. Everyone has the right to liberty and security of the person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law;"
Mentally ill persons, as human beings, are also included in this context. The following points from a) to f) provide exceptions to the right.

[85] Idem, p. 8.

The exceptions are mainly provided on the ground of the commission of an illegal action or a criminal conviction, save on point e) where five diverse "categories" of people are being explicitly set as exceptions on the right to liberty without having committed any illegal action: "(e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts, or vagrants."

On the case of our interest, persons of "unsound mind" are being put together next to alcoholics, drug addicts, persons with infectious diseases and vagrants. Different groups of people with different necessities, but with a common history of segregation. Foucault, in his masterpiece "History of madness",[86] explains how confinement had always found the man to confine. Systems of exclusion had existed in each phase of society as modes of social control. The mentally disordered type was first sent out from the cities and then closed with prostitutes, vagrants and other "deviant" social types. The first became the object of study of medicine and the others of sociology and/or criminology. But still nowadays the ECHR regulates their treatment together in a provision which limit their rights, thus perpetuating their assimilation and segregation.

The case-law of the EctHR and/or the Commission has not justified or clarified on the purpose of this decision[87]. The only reason that the author finds to understand this provision, and citing Margaret G. Wachenfield: is that this situation "reflects society's need to *normalise* and not accept maladaptive behaviour".[88] Being of "unsound mind" is the only requirement set in the exception. The length of the deprivation is neither being specified.

2.2 The term "unsound mind"

The term used in the provision: persons of "unsound mind", raises discussion "per se", being not the most appropriate. It is associate with a pejorative connotation and based on the dichotomy normality/abnormality, sound/unsound, which have already been

[86] Focault, 2006, p. Xvii.
[87] Wachenfield, 1992(b), p. 128.
[88] Idem.

criticised above when psychiatry had used it to categorise mental disorders[89]. It is a subjective term. But law, and particularly when limiting fundamental rights, should not be subjective.

The old confusion about the term to be used to describe mentally disorders is reflected n this article 5. The EctHR states that it is a term evolving through time and culture, thus it avoids defining its scope.

The uncertainty about who is of "unsound mind" leaves the door open to a broad category of people to be included on it just for having a behaviour deviate from the prevailing one in society. The Court states clearly that the term is a changeable one depending on "society's attitude to mental illness". Therefore, depending on society's attitude towards persons whose behaviour is considered "unsound," the subjects englobed in the term will vary as far as their behaviours are more or less tolerated by the rest. As an example's of attitudes´ changes over the time: the former Commission on Human Rights found in 1962 that it was not against the Convention to force an homosexual to undergo a psychiatric exam for his sexual behaviour.[90] The same conclusion would not apply nowadays.

It is established that the meaning of the norms of the Convention, to some extent, has to be determined independently of the national laws or views.[91]But this premise does not happen to be applied when referring to the definition of the meaning of "unsound mind." Contradictory, the case-law provides that each country has to define the term on its own legislation. Some do it, and some do not, but none of them use the term "unsound mind."[92] Consequently, the term remains broad and open to distinct interpretations.

On one hand, this margin of interpretation given to the States is reasonable if thinking about the need of the Convention to be a flexible instrument. One adaptable through time and among various legislative systems. On the other hand, such a free interpretation can raise discrimination on basis of different cultural and societal approaches. For this reason, the Court and the Commission, on their review role, had

[89] See p. 10.
[90] *X v The Federal Republic of Germany,* Appl. Nº 986/61, 5 Yearbook (1962) pp. 192-194
[91] Yourow, 1996, p.11
[92] Wachenfield, 1992 (b), p. 137.

analysed and established some guidelines to clearly define what conditions the term excludes.

The analyse takes two steps[93]:

1) To assess whether the term is reconcilable with the common meaning of it (its "ordinary meaning") interpreted in a narrow sense. [94] This is also one of the general rules of interpretation of the Vienna Convention on its article 31.[95]

Paradoxically to the principle of the narrow interpretation and the use of ordinary meaning of the term, when the Court and the Commission had reviewed the contents of any definitions used in a domestic legislation they had given a wide margin of interpretation to the States.[96]

The margin of appreciation is a necessary margin of flexible interpretation given to the States parties. It reflects the respect of the international judicial authorities to the democratic processes of the various States.[97] The margin of appreciation is based on standards of national discretion, consensus between States, the standards of articles 31 and 32 of the Vienna Convention Law Treaty, by a desire to increase the self-confidence on the judicial organs and by a legitimacy confirmed by acceptance over time.[98] This last point is the alarming one. The history of confinement and segregation of mentally ill started centuries ago.[99] Thus, a continuation with the practice might be seen as a legitimate act accepted through time. A too wider margin of appreciation on this area can support this old national restraint practice.

2) If so, whether it is reconcilable with the Convention.

Where the term used to define "unsound mind" is composed of a series of criteria or findings that must be made, the Court or Commission examine the criteria in similar steps.[100] Then, the criterions used for the analyses of the national definition of the term

[93] Idem, p. 146.
[94] *Guzzardi v Italy*, Application no. 7367/76, Judgement 6 November 1980, § 98.
[95] Article 31 Vienna Convention: "A treaty shall be interpreted in good faith in accordance with the ordinary meaning to be given to the terms of the treaty in their context and in the light of its object and purpose."
[96] i.e. *Winterwerp vs the Netherlands*, Application nº 6301/73, Judgement October 1979, § 38; or the Common Admissibility Decision, Application nº 8784/79, 4 March 1980, § 5.
[97] Yourow, 1996, p. 163.
[98] Idem.
[99] Focault, 2006, p.106.
[100] Wachenfield, 1992 (b), p. 146.

are again broadly defined with a wide margin of appreciation. Resting effectiveness to the protection given by a narrow interpretation.

The author is not against the margin of appreciation. It is necessary in such a variety of cultural and legal systems as the ones forming the State parties of the ECHR. It is also a remain of the "sovereignty" of the states. But it can have a negative effect when it affects vulnerable groups of people that need special protection, overcoming national, cultural and subjective approaches and views.

The author wants to uphold again the significance of having a clear definition of terms: there are no criteria under law to be applied in determining the "ordinary" meaning of this term, neither any law setting how to interpret. Thus, it will depend on the Commissioner's and Judge's values. As human beings they are also subject to prejudices and cultural values.
To set all definitions and criteria by law would not have "sense" on the majority of situations, and there is a need to trust on Judges', commissioner's and legislators' common sense. But law is an "instrument" that serves to overcome human judgements and values in order to balance those situations where "passions" and/or other surpassing instinctive human feelings tend to go beyond the threshold of "humanity "and human dignity. On the case here explained, there is a centurial practice grounded on prejudice and legitimate through time about how to treat insane people. Judges, commissioners and legislators are not free of this legacy.

2.3 Safeguards

Article 5.1.e) establishes a limitation of the rights and freedoms set in the Convention and, moreover, it gives a high margin of discretion to the States to interpret it.
Some safeguards are prescribed by the Convention in order to avoid an arbitrary and indefinite detention. The author wants to proof that they are not "per ser" protective; instead they are part of the discrimination problem suffered by mentally ill. To do so, each of the requirements and "safeguards" will be analyzed through its practice, human rights standards and in a "rational" basis.

2.3.1 Judicial review:

The Convention gives some protection to the mentally ill establishing some procedural safeguards to apply when they are deprived of liberty. On article 5.4): "Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful."
This principle is based on the need of the persistence of the disorder in order to justify the detention. It is one of the requirements set by the Winterwerp Judgement on the cases of deprivation of liberty of "unsound mind" under art.5.1.e).[101]

This article incorporates a judicial review procedure for release. Still not solving the problematic of the lack of a specified length of detention, but giving some guarantees to the detainees. The case-.law just establishes the need to review the lawfulness of the detention at "reasonable intervals", without establishing what "reasonable intervals" are.[102] A judicial authority will promptly and periodically review the detention and decide if its continuance is necessary. The liberty of the individual will not anymore just be pending on a medical decision.

a) The role of medicine

The medical opinion is anyway still the main influence data that the judges usually use to take these decisions.[103] An example of this fact is the reported absence of disagreement between the judges' decision and the medical recommendation in 86% of the cases (reporting an investigation in the United States).[104] Even though the main authorities or persons to decide on an involuntary placement vary across European countries, on most of them forced detention is decided by a non-medical person (judge,

[101] *Winterwerp vs the Netherlands*, Application nº 6301/73, Judgement October 1979.
[102] Under the judgment *Herczegfalvy v Austria*,the Court considered delays between fifteen months and two years to be unreasonable.
[103] Interview with Claudi Camps,
[104] Floud, 2009, p. 93.

authority or major), [105]and only on five of them by the medical personnel (either one or various psychiatrists or a physician).[106]

The question here is not to assess whether it is better to take this decision through a medical professional or through a non-medical one. But to pinpoint the role of the medical diagnosis. The author wants to emphasize the nature of medicine and its influence on the decision taken when facing the possibility of detention.

Medicine has proven to be a powerful tool to "preserve dominant cultural values and stigmatize and segregate non-dominant groups from mainstream society".[107] The medical profession is one of the most powerful institutions in western societies. Its authority had extended from the health care to the law enforcement system.[108] The high non-disagreed rate of judgments with their recommendations is a reflection of this inference in the judicial system. Without standing the need of the opinion of a professional when referring to medical matters, the conflict has its origin on the roots of medicine.

Medical insights are based on the "normality" of white, able-bodied heterosexual males,[109] which quoting Aart Hendriks[110]: "have inspired legislatures to draw boundaries between people for the sake of their abnormality". Those rules have served as the justification for treating people with certain characteristics adversely.[111] This is one of the typical features of legal rules in Western societies.[112]

We can conclude that medicine had played and still plays an important role when the juridical analysis needs to decide on the practice of detaining mentally disordered. However, Foucault expressed that it had little impact on the "world of confinement itself and in the social attitudes it expressed."[113]

[105] Salize, Dressing & Peitz, 2002 (a), p.25: Austria, Belgium, France, Germany, Greece, Italy, Netherlands, Portugal, spain and Uk.
[106] Salize, Dressing & Peitz, 2002 (a), p.25: Denmark, Finland, Ireland, Luxembourg, and Sweden.
[107] Hendriks, 1999, p.181.
[108] Idem.
[109] Hendriks, ,1999, p. 181.
[110] Idem.
[111] Idem.
[112] Minow, 1990, p. 8.
[113]Foucault, 2006, p.130.

At this point, and following Foucault's theory[114], we can clearly differentiate two forms of sensibility towards this group:

1. The legal: as subjects of law the individuals are absolved of their responsibility because are considered incapable, by the decree and definition of the disease. Their powers are limited and are naturally and juridical dispossessed of their powers. On this domain the medicine plays a significant role on the determinism of the disease.

2. The social: as social beings the individuals diagnosed with a psychiatric condition are ethically and socially condemned. Rather than being freed from their responsibility they are made felt guilty for their condition, becoming the "different", the "stranger". It is on this domain where Foucault stress that medicine did little impact.

These domains are nowadays forming a confused unity. The XXI century had inherited the legacy of this unity. The way western society legally treats the mentally disordered reflects the influence of the ethical condemnation.

2.3.2 Not arbitrary detention:

Article 5.1 also prescribes that the detention has to be made "in accordance with a procedure prescribed by law". The Convention gives a great emphasis on the "lawfulness" of the act. It is repeated again in the same 5.e) provision. A "lawful" detention is a detention that is not arbitrary.[115]

The difference between "in accordance with a procedure prescribed by law" and "lawful" is not always distinguishable and is often treated as the same in the case-law.[116]

"Lawfulness" is a complex concept. There are four main aspects of this requirement: 1.The need of legal foundation in domestic law[117]. 2. Need of precise definition of the

[114] Idem.
[115] *Bozano v France*, Application no. 9990/82, Judgement 18 December 1986.
[116] i.e in *Monel And Morris v United kingdom,* Application no. 9562/81; 9818/82, Judgement 2 march 1987.
[117] Example of lack of legal foundation: *Assanidzé v Georgia, Application no. 71503/0,* Judgment 8 April 2004.

law, which gives legal certainty[118]. 3. The State may not seek a purpose not authorized by article 5, aiming in reality to achieve another goal.[119] 4. It has to be necessary in the particular circumstances. The necessity of the detention is explained and discussed on Subchapter.2.3.3 of this Chapter.

As stated in the Winterwerp Judgement[120], a decision is not arbitrary if it is in conformity with the procedural and substantive requirement of domestic law and if the detention is carried out for the purpose for which the restriction of liberty is permitted in the Convention.
The purpose of the restriction of liberty in 5.e) is not stated in the Convention, thus if the procedural and substantive requirements of the domestic law are met, the detention will be lawful.

On the case analyzed in this thesis, were the national laws - and the ECHR - allow the detention of individuals on basis of their personal characteristics, -being diagnosed with a mental illness- we might be facing a direct discrimination. Thus, using as safeguards the same laws that permit and legitimise the discriminatory act is not "rational". Each domestic law should be independently analysed to assess its substantive content.

The Parliamentary Assembly of the Council of Europe, on its report on the situation of the mentally ill on 1977 had already referred to this issue:[121] "(…) continuously problematic about the scope of the Convention bodies. They again exam if the procedure of the national law has been followed, regardless of its content." Moreover, neither the former Commission nor the Court has adopted a literal interpretation of the "procedural requirements" set in article 5. And as one commission member pointed out "mere formal procedural irregularities do not make the detention unlawful unless they affect the actual substantive decision to detain."[122]

[118] The principle is illustrated in a range of cases: *Jecius v Lituania*, Application no. 34578/97, Judgment 31 July 2000; *Baranowski v Poland*, Application no. 28358/95, 28 March 2000.
[119] An example of abuse of authority was the case of *Bozano v France*, Application no. 9990/82, Judgement 18 December 1986.
[120] *Winterwerp vs the Netherlands*, Application nº 6301/73, Judgement October 1979
[121] Taboone & Voogd, 1977, p. 11. "The right to liberty and security of the person – article 5 of the european convention on human rights in the strasbourg case-law." *Human rights law journal. (1980)* p.106
[122] Trechsel, 1980, p. 102.

2.3.3. Objective and reasonable justification:

The need to justify the detention by an objective and reasonable justification has also been established by the Winterwerp Judgement. If this requirement is fulfilled it discards the possibility of the provision being discriminative. Otherwise, we will be facing a discrimination set by a human rights instrument.

The Court establishes that an objective justification takes place when two requirements are accomplished:[123]

1. There is a true mental disorder prescribed by an objective medical expertise.
2. The disorder is of the kind of degree warranting compulsory confinement.

The justification is reasonable when the means used are proportional to the legitimate aim pursued with the exception.

On the following each of the elements will be analysed.

a) Objective medical expertise and true mental disorder

The requirement of the existence of an objective medical expertise asserting that the subject whose freedom of movement will be limited has a "true mental disorder" is of difficult acceptance. As already stated, what actually "is" a mental disorder is still a controversial issue. Objective medical expertise (in the field of our topic) is difficult to proof.

The word "true" used in the judgements is, in the author's opinion, not the correct one. Using a definition by opposites: what would then be a "fake mental disorder"? On the author's view, the use of this term reflects the difficulty to assess what is actually a psychiatric condition considered of "unsound mind", and consequently it reflects its uncertainty to be diagnosed.

[123] *Winterwerp vs the Netherlands*, Application nº 6301/73, Judgement October 1979 & *Luberti v Italy*, Application no. 9019/80, Judgement 23 February 1984, § 27.

The prescription of the need of an objective medical expertise is a necessary requirement to finish with the old practice of detention based on a family, neighbours or authorities proposal. It has worked so far to avoid the "justification of detention of persons whose behaviours or views deviate from the prevailing norms in society".[124]

In contrast, nowadays a big power lies on the hands of the medical expert. It is "logical" and "reasonable" to think that a judge, a lawyer or another juridical person might lack the sufficient medical knowledge to assess the mental condition of someone. However, the case-law shows that when evaluating the objective medical expertise, neither the Commission nor the Court does examine the precise details of the medical evidence.[125] Instead they analyse whether the definition of unsound mind was arbitrarily applied in a particular case. Neither of them usually makes further inquiry in the concrete situation as whether the content of the medical certificate is accurate to the actual applicant mental state or whether it could be treated in a less restrictive manner.[126] Consequently, there is a presumption of the correctness of the medical evaluation. Which gives significant power to the psychiatric or physician over deciding on the limitation of rights of a person.

On the other hand, the exact criteria need for the medical evidence depends on national legislation.[127] This requirement will reflect the "value placed on liberty in each domestic system".[128] On the other hand, it is unquestionable that national authorities are usually better placed to evaluate all the evidence, so they are given a "benefit of doubt" when concerns are raised.

Notwithstanding that the objective of the EctHR and of the Commission is not to judge again the same facts but to review them; when the decision of a rights limitation is taken mainly on the basis of another person's affirmation of the existence of a concrete mental status[129]; on the author's view the jurisprudence should be required to take special care

[124] *Winterwerp vs the Netherlands*, Application nº 6301/73, Judgement October 1979.
[125] Wachenfield, 1992, p. 143.
[126] Idem, p. 148.
However, it seems there are different scopes of review depending on the cases. i.e: *van der Leer v Netherlands*, Application nº 12/1988/156/210, 14 july 1988.
[127] Wachenfield, 1992 (b), p. 143.
[128] Sommerville, 1985, p. 199.
[129] Is not the aim of the author to disqualified the job of the medical professionals, but just to give evidence on the fact tha a decision that affects ones liberty should be carefully assessed and specially

on their reviews. Especially in this field where usually arise many contradictions on the diagnosis of a same case.

a. 1) Examples of discerning psychiatric diagnosis.

In Roth & Bluglass'[130] book are cited the following words from John Hinckley during his trial for the attempt to kill Ronald Reagan on 1981: "The defence doctors found me to be delusional, psychotic, schizophrenic and perhaps the most alienated young man they have ever examined. On the other hand, despite evidence to the contrary, the prosecution doctors said I merely had some personality problems (...)".
The trial to J. Hinckley was the first time that psychiatric testimony was brought into disrepute. On the other side, the public was outraged by the final verdict of insanity. They fear he would be released when the doctors will claim that he is not anymore mentally ill. On 17 December 2003 a federal judge ruled that Hinckley no longer posed a serious danger to himself or other[131]. However, he remains detained nowadays in a psychiatric centre.[132] This trial had huge consequences on the laws of defence for "insanity" in the US.[133]

A more recent case where the contradictions in the psychiatrics testimony are evident is the Breivik's trial in Norway. Breivik had killed 77 persons in Norway on July 2011 at a youth camp. His mental state remains unclear. On a first psychiatric report he was declared insane with paranoid schizophrenia and psychosis. On a second one he was found "narcissistic" and "asocial" but not insane.[134] Such contradictory diagnosis rise disturbing doubts about the certainty of psychiatric testimonies.

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when the doubts of its lawfulness or validity are brought so far as to be claimed in the European Court of Human Rights.
[130] Roth & Bluglass, 1985, p. 234.
[131] Linder, 2002.
[132] Idem.
[133] "Within three years after the Hinckley verdict, two-thirds of the states placed the burden on the defense to prove insanity, while eight states adopted a separate verdict of "guilty but mentally ill," and one state (Utah) abolished the defense altogether.
In addition to shifting the burden in insanity cases, Congress also narrowed the defense itself. Legislation passed in 1984 required the defendant to prove a "severe" mental disease and eliminated the "volitional" or "control"aspect of the insanity defense." More information at:
http://law2.umkc.edu/faculty/projects/ftrials/hinckley/hinckleyaccount.html
[134] Available at: http://www.cbc.ca/news/world/story/2012/04/25/norway-breivik-trial.html

To exemplify again the uncertainty of psychiatry I will expose another case non-related to criminal trials. Because on a trial the adversarial system might artificially generate the contradiction between the psychiatric testimonies.[135]Affirmation which is disturbing on itself.

On 1975 the Rosenhan experiment/study sent several "sane" persons to various psychiatric hospitals were they claimed they heart the words "empty" and "noisy" and they were detained with a diagnostic of "schizophrenia". No one from the medical personal realise they were "sane". Curiously, several of the other patients did realise so. Later on, on a complementary part of the study, the personal from various psychiatric centres were informed that "pseudo patients" will be sent to the centres and they were asked to identify them. The medical personal detected 21% as "pseudo patients". In reality, none "sane" person was sent to the hospitals.

Hundreds of cases like the above mentioned are available. The question is how can then a "true mental disorder" be identified? And how objective is the medical evidence? To answer these questions is not the aim of the thesis, but to rise doubts on the certainty of psychiatric diagnosis which are used as a requirement to involuntary detain someone. In conclusion, a requirement of an "objective medical and true mental disorder" is not a valid and reliable requirement. However, this is not the only requirement.

b) The disorder is of the kind of degree warranting compulsory confinement: Dangerousness and public security

The Winterwerp requirements also demands that the mental disorder is of the kind of degree warranting compulsory confinement. It means that the individual has to be dangerous in order to justify its detention. How assessable is aggressiveness and dangerousness?

[135] Roth & Bluglas, 1985, p. 234.

When an aggressive or violent act has taken place the dangerousness is identifiable. However, in that situation, we will process the subject in question for a criminal act or an attempt to a criminal act.

When no previous aggressive or violent behaviour exist how are medical expertises objectively considering the dangerousness of a person? Psychiatrics and medical expertises use a serial of categorical features (clinical and statistical) to predict danger.[136]

The finality of the thesis is not to assess how objective or how certain are these medical tools. But to assess how far using these criteria is in accordance with human rights. That's why on the following we are going to deeply analyse the criteria of danger and the inconsistencies of its use as a requirement to detain someone considered "mentally ill".

b.1) *Uncertainty of the prediction of danger*

The incapability to accurately predict violent behaviour has been empirically proven in not few investigations. On data reported by Robert J. Campbell, [137]of a group rated too dangerous for release only 34.7% committed a violent crime within five years of their release.

On another study by Jean Floud,[138] emphasise is made on the fact that assessments of dangerousness are not simple predictions, but predictive judgements. As judgements they are liable to error. The same author quotes Frank Knight, already stating in 1936 the existence of an "accumulation of empirical evidence pointing to a high risk of error in clinical judgements of dangerousness."

It shows the acceptance of the uncertainty and high error figures on the prediction of dangerousness nearly one century ago. The same author states that substantial studies in the United States verify that when, against the advice of psychiatrists, subjects have

[136] Esbec & Fernández, 2003, p. 65.
[137] Campbell, 1985, p.55.
[138] Floud, 1985, p. 89.

been released or deinstitutionalised, fewer than 50% have actually caused grave harm as predicted.[139]

To mention other studies giving empirical evidence on the lack of predictability of "dangerousness": the "Clinical Prediction of violent Behaviour" by Monahan, J.[140] and the studies carried by other investigators like Steadman and Morrissey[141] or Dr. Alan Stone.[142]

Quoting the President of the National Council on Crime and Delinquency (1973), "the identification of dangerous persons is the greatest unresolved problem that the criminal justice system faces."[143] The problem is still unresolved nearly forty years later, and the uncertain nature of the predictive judgements is all in what the system relies on.

Another element contributing to the lack of certainty of this prediction is the diversity of human beings and their circumstances. Population is heterogeneous and there is "not a single group enough homogenous to give to the clinician more than an even chance of being right in his/her predictions". [144] It is a matter of "statistical logic."[145] On this line, cultural and social elements are not often taken in account on the predictions done by the dominant "westernised" psychiatry[146].

Already in 1984, the WHO Collaborative Study on Assessment of Dangerousness in Forensic and Administrative Psychiatry[147], shown that the rate of agreement concerning the assessment of dangerousness was low: 60 % of agreement just reached on 4 cases out of 16. In addition, psychiatrists showed a tendency to rate individuals as more dangerous than non-psychiatrists. Consequently, the WHO was already in 1984 not supporting the use of "dangerousness" as a scientifically or operationally valid concept.

[139] Idem.
[140] Monahan, 1982.
[141] Steadman & Morrissey, 1981.
[142] Stone, 1982.
[143] Floud, 1985, p.94.
[144] Floud, 1985, p. 90.
[145] Idem.
[146] Read, 2006 (b), p. 211.
[147] Montandon & Harding, 1984.

On this line, some national legislation are not anymore using the criteria of "dangerousness" to define the characteristics of mentally ill persons who can be involuntary confined: i.e. Spain, Sweden or Italy. They use the criteria of "need of treatment". Several used independently both "the need of treatment" and/or the "danger" posed by the subject: Denmark, Finland, Greece, Ireland and Portugal. While other countries are still just using the criteria of "danger": Austria, Belgium, France, Germany, Luxemburg and Netherlands.[148]

Where the danger criterion is applied is not done in similar manner across the Member States. Some countries include only public threat, while others also add possible harm to the patient himself/herself.[149] On the other hand, from the laws regulating involuntary detention which described the aim for doing so, (not all of them do it) only the one in Netherlands referred to the prevention of danger: "protection from harm."[150]

Once far proofed the fallibility of predictive judgements of conduct, is disturbing to think that this is still often the main criteria required to constraint people's rights, especially when long indeterminate periods of detention take place. Surprisingly, also the European Court of Human Rights is still using these criteria to justify the detention of mentally ill.

b.2) The discrimination inherent in the "dangerousness" criteria

It is lawful to detain a person when it has not commit any illegal act but it has been proven that he/she suffers from a true mental disorder and can be dangerous. On the other hand, it is not lawful to detain anyone (not suffering from a mental disorder) but that is or can be dangerous. This is a clearly discriminative statement for mentally ill. They are treated in a different and more prejudicial manner than "non-unsound mind" people; just because some of their personal characteristics label them as mentally ill.

Reasonable doubts arise often about the potential dangerousness of an applicant. The Court and the Commission's decisions tend again to give a wide "margin of

[148] Salize, Dressing & Peitz, 2002 (b), p. 24.
[149] Idem.
[150] Idem, p .21.

appreciation" to the States.[151]i.e. In the case of the Commission Report: *Dhoest v. Belgium,*[152] where the applicant continuity of deprivation of liberty was at stake, and even when he had demonstrated not being dangerous (had threatened or committed any crimes) during his escapes. Moreover, even when an improvement in the applicant's mental health had been proven, his liberty was rejected on the ground of hypothetical future "danger".

Surveys exist proving there are no more links to violence with mentally ill than with healthy people[153]. i.e. Analysis in England and Wales covering the period 1957 to 1995 indicated little change in the rate of homicide by people with a mental health diagnosis or by the general population as a whole.[154] Even further analysis suggested that the murder was less likely to be committed by mentally ill. On another survey in New Zealand was reported that about 9% of homicides between 1970 and 2000 were committed by mentally ill people. [155]

These data lead the author to question again whether limiting the liberty of mentally ill in the ground of "danger" can be justified by a reasonable objective or whether it is just legacy of a historical treatment.

In order to avoid a discriminative provision, to support "danger" as a reasonable objective justification to deprive someone of their liberty, mentally healthy people who "could be dangerous" should also be included in the provision. Regardless of the disturbing character of this affirmation.

The Convention bodies have some confusing and contradictory rulings about that. On the Guzzardi case, where the Italian government proposes that exceptions under 5.1.e) permit detention of persons more dangerous than the categories explicitly mention in 5.1.e)[156], but who do not specifically have committed any illegal action, thus can not be put under other categories of article 5, the Court rejected that proposal.[157]

[151] Wachenfiel, 1992 (b), p. 149.
[152] Dhoest v Belgium, Application nº 10448/ 83, may 1987, § 140.
[153] Mc Daid, 2008, p. 5.
[154] Taylor & Gunn, 2008, pp. 130 – 133.
[155] Mc Daid, 2008, p. 5.
[156] In the author's view, this affirmation is"per se" a discriminatory one, pressupossing that the people on the category of art. 5.1.e) are dangerous.
[157] *Guzzardi v Italy*, Application no. 7367/76, Judgement 6 November 1980.

Contradictory, on other rulings of the Commission it was set that a "person not necessarily need to be found mentally ill to fall within article 5.1.e) category of person of unsound mind".[158] Again in another case where the applicant could proof that he was not mentally ill, the Commission accepted that the applicant could continue to be detained on basis on its "dangerousness".[159] To justify its decision on that case the Commission stated that "unsound mind" does not just mean mentally ill but also any "abnormal personality disorder".[160]

The contradictions suggest that is not even clear if "unsound mind" are just implying mentally ill or also any kind of behaviour deviate form the social acceptable one. Even though, the Winterwerp Judgement did explicitly prohibit using the term "unsound mind" in this sense.[161] The last provisions proof that someone not mentally ill can also be deprived of liberty because of being "dangerous". Treating mentally ill and not mentally ill in the same way independently of their mental characteristics implies a more equal treatment for everyone, -even though still pejorative and against human dignity.

On the other hand, it is disturbing to see how State institutions could actually deprive anyone of liberty under the only justification of "dangerousness". This is another issue that we are not going to tackle here.

b.3) Conflict of interests between the individual and collective rights

The requirement of "dangerousness" is an implicit one in art.5.1.e). The interest at stake to be protected is the public safety. Although not mentioned explicitly as in other articles,[162] it is implicit in the notion of danger and it permeates the whole art.5.1.e) and the jurisprudence on the issue.

The rulings, case-laws and decisions of the Convention bodies show that "public safety" is the weightiest concern when the interests at stake – society versus the individual- are

[158] *Xv Belgium*, Application nº 5340/72, 8 july 1974.
[159] *X v Federal Republic of Germany*, Application nº 7493/76, 12 July 1976.
[160] Wachenfield, 1992 (b), p. 140.
[161] Winterwerp vs the Netherlands, Application nº 6301/73, Judgement October 1979.
[162] Art 8,9, 10 and 11 ECHR

threatened. Examples of some cases reflecting this situation are: *Huthcison Reid v United Kingdom* [163]or *Silva Rocha v Portugal*[164].

When aggravate crimes like the ones threatening life occur, there is a need to prevent and punish the author, even if he/she has been declared non guilty. On those cases is usually decided that the subject has to be detained until he/she improve his/her mental state. What is the sense to continue the detention once the mental disorder has been cured? This was the case of *Silva Rocha v Portugal,* where the applicant could not start proceedings to test his mental health until the end of the period to which he was sentenced.

A factor contributing to this situation is that society is not willing to take any risks.

However, as Jean Floud explained[165]: "the risk represented by a dangerous person is diffused over a population of potential victims and the risk to a particular individual may be quite small, even negligible, depending on the size of the population under threat (...)". On this line, the risk is so diffused that the collective claim can not outweigh the weakening of each individual claim.

What the author is trying to expose is that, even though when statistically few real danger exist of the "potential harmer" to actually commit any harm, society seem to prefer to reduce individual liberties of the mentally ill in order to increase protection for the public.[166] Justice permits us to punish for an act that had still not happened and that might not happened. Or that, even if finally take place, could inflict less harm than the harm caused by the preventive act.

Without standing that the communities have the right to be protected and prevented from insecurity and physical attacks, when they are well-founded.

The problem is that when fear exists risks are perceived as dangers.[167] Nowadays, society constantly perceives fear. Fear is a powerful tool of Governments to deny their responsibilities with the individual and to curtail individual liberties.

163 Hutchison Reid V The United Kingdom, Application no. 50272/99, 20 February 2003.
164 Silva Rocha v Portugal, Application no. 18165/91, 26 October 1996.
165 Floud, 1983, p. 84.
166 Floud, 1985, p. 81
167 Idem. p.82

Another example where we observe a relaxation of the safeguards is on the cases denominate "emergency situations"[168]. The Winterwerp judgement establishes itself that the safeguards for a "fair" deprivation are not applying in an emergency situation.[169] Those requirements like medical expertise can be met after the detention. Therefore, the detention takes place on the only ground of "danger" to others or himself/herself.

We can conclude that an outweighed and sometimes non-founded concern for public safety bring individual rights to be denied or curtailed on the name of society. Even when lack of substantial evidence or vague concepts of the term "dangerous" had been used, the Convention bodies had often responded in favour of the public safety and not of the individual rights.[170] Without standing that the role of public guardian is for the State, not for the EctHR.

The author is not denying the existence of a legitimate aim to protect the general public. But is wondering whether this had not been used too widely for governments to enact laws restrictive of individual liberties under the international legitimacy of the ECHR and its bodies.

To assess when and whether the protection of public security is a legitimate aim, it would be necessary to weight the proportionality of the aim with the measures taken. The next subchapter analyse this point.

c) A reasonable justification.

For a justification to be reasonable needs to protect a legitimate aim in a proportional way.

The legitimate aim is the already mentioned "public security". Proportioned means imply that the measure taken to protect the aim, deprivation of liberty in this case, is the one less restrictive possible to achieve it.

[168] What is an "emergency situation" will be decide also by the national laws.
[169] *Winterwerp vs the Netherlands*, Application nº 6301/73, Judgement October 1979.
[170] Wachenfield, 1992 (b), p. 141.

To assess if less restrictive measures exists to assure public security it would be necessary to do so in an individual case-by-case study. Nonetheless, an overview on the measures shows that alternative and less restrictive measures than forced detention exist. Treating mentally ill using social models approaches instead of medical models[171]would probably result on less restrictive measures with the same finality.
Lots of alternative less restrictive institutions exist. On the following, some examples will be exposed:

***c.1) Less restrictive methods than forced detention*.**

The Soteria model

Soteria is a community service founded by Loren Mosher based on a social model. Some elements of this system include the use of non-restraining means. Soteria are open, non-closed institutions with minimal use of antipsychotic medication and when used are based on free consent and from a position of choice. Soteria's also support the preservation of the resident's autonomy and personal power, his social networks and communal responsibilities.[172]At some extent, the modern substitute of Soteria's will be the community services.

The Hearing Voices movement

This is a movement which brings together people who hear voices and mental health professionals and any other people who can be interested. They interact, dialogue and explore the experiences of the "voice hearers". They use psychological, spiritual and/or practical methods to do so.

The Icarius Project

This is a project which consists on getting together individuals diagnosed with a disorder and local support groups. They mainly dialogue and tackle such topics as whether or not to use medication, the spiritual dimension of the experiences of the disordered and other. They take a "harm reduction" approach to psychiatric pharmacs. They are not totally against, but they try to reduce their negative effects and involve the patient on the decision of being or not being medicated.

[171] Further information on p. 61.
[172] Calton, Ferriter, Huband & Spandler, 2008, pp. 181–192.

A common feature between these projects is that the disordered takes an active role on the decisions that affect him/her. And he/she stays in a position of equality with the rest.

The national law is the one limiting and deciding the scope of the system of involuntary detention. It is the one that has to provide the safeguards in order to avoid unjustified detention.
But the law tend to overlook the existence of alternative methods to forced detention. Either because they are not medical based, either because these services do not exist on certain countries and their establishment suppose a cost burden for the State.
On the other hand, some already mentioned case law serve as example to proof that concern for society often relaxes the safeguards established in the Convention.[173] Thus, also the use of effective and valid less restrictive measures can be overlooked and justified because of public safety.

2.4. Conclusion on article 5.1.e)

Article 5 of the ECHR and its jurisprudence reflects the inhered dichotomy between the need to protect society and the growing need to avoid "unfairly" detentions that would constitute a human rights violation. There is no just solution for the conflict between individual and collective interests. It will depend on the approach taken which will reflect each society's scale of values. The EctHR tend to favour collective interests.

The only solution seems to try to improve the safeguards for those subject to detention and minimise the rights violations overall. The concern here is how far there is scope for improvement, if the basic criterions upon we are relying on are "wrong" on themselves? Moreover, lacks the aim to implement certain of the safeguards like the one on the less restrictive measure.
Even though the establishment of safeguards shows the growing concern towards the rights of the mentally ill they do not avoid the continuity of their segregation. Article

[173] *Huthcison Reid v United Kingdom or Silva Rocha v Portugal*

5.1.e) internationally legitimise the detention of mentally ill. Therefore, it contributes on the stigmatisation, exclusion and discrimination of mentally ill.

3. STIGMA AND DISCRIMINATION OF MENTALLY ILL AND ITS CONSEQUENCES.

On the above subchapters we had focused on the treatment of the mentally ill when they are deprived of liberty in the ECHR. On the next subchapter I will explain in what consists stigma and how is suffered by the label of mentally ill. Lately, I will compare article 5.1.e) ECHR to equality and non-discrimination standards with the aim to proof that the ECHR and its bodies are also influenced by prejudice, reinforcing the stigma of mentally ill.

3.1 Stigma as a human rights abuse.

Stigma can be described as "a severe social disapproval due to believed or actual individual characteristics, beliefs or behaviours that are against norms, be they economic, political, cultural or social."[174] The stigmatisation of people with mental health problems is not new, but nowadays it leads to discrimination on their daily life.

Society understands "mental illness" with a negative connotation. In one survey were 250 terms were used by 400 adolescents to describe mental illness, not even one of these terms expressed people with mental health problems in a positive light or sense. And more than 100 of them were hardly pejorative.[175]
This early negative attitudes developed towards mentally ill are caused by the inaccurate view that they represent a danger to the general population. A perspective reinforced by

[174] McDaid, 2008, p. 5.
[175] Rose, Thornicroft, Pinfold & Kassam, 2007.

the media. They tend to report sensationalist tragic events involving mental health problems preferably to the ones not involving this element.[176] Even some studies report that psychiatrists have a similar negative attitude than the general population towards mentally ill.[177]

Stigmatisation has hard negative consequences. It increase the social distance with the stigmatised group, supports their social exclusion, increase prejudices and discrimination. Moreover, due to the fear of being labelled mentally ill, an amount of the population suffering from these problems might not seek help.[178]

Stigma is considered "per se" a human rights abuse,[179] and one of the worse, due to the strong negative consequences that it entails. Which affect all aspects of the life of people suffering them: employment, housing, affective relations, health access, etc.
Consequently, deinstitutionalisation is not the end of the stereotypes carried by mentally ill, neither of their segregation. Nowadays, individuals with mental health problems can be "as neglected and isolated within their communities as they were previously in the institutions."[180]

Moreover, stigma is also affecting policy's makers' decisions. Who are not immune to prejudice and stereotypes and, more importantly, who try to implement through policies and programmes what society wants and expects. Even though the EctHR had noted that "where a general policy or measure has disproportionately prejudicial effects on a particular group, it is not excluded that this may be regarded as discriminatory notwithstanding that it is not specifically aimed or directed at that group"; [181]one survey shows that mental health is one of the low priorities when investing in health care.[182]

[176] Angermeyer & Schulze, 2001, pp. 469 – 486.
[177] McDaid, 2008, p. 6.
[178] McDaid, 2008, p. 3.
[179] Bowis, 2008, p. 2.
[180] Idem, p.3
[181] Schutter, 2011, p.28.
[182] Schomerus, Matschinger & Angermeyer, 2006, pp. 369 – 377.

On this context of deep-rooted prejudice and stigma towards mentally ill, the role to be played by legislation is crucial. Is necessary the enactment of anti-discriminatory and inclusive legislation at supra, international, regional and national level.

3.2 Discrimination and mentally ill in the international human rights bodies.

No standards of non-discrimination had been set. Few case-law exist on the issue of discrimination in the EctHR.[183] None on discrimination on ground of mental illness; being race, sex and religion the major ones tackled.

On the Convention, article 14 states a non-exhaustive list of grounds protected against discrimination. Discrimination on basis on a different physical or mental health status is not mentioned. It has to be understood as englobed in "other status".

It is more difficult to protect those discriminations non-based on an explicitly mentioned group. "Others" may involve a broad amount of subjects and the term remains dependent on jurisdictional interpretations. Thus, it is a high "changeable" and "volatile" group and therefore it is logical to state that they will receive less protection and/or their rights will be easily denied, in comparison with the explicitly mentioned grounds.

The case-law on article 14 prohibits both direct and indirect discrimination[184] and differentiates, to a limited extension, discrimination on basis of "suspect" [185] and "non-suspect" grounds. Mental illness is included in the second one. However, the boundaries between both grounds are not clear and have a shifting character which evolves on time.[186]

Age and disability[187] are the next candidates for being treated as suspected grounds.[188] The significance of being categorised in one or the other group is that the first ones

[183] Schutter, 2011, p.6.
[184] Idem, p.14.
[185] Suspect grounds at the moment of this writing: birth out of wedlock, sex, sexual orientation, race and etnic origin and nationality.
[186] Schutter , 2011. p.16
[187] We will further see in Part 3 how and when mental illness can be considered disabilities.
[188] Schutter, 2001, p. 20.

receive more protection. Because "weight reasons" are need to justify discrimination on those grounds.

On any case, we need to justify discrimination in two cases[189]: 1) When explicit or implicitly a rule forbids a particular differentiation or any at all. i.e. article 14 ECHR
2) When the differentiation made falls within the scope of the rule. i.e article 5.1.e) ECHR, which legitimises a differentiate treatment to persons of "unsound mind" compared to the rest of the population that results in a limitation of their liberty.
This clause would create a direct discrimination: "Where certain categories of persons are treated differently without this difference in treatment having an objective and reasonable justification, either because it does not pursue a legitimate aim or because there is no reasonable relationship between the means employed and the aim pursued."[190]

The reasonable and objective justification to justify this limitation of rights has already been analysed above.[191] The author wants to emphasise here the invalidity of this justification. Though the protection of "public security" is a legitimate aim; the means employed (the detention of mentally disordered on an indefinite ground) are not the less restrictive measure to assure it.[192]
Moreover, is necessary to show evidence of an inequality of treatment that would not have happened if the complainant had not had certain special/personal characteristic (a psychiatric diagnosis on this case). As an example of this inequality of treatment is easy to adduce to the cases were "dangerous" but "sound mind" persons (without a diagnosis of a mental illness) are not detain on the same basis[193], notwithstanding that they might imply the same risk for the general population. Therefore, the provision is clearly discriminating those suffering from a mental illness because of these personal characteristic: the psychiatric diagnosis.

[189] Asscher-Vonk, 1999, p. 40.
[190] Schutter, 2011, p.23.
[191] See subchapter 2.3.3.
[192] See subchapter 2.3.3. c)1.
[193] Though some contradictory case-law on that issue exists in the EctHR. See subchapter 2.3.3. b)2.

The difficulty to bring a successful claim on direct discrimination on article 5.1.e) is that we need to proof intention as prerequisite.[194] It is hardly difficult to prove so. Especially because the provision also provides some safeguards[195] to avoid an arbitrary use of the detention. The role society plays is also very significant. This is not willing to take the risks that a total prohibition of institutionalisation might imply.

On the other hand, and continuing with article 14, this one does accept the existence of positive discrimination. Thus, a failure to correct inequalities through different treatment may give rise to a breach of the article.[196] Those diagnosed with a mental health problem suffer inequalities:
Very low rates of employment, the majority of EU countries report 20%-30% employment rates of this group.[197] Difficult access and low utilisation of health services. In a survey in the World Mental Health (WMH) for anxiety and mood and substance abuse disorders only around one third of those who could benefit from treatment make use of the services.[198] The access and contact with the health services varies depending on the disorder. They also have limited access to housing.[199]

This negative consequences created between identifiable differentiate groups in society are visible as problems of equality. The underlying inequalities are the ones that are not addressed.[200] On the author's opinion, they are also the ones that rise indirect discrimination. Striving for substantive equality belongs largely to the legislature, because courts do not have the power to reconstruct law, though they can invalidate legislation and provide appropriate remedies.[201] On our case, mentally disordered is a vulnerable group who does not receive the protection expected in the law with the negative consequences that follows.

[194] Willem, 1999, p. 32.
[195] The description and anlyse of the "safeguards" lead to the conclusion that they are weak and some of them even invalide justifications. See subchapter 2.3.3.
[196] *Oršuš and Others v Croatia,* Application no. 15766/03, Judgement 16 March 2010.
[197] Mc Daid, 2008, p.7.
[198] Wang, 2007, pp. 841-850.
[199] Mc Daid, 2008, p. 3.
[200] Loenen, 1999, p.204.
[201] Idem, p.207.

No laws are enacted at EU level to avoid their discrimination[202] and no specific protection is given in such an important human rights instrument as the ECHR. Contrary and paradoxically they are the target of a rights limitation clause. The most significant general non-discrimination rules found in international human rights documents: art.2 of the UDHR, art.26 of the ICCPR and art. 2.2 from the ICESCR do not mention explicitly "mentally ill" as one of the grounds of discrimination, where they rest again englobed in the general clause "other status". Neither exist a specific Convention protecting this group from discrimination.

This treatment on the law or this lack of treatment that leads to increase stigmatisation is due to a prejudice against mentally ill that "permeates" the whole society and consequently the legislative system.

The recently approved CRPD is calling the attention of the advocates of the rights of mentally ill. It is being assessed and discussed if and how it could better protect mentally ill than the old dispersed legislation. The next chapter of the thesis will analyse the treatment of the mentally ill on the CPRD and will compare it with the treatment of the ECHR and its bodies.

3.3. Conclusion

Mentally ill are clearly suffering stigma that leads to various human rights abuses and especially to discrimination and inequalities. Discrimination is visible in all forms of society but is supported by a lack of anti-discrimination laws specially enacted to protect mentally ill. The same situation is observed in the international human rights field and especially in article 5.1.e) ECHR and in some jurisprudence of the EctHR.

The problematic is widely recognised among professionals but there is a long way to improve the image of mentally disordered in the general public and raise awareness on their situation.

[202] Is currently discussed at the moment of the writing of this thesis the adoption of a "Directive on implementing the principle of equal treatment between persons irrespective of religion or belief, disability, age or sexual orientation." It could benefit mentally ill if treated as disable.

PART 3

ANALYSIS OF THE CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES AND ITS APPLICABILITY TO MENTALLY ILL.

On 13 December 2006, the General Assembly (GA) of the UN adopted the CRPD and an associated Optional Protocol (CPRD Optional Protocol). The first UN human rights treaty to be adopted in the 21st century and reputed to be the most rapidly negotiated ever.[203]At the moment of this writing 112 States had ratified the treaty and 67 States had ratified its Optional Protocol.[204]

The following is dedicated to the CRPD in relation to mentally ill.

Firstly, it will be briefly presented the significance of the CRPD as the first human rights treaty to consider disability as a human rights issue.

A brief description on the existing medical and social approaches to disability and in extension to mental illness will follow. Their knowledge is necessary to better understand what actually represents the innovations on the CRPD.

Follow a subchapter where the scope and content of the Convention is discussed. Whether disability englobes mental illness or not is crucial for our study.

The "paradigm shift" represented in the CRPD and the human rights principles which precede it are developed on subchapter 4.

The next one is dedicated to the possible impacts and benefits for mentally ill of the provisions on the treaty. With a special dedication on the way the CRPD approaches involuntary detention on article 14. And on the consequences of this article.

Finally, the critics that the CRPD had received are exposed on the last subchapter.

Some paragraphs to summarise and conclude bring the end to this chapter.

[203] Official Statement of the UN- Secretary-General, 13 December 2006, Secretary General Hails Adoption of Landmark Convention on the Rights of People with Disabilities, Doc. SG/SM/10797 HR/4911 L/T/440013 December 2006, available at: www.un.org/News/Press/docs/2006/sgsm10797.doc.htm

[204] United Nations, United Nations Treaty Collection, available at: http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-15-a&chapter=4&lang=en and http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-15&chapter=4&lang=en

1. DISABILITY AS A HUMAN RIGHTS ISSUE AND OTHER INNOVATIONS OF THE CRPD

More than 500 million people suffer of some kind of disability around the world,[205] and they are considered the "world's largest minority".[206] Until recently they have been one of the most forgotten groups in the international legal human rights field. Was not until the GA Resolution in 1981 (recalled as the Year of Disable Persons) that growing activity on the advocacy for disable's rights started.[207]
The recognition of disability as a human rights issue implies the recognition of the equality of people regardless of abilities, disabilities or differences and the according obligations that this implies.

Until nowadays two main barriers had prevented people with disabilities to benefit from their rights: 1. the medical model that impermeates the whole legislation, jurisprudence and societal attitudes; 2. the imposed separation of civil-political and economic-social-cultural rights.

The CRPD had innovated in both issues. It goes beyond the traditional approach which had influenced the legal treatment of human rights issues at an international level since the origin of human rights.

2. THE MEDICAL AND THE SOCIAL MODELS

To understand the significance and consequences of the social model in the CPRD, it is necessary to have an overview on the existing theoretical formulations of disability.

205 United Nations, Office of the High Commissioner for Human Rights, Persons with disabilities: CESCR General Comment 5, 9 December 1994, § 8.

206 Perlin, 2012, p.14.
207 For a more detailed overview on the development of disability as a human rights in the international human rights field see Perlin, 2012, pp. 8 -13.

Each theory seeks different causes of the disability. Consequently, each will reflect diverse ways to understand disability, and by extension mental illness, and divergent even though not always incompatible ways to react to it.

2.1 Classification

We are going to use the classification establish in the H. Rioux's study [208] Two approaches emanate from theories of individual pathology (the "medical models") and two from theories of social pathology (the "social models"). These theories also reflect the various formulations of mental illness.

1. The medical approach.

The theories that emanate from a medical approach have in common that they identify the disability or impairment in the individual's pathology, regardless of the societal and environmental situation. Thus, they search solutions through the improvement of the capacity of the individual on a biological basis and not on the improvement of situational and environmental factors.

On one side, there is the *biomedical approach.* It restricts the State responsibility to the social welfare and medical care. People with disabilities and mental illness are seen more as objects of welfare than subjects with rights. Consequently, they are seen as unproductive and their individual capacity is usually contested and their rights entitlement restricted.

On the other side, there is the *functional approach*, which regardless of the medical cause, it understands the condition depending on the impact it has on the functional capacity of the individual and its goal is to achieve an improvement on the person's skills. Thus, usually the services developed through this approach go beyond biomedical treatment and involves occupational therapy, physiotherapy, health visiting, job training, etc.

[208] Rioux, 2003, p. 288.

2. The social model.

The theories emanating from a social model approach appear as a reaction to the dominants medical models. They have in common their understanding of the mental, physical, intellectual, sensorial or other impairment not as a disability "per se" but as the society's failure to take them in account and adapt to them, thus creating barriers, negative attitudes and exclusion. Therefore, the social model tries to find social solutions to overcome impairments or limitations.

Roux's classification differences the *environmental approach* which limits the social responsibility on the elimination of social, physical, economical and political barriers. It understands the impairment by the failure of the environment to accommodate people's differences.

And the *rights outcome approach*, which goes beyond particular environmental factors. It focuses on broad social factors as the causes that keep these groups of people separate and unable to participate in society as equals. This perspective tackles the structural cause of the disability which is regarded as a "normal" condition, inevitable in a part of the population, and not a deviant one that has to be "normalised". Society is the one that has to be adjusting to respond more effectively to the presence and needs of those who have been systematically marginalised. The entitlement of social, economical, political and civil rights based on self-determination and autonomy is the basic mean to achieve equality.

As an innovative feature, the CRPD legitimates for the first time the social human rights outcome approach at an international human rights level.

2.2 On the application of the social model to questions of mentally ill. Why the medical model is more harmful?

To understand how the application of a social model can benefit mentally ill it will firstly be exposed how, contrary, the biological/medical model is harmful for this group.

There are studies that prove that biogenetical explanations are not always certain and moreover promote fear and prejudice.[209] The relation between the belief of the medical cause and the attitudes it promote is reflected on Sarbin and Mancuso's study cited by Read & Haslam[210], which shows that when the general population use the term "illness" tend to refuse the subject and quoting Goldin "consign them to an infantile role as a non-person".[211] Moreover, the same study affirms that people who support medical explanations are more reluctant to make friendship with people with these diagnoses.

The idea to compare psychological problems with physical problems creates the image of phenomena about which the individual does not have any control. Thus, people are more pessimistic about the patient's recovery and rated them as more dangerous and unpredictable.[212] Thus it is less probable that they will interact with them, in comparison with those who have a psychosocial belief of the causes.

The fact of labelling someone as mentally ill, when understood as a biological dysfunction, increases the perception that the difficulties of the person to interact and life in society are more serious.[213] Which "negatively influence on the evaluation of his/her social abilities"[214]; produce a more negative attitude about the possibility of rehabilitation and leads to the refusal of that person.[215]

Other studies from Langer & Abelson (1974) show that mental health personal who approaches the issue through the biological perspective considers that the patients are more perturbated.[216] Consequently, as stated by Kent and Read[217], they are less willing to involve them in services of planning. Thus, they have fewer chances to benefit from these means of support.

Furthermore, it has been claimed by the psychiatric users that the "medical model" ignores the multiplicity and complexity of the explanations of their experiences and

[209] Read & Haslam, 2006 , p. 165.
[210] Idem, p. 171.
[211] Read & Haslam, 2006, p. 171.
[212] Lam & Salkovskis, 2006, pp. 405 – 411.
[213] Jorm, 1999, pp. 77 – 83.
[214] Read & Haslam, p. 172.
[215] Idem.
[216] Idem, p. 173.
[217] Kent & Read, 1998, pp. 295 – 310.

their diversity.[218] Another proven fact is the ignorance of this model of cultural, gender or ethnic differences among diagnosis.[219]

Contrary, the social model promotes the diversity, and understands the different social, cultural and individual contexts as factors that influence certain diagnosis.

Due to the belief on its biological cause, a medical model also seeks for solutions through electrical or chemical means; whose secondary effects are highly dangerous. Since the beginning of the medical "treatment" of these disorders, is not clear whether they were used with the aim to cure an illness or with the aim to suppress socially deviant conducts.[220] Anyway, what is clear is that the medical model is more prone to use psychotropic drugs and means of coercion as part of the treatment. Moreover, the effects of the medical treatments, like obesity or diskinesia, are also stigmatizing "per se".

The social model promotes "treatment" through a higher use of human intervention, thus is more based on psychotherapy, and claims a lower use of psychotropics. It uses force just as a last resort to avoid the patients to get hurt or to hurt someone, but never as a punishment or tool of humiliation. It also promotes work and socialisation.[221] There is evidence that even on the XIX century, the so-called moral treatment (or psychological treatment), which is based on a social understanding of the mental disorders, achieve a rate of discharges from hospitals up to a 70% when they were first admissions. A century later, there is evidence that the rates went down to a 20 or 30 % of discharges, when rose the use of treatments based only on drugs.[222]

Furthermore, the social model promotes the prevention. Prevention understood as the need to built an "emotionally more healthy and just society."[223] It is crucial for the prevention that anyone has enough autonomy to decide on his/her life. Autonomy, as described by Emma Davies & Jim Burdett (2006),[224] consists on having the will,

[218] Rea & Haslam, p. 175.
[219] Read, 2006 (b), p. 197.
[220] Read, 2006 (c), p. 39.
[221] Silver, Koehler & Karon, 2006, p. 255.
[222] Idem, p. 257.
[223] Davies & Burdett, 2005, p. 330.
[224] Idem. p. 331

information, capacity and freedom to take decisions. This autonomy is achieved through the fulfilling of two factors[225]:

On one side, through the creation of the capacity for the autonomy of the individuals (or the autonomy of the family group in some cultures). On the other side, assuring a social, political and economical environment where the autonomy can be promote and practiced.

Autonomy as one of the values and grounds of the social model is further analysed on subchapter 4.2.3. Anyway, it derives from these observations that it is not enough to attend and support the individual, but is need a change on the social structures that keep mentally ill powerless.

To summarise, the medical model have more harmful effects on the social environment of the person suffering a mental disorder than a social model. It is especially harmful because of the negative attitudes towards mentally ill that it rise. These social negative effects decrease their self-stem and increase stigma. It often makes use of forced measures, deeming the affected subjects incapable. Moreover, the medical model ignores certain significant causal and contextual factors, consequently decreasing their opportunities to be rehabilitated.

A social model takes in account environmental factors, and approaches the disorder through a social perspective. It tries more psychotherapeutically treatments and seems to rise more friendly attitudes. Which might help on the inclusion and integration of these subjects, and therefore on their rehabilitation. Because it beliefs that social factors play a role on the rise and subsequent treatment of the illness, it seeks also to transform the social structures that might cause the segregate and excluding situation of mentally ill.

After explaining how the social model can be applied to mentally ill and its benefits, it will be studied whether the scope of the CRPD englobes this group or not. If so, they could benefit from its social approach.

[225] Davies & Burdett, 2005, p. 331.

3. SCOPE OF THE CONVENTION

Article 1 of the CPRD describes its scope on the following way: "Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society". Mental illness is not explicitly mentioned. But on some occasions a mental illness can be a mental impairment. Overwhelming evidence exist of the obstacles that suffer mentally ill due to attitudinal barriers on their effective participation in society on an equal basis with others.

The reference in the article to a "long-term" impairment can lead to misinterpret too narrowly the scope of the CRPD. Thus, and to avoid contradicting the nature of the treaty and some of its provision, "long-term impairment" should not be interpret to exclude those whose illness is intermittent or of a shorter duration.[226]

Each one of the two main approaches explained above[227]: the medical and the social one, understands and interprets the term "disability" differently.

The medical dimension of the term has been largely used. This approach is linked to paternalist views which tend to come about with the image of an incapable person who needs of supplant decision-making, linked with feelings of pitying and need of care.

The international human rights instruments created before the CRPD had relied on the medical perspective of the term disability. The CESCR General Comment 5 (Persons with disabilities: 09-12-1994)[228] relies on the approach adopted in the Standard Rules of 1993 and states: "The term disability summarizes a great number of different functional limitations occurring in any population (...) People may be disabled by physical, intellectual or sensory impairment, medical conditions or mental illness. Such impairments, conditions or illnesses maybe permanent or transitory in nature." On this occasion, mental illness was explicitly referred as one of the possible causes of the disability.

[226] Minkowitz, 2010, p. 155.
[227] See subchapter 2.2.
[228] United Nations, Office of the High Commissioner for Human Rights, "Persons with disabilities: CESCR General Comment 5", 9 December 1994.

Contrary, the CRPD in its preamble manifest and recognise disability through a social approach: “an evolving concept that results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others.”

For the first time in a binding human rights document disability is understood as the failure of society to accommodate people with different abilities or disabilities, responding to a social model framework in a human rights approach.

Through the social lens, the “disability” term loses part of its negative connotation. The cause of the disability is not anymore the illness on itself but the way society reacts to it. A reaction which tends to patronize and stigmatize people with impairments. With the excluding and negative consequences that these phenomena carry. Thus, the social notion of “disability” relates better linked to a notion of inequality, discrimination and lack of accommodation.

The term “mental impairment” mentioned in article 1 CRPD is a narrower term than mental illness. Should mentally ill be considered disable? On the next subchapter we are going to weigh up if a mental illness can and should be identified as a disability.

3.1 Mental illness as a disability.

Not everyone with a mental illness will consider themselves, or be considered, disable. Because “disable” or “handicap” used to entail a negative connotation. The etymology of the term implies a lack of “ability”. Thus, the term is constructed in a “normalise” bias ground. It is comparative on itself. However, it does not have to entail a negative connotation “per se.”

Regardless that mentally ill are not explicitly mentioned on article 1 and that a definition of “disability” could not be resolved.[229] The inclusion of “persons with mental impairments” on article 1, the high degree of participation of this group on the

[229] Kayess & French, 2008, p.23.

creation of the CRPD and the social framework used, leads without doubt to the conclusion that diagnosis of a mental illness or subjective experience of oneself as having a mental illness comes within the concept of "mental disability" under the CRPD. [230]

On the other hand, the relationship and/or differences and/or similitude between psychosocial disability, mental illness and health status remains unclear[231] and needs to be defined.

The Convention is still a recent instrument and is going to take a long time until a clear and consensual interpretation of it is universally accepted[232] and its terms defined. Anyway, we can already state here that generally, and without standing the variety and degrees of illness englobed in the term, mentally ill can be included between the subjects who can benefit from the provisions on the CRPD.

On the other side, the mentioned shift of the Convention to a social model approach can help to reduce the negative and paternalist attitudes attached to the "disability" term and in extension to mental illness. The social approach can also help to understand that not each person suffering from a mental illness is disable just for carrying that diagnosis. Insofar he/she is not treated unequal[233] he/she is not disable. The disability is not caused by the illness but by the society attitudes versus it.

4. THE PARADIGM SHIFT

Since the ratification of the CRPD interpreters and scholars had claimed that the Convention is setting a "paradigm shift" on the issue of disability. We are going to analyse on this subchapter what does this paradigm shift actually means and which

[230] Minkowit, 2010, p. 155.
[231] Idem-
[232] Lewis, 2010, p. 106.
[233] When not specified the author understans equality as equal opportunity or structural equality and not as formal or juridical equality. Further information on subchapter 4.2.2.

changes and benefits it foretells in the specific situation of mentally ill. Since now on when referring to "persons with disabilities", regardless of all the persons included in the term, the thesis seeks to refer to mentally ill, because they are the focus of the study.

4.1 The shift on the approach. Aim: to tackle the structural conflict.

The CRPD does not develop any new human rights,[234] but for the first time applies existing human rights to persons with disabilities and their particular circumstances. The paradigm shift seeks to move towards inclusion[235]and uses a social model framework to do so, reclassifying disability as a human rights issue.[236] The change comes on the way the Convention seeks to tackle the problematic.

Previous human rights treaties try to grant formal equality while prohibiting discrimination. However, they failed to bring equality on opportunities. The difference between the CRPD and other treaties is that the other ones have sought to achieve human rights through the proclamation of rights. Rather, the CRPD deals with the entitlement of the basic foundational rights of non-discrimination, equality and social participation that must guide and serve as principles to construct the social fabric.

Is not just necessary to entitle them with the corresponding civil and social rights. Other Conventions had already done it. But to tackle the foundation bedrocks of the situation of inequality, segregation and stigmatization that suffer disable persons in all aspects of life, in order to achieve the perfect formula of equality that will give them the means to really use these rights. "Reasonable accommodation" and "positive discrimination" are necessary means until our society will be prepared to accept diversity.

The aim of the CRPD is to address the structural conflict and change societal attitudes through the empowerment of the affected persons. Giving them back the power of decision and autonomy. Thus, they will be able to act at an equal position with other individuals. This shift of paradigm should change society's ideas about mentally ill.

[234] Kayess & French, 2008, p. 20.
[235] Mitller, 2003, p. 32.
[236] Degener , 2003, p. 152.

4.2 The human rights values of the paradigm shift.

For the first time, an international human rights treaty includes a list of guiding principles in one of its articles (article 3). Four of them are relevant for our study:
a) respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of the persons b) non-discrimination c) on participation and inclusion in society e) equality of opportunity.

On the following is given a brief overview on the concepts of human dignity, equality and autonomy. Though as important as the others, we are not going to tackle here non-discrimination and participation and inclusion in society. They are narrowly linked to the other ones and can result from the fulfilling of the firsts.

- **4.2.1 *Human dignity*:**

Human dignity is the central value of the CRPD, mentioned in the preamble as the "inherent dignity and worth of the human person." Is mentioned again on its article 3.a) On this occasion, the CRPD takes human dignity as the milestone for all the human rights set in the treaty. Consequently, it can be further seen referred in many of the provisions of the treaty, more than in any other human rights treaty.[237]

On the mental health field claims rise that involuntary treatment and detention in base of a mental diagnosis and some level of dangerousness conflict with the claim of human dignity.[238] Because respecting human dignity requires respecting one's choices, diversity and integrity of the person.

The UDHR and the UN Charter had clearly linked human dignity with equality.[239]

- **4.2.2 *Equality*:**

Various concepts of equality exist. Is significant to understand their differences in order to better acknowledge the consequences that carry the paradigm shift set in the CRPD.

[237] Kämpf, 2010, p. 137.
[238] Idem.
[239] Idem, p. 136.

To identify the various forms of equality we are going to refer to the classification used by T.Degener in her article "Disabiliy as a Subject of Law":[240]

1. Formal or juridical equality. It was the most used in the previous human rights treaties. It prohibits direct discrimination and thus it requires ignoring the differences. It can bring benefit through preventing stereotypes and stigmatization but it does not "justice to the reality of the difference."[241]
2. Equality of results. As it names explains it focus on the equality of the results. This point raises controversies. It does not just matter that there has been an equal allocation of resources, but the results of that allocation have to give the same results. When it does not happen who is the responsible to provide those equalitarian results? The state? Or the private sector? This concept of equality can enter in conflict with the free market economy.
3. Equality of opportunities. It requires equal chances but not equal results. Thus, it is more compatible with the free market economy and it has more chances to adapt to reality. Its key term is the provision of "reasonable accommodation". It tackles stereotypes and structural barriers seeking for inclusion. Nowadays equality of opportunities is the most frequently applied equality concept in modern national disability legislation around the world.[242] Before the creation of the CRPD the international human rights instruments were obsolete on this point.

The CRPD explicitly mention "equality of opportunities" as one of the guiding principles on its article 3. It also defines "reasonable accommodation" on its article 2: "necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms."

The "paradigm shift" does not just refer to the move from the medical paternalist approach to the social one, but also to this shift on the conceptualisation of equality.

[240] Degener , 2003, p. 153.
[241] Idem.
[242] P.154 Degener, 2003, p. 154.

This principle implies the responsibility of States to take positive actions, when not disproportionate or when do not create an undue burden, in order to achieve the mentioned “reasonable accommodation.” These obligations are set in article 4.

- **4.2.3 *Autonomy***

This is without doubt also one of the bedrock principles and the great innovation of the CRPD. Moreover, it is of crucial significance for mentally ill. It is mentioned next to human dignity on article 2.a). Thus, we can deduce that they are intrinsically interrelated.

Until nowadays, presumption of incapacity often arises automatically when someone is diagnosed with a mental illness. Article 12 of the CRPD entitles mentally ill to enjoy legal capacity on an equal basis with others in all aspects of life. It recognises on point 3 of the same article that sometimes support might be required. On those cases, article 12.4 establishes important safeguards. Beside article 12, the value of autonomy is the guiding principle for most of the provisions on the Convention.

The Convention promotes dialogue and collaboration through the supporting system. On this path, it gives back the voice to this vulnerable group whose preferences and wills have been usually ignored due to the fact that they were systematically placed under guardianship and deemed incapable.
On the other side, no mention is done to the possibility to substitute decision-making even in the most extreme cases. Consequently, when it takes place it should be understood to be based on and individual careful assessment and applied restrictively and based on equality. Otherwise it will contradict the nature of the treaty.

The affected subjects which might lack the full capacity to understand have to be supported when necessary in exercising their free will. But the legal capacity should not be taken totally away anymore. From this statement arise the conflictive question whether a new human rights to legal aid has been created. We are not going to tackle this issue here.

The value of autonomy and article 12, where it is better reflected, is very significant because it can avoid the repetition of the past human rights abuses that mentally ill had suffered when they power of decision had been suppressed.

As A. Kämpf emphasises, "taking risks is an element of many health decisions that should be safeguarded, not excluded."[243] Some persons who are not mentally ill decide sometimes not to take life-saving treatments based on religious, cultural or other beliefs that others might find incomprehensible. But it seems that mentally ill can not take such incomprehensible decisions. It is doubtless that some persons who have undertaken involuntary treatment and/or involuntary hospitalisation or detention had improved their life quality or even cured. However, to avoid the repetition of power abuses it is very important to highlight the autonomy and self-determination of persons with mental disorders. The power to decide should not be taken away under any circumstances, even though some might need support on their decisions. Otherwise, incapacitation directly deprives of the possibility of being an active subject and transforms the individual on a passive object of welfare.

5. POSSIBLE IMPACTS AND BENEFITS ON THE TREATMENT OF MENTALLY ILL

The articles and provisions on the CRPD reflect the above explained values and entitle mentally ill with significant civil, political, social and cultural rights founded in equality and autonomy.

Article 10 to 23 and article 29 are based on civil and political rights. And articles 24 to 28 and 30 are based on economic, social and cultural rights. Without standing that they are not totally mixed, non explicit separation of these two "groups of rights" is done in the Convention. On this way it overcomes the traditional distinction between civil-political and economic-social-cultural rights.

[243] Kämpf, 2010, p. 142.

Is not the purpose of this thesis to analyse the whole Convention. Consequently, only the articles which can have a higher impact on the lives of mentally ill will be identified and briefly explained.

On the context of the thesis the author wants to stress article 12 (already mentioned above in the last subchapter). This article will benefit mentally ill because it empowers them with legal capacity in all aspects of life.

Also article 13, which extends the right of equality before the law into a positive obligation to ensure access to justice. This provision might imply the obligation of a human right to legal aid.[244]

Article 17 protects the physical and mental integrity of the person. Though it has not been furthered developed, it is vigorously used by advocacies against compulsory treatment to illegitimate such practices.[245] A future interpretation and jurisprudence on the article will define its scope.
On the other side, article 25 on the right to health, specially require to health professionals on its .d): " (...) [to] provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity and autonomy and needs of persons with disabilities (...)." This provision states without doubt that free consent to health treatment is required.

Together with article 17, article 19 (about living independently and being included in the community) and article 20 (about personal mobility) extend the traditional right of liberty and security in ways that are "unexpected and difficult to predict."[246]

Article 26 is also of significance because extends the traditional right to health to the right rehabilitation. It can ensure that mentally ill will have access to programmes that can enable them to develop (or recover) their maximum potential. Though it is based on a medical functional approach, it raises the standards of the traditional health obligations of the States, and anyone suffering from a mental illness can benefit from it.

[244] As expressed in suchapter 4.2.3 it is not totally clear whether had been created such a right, but the question had arised.
[245] Kayess & French, 2008, p. 29.
[246] Idem.

From article 4 to 8 are enumerated a list of general obligations which States parties must undertake.

Article 8 stresses the obligation to raise awareness in order to promote a fundamental change in societal attitudes. Thus, finally the attitudes of society are directly recognised as a significant cause of the human rights abuses.

Article 4 enumerates a long list of general obligations of the States, mainly negative obligations but from which derives necessary positive ones.

The manifestation of positive obligations in an international human rights treaty is considered an innovation in the human rights field. On the past, they had received several critiques regarding the excessive focus on "negative" rights to the neglect of "positive" rights.[247] On this way, they failed to deal with the structural causes of the injustices.

An example to support the view that "positive" obligations actually derives from the Convention is article 19. It provides that States parties must ensure the access of persons with disabilities to a range of in-home, residential and other community support services, including personal assistance, etc. Before ensuring the access to these services, it will be necessary that the governments create the services, in those cases where they do not exist yet.

Is of special significance on our topic the obligation to the States mentioned on article 4.a) .b): "To adopt all appropriate legislative, administrative and other measures for the implementation of the rights recognized in the present Convention." "To take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices that constitute discrimination against persons with disabilities."

These obligations bring us to reconsider the legality of mental health laws and their compliance with the Convention. This point is going to be extended on the following subchapter 6.

Before going on, the thesis wants to dedicate some paragraphs to analyse the way the CRPD regulates involuntary detention.

[247] Zückerberg, 2010, p. 326.

5.1 How the CRPD approaches involuntary detention

No provision on the CRPD explicitly mentions "involuntary detention" or "involuntary hospitalisation" for individuals with mental illness.

However, article 14 about the liberty and security of the person, clearly states: "1. State parties shall ensure that persons with disabilities, on an equal basis with others: a) Enjoy the right to liberty and security of the person". "b) (...) the existence of a disability shall in no case justify a deprivation of liberty. (...)"

This provision clearly banns any justification of deprivation of liberty on the ground of a disability. If a mental illness is considered a disability, as we have argued before,[248] the detention of a mentally disordered could not be justified because he/she is suffering a certain psychiatric condition. Moreover, when article 14. 2 states that: "(...) if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitle to guarantees in accordance with international human rights law (...)" we have to understand that persons with disabilities are still subject to lawful arrest and detention exercised only on disability-neutral grounds, such as criminal law enforcement, immigration status violations, etc. But not as it is creating special or separate standards to detent mentally disordered.[249]

Thus, it seems that institutionalisation is prohibited by the Convention. But then, why it has not been explicitly banned? Professor Arlene Kanter[250] thinks that though the Convention is stronger on its rights and obligations than any prior UN document it stills views institutionalization "as a last resort".

On the opinion of the author, regardless of the reasons that could justify such a silence, – either simply a political compromise to finalise the treaty or either to offer domestic legislations a wide margin to work on,- some of the other rights mentioned in the Convention would have no significance if article 14 is not interpreted as banning involuntary institutionalisation.

[248] See subchapter 3.1.
[249] Minkowitz, 2010, p. 167.
[250] Kanter, 2009, pp. 527 – 573.

To start on, article 12 ensures equality before the law and legal capacity in all aspects of life. When involuntary institutionalisation takes place, the affected person automatically sees his/her capacity to decide denied. It is in contradiction with article 12.

Furthermore, the Special Rapporteur on Torture, Manfred Nowak[251]had noted that the CRPD "complements" on the prohibition of torture "by providing authoritative guidance." He mentions article 3, article 12 and also article 25 on relation to torture. On the same paragraph of the report he clearly states that the "acceptance of involuntary treatment and involuntary confinement runs counter to the provisions of the Convention on the Rights of Persons with Disabilities". In a further paragraph (64), he recalls article 14 of the CRPD in relation to those States which allow for the detention of persons with mental disabilities in institutions without their free and informed consent, on the basis of a mental diagnosis and often of a "dangerous" criteria. The recallment makes reference to the illegality of such practices in relation to article 14.

The Special Rapporteur also refers to the arbitrary or unlawful deprivation of liberty based on the existence of a disability as the source of "severe pain or suffering on the individual."[252] Thus, this kind of detention might also fall under the Convention against Torture and therefore it is clearly banned.

The Office of the High Comissioner for Human Rights (OHCHR) had mentioned in relation to article 14, that it requires the: [253]"repeal of provisions authorizing institutionalization of persons with disabilities for their care and treatment without their free and informed consent, as well as provisions authorizing the preventive detention of persons with disabilities on grounds such as the likelihood of them posing a danger to themselves or others, in all cases in which such grounds of care, treatment and public security are linked in legislation to an apparent or diagnosed mental illness."

Also a report from the European Union Agency for Fundamental Rights (FRA)[254], published as recently as on June 2012, had arrived to the same conclusions that the thesis is supporting: involuntary placement and involuntary treatment of persons with mental health should be prohibited because it constitutes a human rights violation.

[251] Nowak, 2008, § 44.
[252] Nowak, 2008, § 65.
[253] United Nations, Thematic Study by the OHCHR on *Enhancing awareness and understanding of the Convention on the Rights of Persons with Disabilities.*",UN Doc A/res/10/48, 26 January 2009, at: http://www2.ohchr.org/english/issues/disability/docs/A.HRC.10-48_sp.doc
[254] Fundamental Rights Agency, 2012.

The latter statements and a logical interpretation of article 14 leads to the conclusion that involuntary institutionalisation based on a mental diagnosis, sometimes together with the criteria of "danger", is prohibited by the CRPD.
Contrary, it would be a discriminatory practice which might amount to torture and inhuman treatment and be against the integrity of the persons. In addition, it would contradict the equality and autonomy principles which are the essence of the nature of the CRPD and it might even run against other human rights instruments, like the Convention against torture.

Consequently, the above-mentioned obligations on art.4.a).b)[255], several of the provisions and rights set forth in the CRPD, such as article 12, article 15 and/or article 17 ; and specially article 14, brings us to reconsider whether it is necessary to have mental health laws at all. Furthermore, and not less disturbing, it brings us to reconsider article 5.1.e) of the ECHR and several of the case law of the EctHR. [256]

On the following point, the author will broadly explain and support why mental health laws should be abolished in order to comply with the Convention.

6. ABOLISHING MENTAL HEALTH LAWS TO COMPLY WITH THE CONVENTION

Mental health laws regulate the care and treatment of mentally ill persons. Mainly whether involuntary treatment and involuntary psychiatric hospitalisation is necessary, its management and requirements. They also establish safeguards for the patients. Even though they are increasingly rights-based, they are still based on the idea that a mentally

[255] Article 4.a).b) CRPD" To adopt all appropiate legislative, administrative and other measures for the implementation of the rights recognized in the present Convention." " To take all appropiate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices that constitute discrimination against persons with disabilites."

[256] A comparisson between the CRPD and the ECHR takes place in chapter 10.

ill person can be involuntary treated if necessary.[257]Actually their main reason of existence is the regulation of these processes. Therefore, they legitimise and limit coercive state power in relation to confinement and psychiatric treatment.

Some of the articles of the Convention, already analysed, are totally in contradiction with such practices. The CRPD is created on the premise of non-discrimination based on disability. It deems persons with disabilities to be capable to decide in all aspects of life, including hospitalisation (article12). It deems equality in the treatment in front of the law including the non deprivation of liberty because the existence of a disability (article 12 and article 14). It stresses free and informed consent on the care of the patient (art.25.d)) It also deems forced or non-consensual psychiatric interventions as torture.[258]

On the other side, mental health laws regulate the treatment of mentally disordered people just on the ground of their mental state. Thus, they are dealing with the treatment of people with a mental diagnosis with separate and/or special standards that only apply to persons with these characteristics. This is discrimination. Moreover, they limit their rights of freedom of decision, autonomy, liberty, dignity and human treatment; which are internationally recognised human rights on the CRPD and other instruments.

Therefore, mental health laws as we know them must be abolished and any detention in psychiatric institutions based on a certain mental state should be considered unlawful imprisonments.

On the other hand, as an international instrument created by not few different cultures and countries with a variety of legal systems, the CRPD is not solving all controversial matters and thus is not free from critics. Afterwards, the thesis will briefly mention the main conflictive points of the CRPD.

[257] Kämpf, 2010, p. 129.
[258] Minkowitz, 2010, p. 169.

7. CRITICS ON THE CRPD

The following three critical points of the treaty are based on the study done by Rosemary Kayess and Phillip French, on their article in the "Human Rights Law Review" [259]:

7.1 Not definition of disability and impairment

Firstly, they mention the perpetuation on the treaty of the conceptual confusion between impairment and disability.[260] For various reasons the treaty does not solve this point. Among the justifications of the States are[261]: the concern about the impact of having a definition, which might lead to a too narrow one which will leave people without protection; or contrary to a too broad one with whom too many people could be incorporated.

On the other side, the reticences of the International Disability Caucus (IDC)[262] to adopt any definition did pressure the decision not to do so. They objected that a definition would inevitably derive from the medical model. Also because they understood "disability" as a social category evolving over time and society. Thus, adopting any definition would inevitably reflect a western view of the notion. Consequently, the CRPD only describes on article 1 "persons with disability" without providing a clear definition of disability and impairment. Is not the purpose of the author to analyse whether this decision is a beneficial or a prejudicial one.

[259] Kayess & French, 2008, p. 21.
[260] Idem.
[261] The question of such definitions was discussed in the Ad Hoc Committes 2nd, 4th , 7th and 8th Sessions and in the Working Group.
[262] The IDC was the representative voice of persons with disabilities in the process of the Ad Hoc Committee, made up of government delegates. The IDC was composed of more than 70 world-wide, regional and national Disabled People's Organizations (and allied NGOs) who had decided to work together and coordinate their efforts. The IDC included all the different disability groups and had organizations from all regions of the world. It was open and inclusive to all Disabled People's Organizations (DPOs) as well as other organizations which recognized and accepted the leadership role of DPOs. The IDC was established by disability organizations during the first Ad Hoc Committee meeting in order to ensure that the views of people with disabilities would be taken into account in all stages of the negotiation process of the Convention.

7.2 Not preventive protection

Even though neither a definition of disability nor of impairment is given, Kayess and French affirm that the human rights protection provided by the CRPD has its roots on the disability, not on the impairment itself. Consequently, only those who are already being discriminate and whose rights are already abused can seek protection.

The author has to disagree with this statement. Several obligations on articles 4 and 8 are explicitly aiming to raise awareness, research and development and promotion of the human rights. Also article 25.b) requires States to provide "services designed to minimise and prevent "further" disabilities." In the modest opinion of the author, these obligations seek to prevent the arising of new social forms of abuse and exclusion. Therefore, not just the groups that are already suffering such negative consequences will benefit from the treaty.

7.3 Indeterminate scope of the Convention

Article 1 lists a category of impairments which fall under the protection of the Convention. But to determine who exactly falls between the boundaries of those impairments will be left to the discretion of the States, at least until international jurisprudence is developed on the issue.

This fact can lead to the States to specially deprive some groups of protection. We had above lead to the conclusion that mentally ill where falling inside the category of "mental impairment". However, as stated at the beginning of the thesis, mental illness and mental disorders are very broad and unclear terms whose boundaries are not even clear nowadays. They imply a broad amount of different categories of illness and disorders and their respective degrees of impairment. This fact and the legacy of discrimination and exclusion that they hold give high chances to some of them to become one of the forgotten groups by the States. Thus, it would be necessary to assess case-by-case how each State is implementing the Convention and which groups are being taken in account.

8. CONCLUSION ON THE CRPD

The above mentioned articles and values can benefit mentally ill to fully enjoy all the rights they ought to enjoy as human beings and that they have seen denied since there is documentation on history about their treatment.

The most significant innovation on this treaty is the shift of the paradigm and the fact that it can give back the autonomy and self-determination to the mentally disordered; whose lack have been the direct cause of several human rights abuses. However, the recent creation of the CRPD and thus its lack of jurisprudence, interpretation and implementation still leave some questions unsolved. We will have to wait to see how far its provisions can reach and change the reality of mentally ill in each State party.
It remains the States' responsibility to "enforce" the Convention.
Cynical views on the issue, like Eric Neumayer,[263] manifest that States only enforce the provisions of the treaties they sign as far as their interests coincide with it. Also Phil Fennell[264] points out that governments tend to take a narrow approach to what human rights law require. But on some occasions when the political environment is the adequate,[265] some treaties can trigger the transformation of society.[266]

On this occasion, the success of the treaty and its potential to transform society will basically depend on its capacity of implementation. Policy-makers will have to embrace new politics and programmes to comply with some of the provisions on the Convention, i.e. article 12. It will also be crucial the position which the subjects affected, their families and the civil society will take on the issue. Finally but not less important, will play a significant role the capacity of the society concerned to be opened to think about new ideas which might be seen at the beginning against what is culturally accepted.
Policy-makers and legislators reflect the changes they national society wants to see. If there is not a transformation on the societal attitudes, it will hardly be a change on the willingness of the policy-makers to embrace new politics.

[263] Perlin, 2012, p .157.
[264] Fennell, 2010, pp. 13 – 49.
[265] Professor Elizabeth Defeis talks about how the UDHR was central in the struggle in South Africa against apartheid.
[266] Perlin, 2012, p.157.

On the other side, legislation that aims to transform society, like the CRPD and mainly all human rights legislation, usually establishes some kind of special enforcement mechanisms.[267] The CRPD counts with the Committee on the Rights of Persons with Disabilities (Committee). The States are obliged to submit periodical reports and the ones who have ratified the Optional Protocol can also be brought in front of the Committee for individual complaints.

To assess how far the CRPD is having an effect over mentally ill, the reports that have already been submitted to the Committee will be analysed in the following chapter.

9. REAL IMPACTS OF THE CRPD

This chapter has the aim to assess the real impacts of the CRPD on the State parties. The only available tools at the moment to assess how far the States had implemented the provisions of the treaty are the State reports. Therefore, the author has look through the reports for any reference on the situation of mentally ill and/or to any reference to the elimination or modification of mental health laws.
Before entering into the analysis of the reports, the functioning of the enforcement mechanisms is briefly explained.

9.1 The enforcement mechanisms.

Article 35 CRPD establishes the obligation of each State party to submit periodical reports to the Committee, through the Secretary-General of the United Nations. Article 34 regulates the body responsible to control the reports.

[267] Degener, 2003, p.173.

The Committee is the body of independent experts which monitors the implementation of the Convention. It shall be formed at the beginning by twelve members with the possibility to increase them until a maximum of eighteen. They are elected for a term of four-years with the possibility to be re-elected once. States have to submit the initial report within two years after the entry into force of the Convention for the State party concerned. On these initial reports States have to explain the measures taken to give effect to the obligations of the treaty and on the progress made.
Afterwards, the reports shall be submitted at least every four years or whenever the Committee requests them. The Committee analyses the reports and make general recommendations on them. Thereafter, it forwards these suggestions to the State concerned. They usually also ask to the State for specific topics or for the specification on some of the statements on the report which might concern them. Finally, the Committee writes on the general conclusions about the report. The reports, as well as the inquiries and answers of the State and the concluding observations, are published and available at the website of the OHCHR.[268]

Complementary, the Optional Protocol to the Convention (OP) gives to the Committee competence to examine individual complaints and groups of individual complaints with regard to alleged violations of the Convention by the State parties of the Protocol.[269] The OP also establishes an inquiry procedure in relation to gross violation of CRPD rights.[270]

The enforcement mechanisms on international human rights law had usually failed for their low capacity to pressure states parties to comply. Shall be different in this occasion? The CRPD was the treaty most rapidly negotiated ever and is claimed to be received with "unprecedented enthusiasm" by the international community.[271] Is still early to assess how far its provisions will have an influence on the national realities. But whether exist a will or not on the States to implement it is reflected in the initial reports.

[268] United Nations, United Nations Human Rights, Office of the High Commissioner for Human Rights, at:
http://www.ohchr.org/EN/HRBodies/CRPD/Pages/Sessions.aspx
[269] See article 1 OP.
[270] See article 6 OP.
[271] Kayess & French, p. 2.

9.2 The initial reports to the Committee on the Rights of Persons with Disabilities.

The author has gone through the reports presented to the Committee looking for any mentions on the situation of mentally ill and/or any improvements and/or changes or elimination of mental health laws.

First of all, to assess whether the States englobe mentally ill into persons with disabilities it is interesting to see whether any mention to them is done or not. Later on, to evaluate how far improvements have taken place, the author will refer to the mentions on the reports about articles 14 and 17.
These articles had been chosen because they are the ones which can better reflect the situation of the mentally ill. It would not be effective to evaluate the whole reports because they do refer to a wide range of persons with different kinds of disability. On the other side, due to a time and space constraint it would be neither effective to mention all the provisions on the Convention.

9.2.1 *Few quantity of reports*

112 States had formally ratified the Convention. Thus, after the thirtieth day of its ratification the Convention had entered into force for the concerned ratifying State.[272] Since that moment, the States count on two years to submit their initial report. More than eighty States[273] had ratified the Convention more than two years ago. But just 27 States had submitted their initial report.[274] From these reports just eight had been commented on the Sessions of the Committee,[275] and some inquiries had been hold. Only three States had received the Concluding Observations on the reports: Tunisia, Spain and Peru.

[272] See article 45 CRPD.
[273]United Nations, United Nations Treaty Collection, 11 June 2012, at: http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-15&chapter=4&lang=en
[274] United Nations, United Nations Human Rights, Office of the High Commissioner for Human Rights, at: http://www.ohchr.org/EN/HRBodies/CRPD/Pages/Sessions.aspx
[275] Seven sessions had been held until the moment of this writing. The last one on the 16-20 April 2012. The eight session is scheduled for the 17-28 Setember 2012, available at: http://www.ohchr.org/EN/HRBodies/CRPD/Pages/Sessions.aspx

These data denote low participation and low implication of the States on the real implementation of the treaty.

9.2.2 *Mentally ill on the reports*

Mainly all the reports of the States mention mentally ill, - even though they might not do it explicitly when defining the scope, where is better preferred the statement "persons with mental impairments",- but at some point of the report there is always a mention to persons with mental illness or to mental health. These allusions are sufficient to affirm that persons with a psychiatric diagnosis are considered englobed into the subjects of the Convention. However, mentally ill and/or mental health is always also referred fewer times than other disabilities.

We have to be very sceptic with the initial reports, because they are written by the States and they might not be very critical. But on the Concluding Observations on Tunisia and Spain's report, the Committee was especially concerned about mentally ill as one of the groups that might be falling out of the protection of the treaty.
On the other side, on the report of China, were reported just 7.4% of mental disable. Most of the disabilities percentage shown was about physical impairments. While rates of psychiatric disorders varies among countries and surveys, this data is still surprising considering that a 2005 survey in 16 European countries[276] found that at leas 27% of adult Europeans are affected by at least one mental disorder in a twelve months period. Other reports, like the one on Croatia, does not include mentally ill directly under the persons protect on its Disability Act. However, other's like the one on Peru, had recognised mental disability as the second one more prevalent (after hearing disabilities).

To summarise, though mental disorders are being considered in all reports as one of the impairments that might fall into the CRPD and benefit from its protection, their high predominance is still not being widely recognised. People with mental illness are easily being forgotten or left at a second or third priority stage.

[276] Wittchen & Jacobi, 2005, pp. 357–376.

These results might be the consequence of the lack of specific inclusion of this group in the Convention and to the wide margin of discretion of the States to decide who they will englobe in the scope of protection.

9.2.3 *Treatment of mentally ill through articles 12, 14 and 17*

The following table shows how each country which had submitted the initial report had adopted article 14 and 17 of the Convention, whether they count or not on mental health laws and whether some kind of independent supervisor authorities exist.

To reflect the implementation of the latter articles, it will be mentioned whether institutionalisation is permitted or not, and whether forced treatment is allowed or not. About article 12, it has not been introduced on the table because all the States provide incapacitation on substitute-decision making when the subject is under severe mental impairment. Some of the systems are more supportive of the support-decision process than others. But they all provide some exceptions on the full legal capacity of the mental disable.

Table on the implementation of the State Parties of some provisions of the CRPD and on the existence of independent supervisor authorities.

State Party	**Article 14. Involuntary institutionalisation. Criteria**	**Article 17. Involuntary treatment.**	**Mental health law**	**Existence of independent supervisor authorities.**
Argentina	Yes. Criteria: therapeutic benefits.	No. Free and informed consent is necessary.	Yes.	The Board of Mental Health, Justice and Human Rights (2005)
Australia	Yes. Criteria: danger.	Yes. “as last resort”	Yes.	Guardianship Boards and

				Tribunals.
Austria	Yes. Criteria: mental illness + danger.	Yes.	Yes.	No.
Azerbaijan	Not mentioned	Not mentioned	Not mentioned	No
China**	Not mentioned	Yes	No	Not mention
Cook Islands	No. Exception: danger (they are removed to NZ facilities)	No	Not mentioned	No
Croatia	Yes. Criteria: health + danger	Yes	Yes	Not clear
Costa Rica	Yes. But not direct mention	Not mention.	Not mentioned	Not mention
Czech Republic	Yes	Yes	No	No
Denmark	Yes	Not mention	Yes	Yes. Danish National Board of Health
El Salvador	Not mention	Not mention	Not mention	Not mention
Germany	Yes. Criteria: danger + unable to decide due to an illness	Yes. Criteria: unable to decide + will benefit them	Yes	Yes
Hungary	Yes	Yes	Not mention.	No
Kenya	No explicit mention. Exception: for children	No. Free and informed consent necessary	No	Not mention
Mexico	Yes. Proposal to eliminate	Yes	No. Proposal	Not mention

	involuntary detentions		to enact one	
New Zealand	Yes: danger + serious mental illness. But no existence of large psychiatric institutions since 2006. Use of Community model	Yes: danger + serious mental illness	Yes	Mental Health Review Tribunal
Spain*	Yes	Yes	No	No
Sweden	No.	Yes.	Yes	National Board of Health and Welfare
Peru*	Yes	Not mention	Yes	No
Paraguay	No	Not mention	Not mention	Not mention
Republic of Corea	Yes	Yes.	Yes	Central Mental Health Deliberative Commission
Tunisia*	Yes	Lack of clarity	Not mention	Not mention
United Kingdom of Great Britain and Northern Ireland	Yes. Criteria: danger + mental illness	Yes. Criteria: danger+ mental illness	Yes	Care Quality Commission (England) and the Healthcare Inspectorate Wales (Wales) and Health Review Tribunal (Northern Ireland)

The Belgium report could not be displayed in the website. The Ukrainian report could not be interpreted by the author because it was just written in Russian.

*The only countries with the Concluding Observations from the Committee.

** On the reports on China has not been considered the report on Hong Kong, neither the one in the region of Macao.

We observe that the situation on the State parties that had elaborated a report is far from the desirable results of the Convention. Nearly all of them still use the institutionalisation of persons with mental illness as a "resort" to treat them or/and to prevent harm to others or themselves, save for New Zealand, Sweden and Paraguay. The firsts seem to have turned totally to a system of community care. The report on Paraguay's situation was not as clear about it.

All of them, regardless Argentina, Kenya and the Cook Islands, declare that they allow for involuntary treatment on some occasions.

Moreover, nearly half of them have a specific mental health act. Most of the others do not mention whether they have or not, and few are know as not having them. Surprisingly, even though it has been established that mental health laws contradict the nature of the Convention, none of them refer to the intention to modify, adapt or eliminate these laws, where they exist. Even Mexico, who does not count on one at the moment, manifests its intention to enact one in the future.

What is interesting, even though it has not and is not going to be further developed on this thesis due to a time and space constraint, is the fact that several countries count on independent supervisory authorities to decide and monitor the treatment of mentally ill, especially when their rights are limited. These authorities are usually composed by experts on various fields: medical, judiciary and sometimes others like psychosocial, etc.

It would be interesting to conduct a further study on the beneficial impacts of these independent bodies and evaluate how far they can substitute the common judicial system when decisions are to be taken related to the treatment and/or incapacitation of mentally ill. It would also be very interesting, on the same line, to analyse how far therapeutical jurisprudence could complement those bodies and its beneficial impacts.

Therapeutical jurisprudence has been initially explored in cases involving individuals with mental disabilities, but had expanded to other areas. It is based on the belief that case law and legislation are also therapeutical or antitherapeutical agents. The aim of the

therapeutical jurisprudence is to assess whether laws and the jurisprudence and lawyers' and judges' roles can be reshape to "enhance their therapeutic potential while not subordinating due process principles."[277] Thus, to use law and case law as a tool which have direct effects on "people's lives" and to try to use it in the more possible therapeutical way.

9.3 Conclusion on the real impact of the CRPD

The reports show that few implementation and/or improvement have taken place in the field of the treatment, autonomy and institutionalisation of mentally ill.
The high expectative of the treaty and its social framework are not reflected in the national situations when referring to mentally ill. Some of the reports reflect a lack of understanding and an erroneous interpretation of the provisions. Others nearly avoid treating the issue of mentally disordered.

It is still a very recent treaty, and we will have to wait to see how far it can change national policies and society's attitudes reactions versus mental illness. However, these results show again how far can be legal international human rights obligations from changes on national realities and how difficult is their enforcement and implementation. Just 27 out of more than eighty ratifying countries had complied with their very first obligation to submit an initial report.

[277] Perlin, 2012, p. 203.

10. COMPARISSON BETWEEN THE CRPD AND THE ECHR

Without standing the more limited scope of the ECHR,[278] it had been one of the first international human rights treaties[279]and is still nowadays the only international human rights treaty providing for a Court where individuals can held complaints (EctHR).

On the field of mentally ill, at the beginning it was of great support on the achievement of civil rights determination and to prohibit degrading treatment and torture.[280] It entitled a detained mentally ill person with a speedy court proceeding to determine its legality[281]and also to a "fair and public hearing within a reasonable time by an independent and impartial tribunal established by law" for anyone seeking a civil rights determination.[282] On a moment were the advent on chlorpromazine and other antipsychotic drugs was moving deinstitutionalisation to the forefront in various countries in Europe, the safeguards established by the ECHR could be seen as innovative advancements. However, detention on large psychiatric institutions and continual human rights violations to mentally ill were still widely accepted as the common way to treat these persons.

The ECHR failed on overcoming the historical legacy of entrenched attitudes and stereotypes towards mentally ill. Reflected on the shortcomings of its article 14 and on the "lawful" detention of "persons of unsound mind" on its article 5, where they are treated as rights violators even though they are, by contrast, right holders.
The ECHR turned into an instrument of legitimisation for the perpetuation of discriminatory treatment and segregation for mentally ill.

Moreover, issues like the "forced treatment" remained unsolved and no means or positive duties were set for the States in order to allow the achievement of the

[278] Is a regional treaty with 47 member states, the members of the Council of Europe.
[279] Drafted in 1950 and entered into force in 1953.
[280] Article 3 ECHR.
[281] Article 5.4 ECHR.
[282] Article 6 ECHR.

safeguards. i.e. the right to a review is established,[283] but no mechanisms to aid to access the courts are provided.

The jurisprudence had supported these views with its restrictive interpretations in "psychiatric cases".[284] For example, where sentencing the handcuffing of patients as "therapeutically necessary"[285]or were accepting the use of seclusion for "disciplinary" purposes.[286]Another controversial example is the case of *Johnson v UK*[287] were the complainant does not hold anymore the criteria to be detained; but the EctHR argues a positive duty of the state to take care of the complainant inside the institution because it lacks the means to take care of him outside it. But it does not argue a positive duty of the state to create outsider services were the individual could be better treated on his condition. The ECHR fails on this way to enact positive duties to the state; regardless of this being claimed to be the universal failure of the human rights treaties.
Some requirements of the *Winterwerp's*[288] case, like the one that establish a right to be cared for in the least restrictive alternative, if taken seriously, would require the governments a creation of a full range of community services and other therapeutical and social means. However, these requirements were never set in the jurisprudence.

The decisions of the EctHR reflect "sanism" [289] and pretextuality.[290] And even though there have been many decisions about many aspects of the treatment of mentally, they can not be considered, on the contemporary context, to form a robust corpus of international human rights law.

On the other side, even though the CRPD have also avoid to directly tackle controversial issues like the "forced treatment", it has definitely set higher standards on

[283] Article 5.4 ECHR.
[284] Hewitt, 2001, pp. 1278-1287.
[285] *Herczegfalvy v Austria*, Application no. 10533/83, Judgement 24 Setember 1992.
[286] *Dhoest v Belgium*, Application nº 10448/ 83, may 1987.
[287] Wachenfield, 1992 (b), p. 142.
[288] *Winterwerp vs the Netherlands*, Application nº 6301/73, Judgement October 1979
[289] Defined in Perlin, 2012, p.34 as: "an irrational prejudice of the same quality and character of other irrational prejudices that cause, and are reflected in, prevailing social attitudes of racism, sexism, homophobia, and ethnic bigotry. It permeates all aspects of mental disability law and effects all participants in the mental disability law system: litigants, fact finders, counsel, and expert and lay witnesses."
[290] Defined in Perlin, 2012, p.34 as: "the ways in which courts accept, either implicitly or explicitly, testimonial dishonesty and engage similarly in dishonest decision making (...)"

the rights of mentally ill. Especially it has stand for their legal capacity[291] and their right not to be forcedly detained.[292] It does ensure access to justice,[293] which could solve the lack of a human right to legal aid. And, for the first time in a human rights treaty, it enumerates several positive duties for the State. Its social framework is an innovation that seeks to tackle the structural conflict towards mentally ill: society's attitudes versus them. However, it has also been shown that its implementation is far from reaching a desired point.

What is undoubtedly stressed from an analysis of both documents is that the CRPD highly overcomes the standards set in the ECHR and even contradict some of its provisions (article 5). As we have argued above,[294] mental health laws should be abolished in order to comply with the CRPD. But also article 5.1.e) of the ECHR is against the CRPD and has been proven obsolete and perpetuator of discrimination, stigma and exclusion. Thus, it should also be modified or eliminated in order to avoid contradicting the CRPD.

On the other side, independently of how far is the CRPD from triggering a real change in national legislations and policies, its enactment reflects the beginning of a turn on the approaches towards certain psychiatric diagnosis, which if implemented can certainly bring a future improvement in the lives of "mentally ill".

[291] Article 12 CRPD.
[292] Article 14 CRPD.
[293] Article 13 CRPD.
[294] See subchapter 6. Part 3.

CONCLUSION

We can conclude from the above study that the legal treatment of the mentally ill on the international human rights instruments does not differ a lot from the treatment received by these people in society. Furthermore, their treatment in the international human rights instruments is evolving through time parallel to the development of society's reaction towards mentally ill.

Human rights instruments are not free from cultural, historical, social and any other contextual influence. Thus, like any other instrument of law, they are the result and consequence of a certain moment in time and of a certain culture and society.

The long time forgotten recognition in the human rights instruments of the existence of a "right to mental health", and consequently the "oblivion" of mentally ill as subjects of protection, reflect their place in society. The position hold by a forgotten segregate group, whose exclusion has been longley preferred than their integration.

The use of forced institutionalisation and forced treatment show the way society copes with mentally ill. Forced detention can easily be interpreted as a will to exclude a group from the rest, with the negative consequences and human rights violations and abuses that this situation implies. Forced treatment is the manifestation of an "intent" to "normalise" certain behaviours which are out of the norm.

This and other features which had characterised the perception on mentally ill: being considered incapable, being considered on "need to treatment" under any circumstances, being considered dangerous, etc; are reflected in their legal treatment. But these are characteristics changeable through time and culture. Thus, they are neither objective nor immovable.

The legal treatment of mentally ill lives a duality. They are being protected. But at the same time their forced detention and forced medication is regulated by law. They are subjects of protection while they are subjects of coercive and discriminatory measures. The paradox is a reflection of society's attitudes versus mentally ill. A reflection of the fear and the stigma but also of the paternalist views entrenched in the medical model.

Whether is taken in account a medical or a social model approach will directly influence the direction of the law. The non-solved problematic about the delimitation and scope of "mental illness" and its definition are also influential negative elements. They result on

ambiguous laws and non-committed jurisprudence, which does not dare to tackle the structural problematic facing those diagnosed with a psychiatric condition.

The medical model is the one that has dominate the psychiatry and consequently the legal treatment of the mentally ill for decades. It is the model which impermeates the provisions and jurisprudence of the ECHR and the EctHR. And it is specially reflected on article 5 ECHR.

The position of the ECHR on its article 5, which legitimate at an international level institutionalisation and recognise "unsound mind" as a deviant group whose detention is sometimes necessary, is not a based on a human rights approach and can not be considered a human rights measure. It is a discriminative and pejorative measure. Moreover, the safeguards set by the jurisprudence of the EctHR as justifications of the measure, are not valid, not coherent and contrary to human rights discrimination standards. However, is undeniable that a majority of the society still might prefer them.
Few countries had embedded completely the deinstitutionalisation process and the community services which should bring back the capacity of autonomy to mentally ill and help to end with their stigma and discrimination. Most are still entrenched in the old model of incapacitation and forced institutionalisation, even though claimed "as last resort".

Anyway, a part of the society has recently started to turn its mind on the mentally ill issues. The CRPD reflects this "shift of paradigm" on the social framework where it is constructed, enhancing human dignity, autonomy and equality of opportunities. If mentally ill are considered englobed in this Convention, they will undoubtly benefit from it. As far as there is a will of the governments and policy makers to implement the provisions.

The CRPD does not just reflect the raise of awareness that might have taken place last years in society. But it highly promotes this change of mind. It is innovative because it overcomes society's attitudes. The social model enhances positive attitudes towards mentally ill, promote their inclusion and equality and turn the approach towards the problematic. The transformation needs to be done tackling the "heart of the problem", the structural causal: society's attitudes.

Like the UDHR did at its time, legacy of some of the most horrendous acts committed by the human race after IIWW, but a promoter of big changes in situations of grave human rights violations, like the “apartheid” on South Africa. The CRPD plays a similar role on nowadays situation of mentally ill. It is obviously a consequence of the fact that a change might be taking place on the way society “sees” mentally ill after centuries of being a targeted group for human rights violations, but is also pushing the change to take place.

On the other hand, while society and culture evolves on time (as the EctHR had also referred to when avoiding defining unsound mind), human rights instruments’ aims also change through time. Though the safeguards and measures of article 5 ECHR and its jurisprudence might have been innovative when they were enacted, should be seen nowadays as obsolete measures, which reflect the beliefs of the society of the fifty’s still bund to deep-rooted stereotypes towards mentally ill. They are not according to human rights standards, because they do not promote equality and inclusion.
If mental health laws should be abolished because are in contradiction with the CRPD and human rights standards (statement which is not just supported by the author but also by the OHCHR and the FRA), also article 5 ECHR should be reviewed and abolished if necessary.

International human rights law is the consequence of a “good” will seeking to overcome human injustices worldwide that had been legitimacy perpetuated over time. But they are also a human creation; therefore they inevitably reflect human values, prejudices and powers. The ECHR and also the CRPD does it. But human rights instruments are also subject to improvement and are evolving through time. Thus, the ECHR should change its treatment towards mentally ill in order to be coherent with the human rights nature.

On the other hand, is also undeniable that another change needs to be done at "the heart" of the conflict. Thus, there is a need to change society's approach towards mentally ill. For the first time, a human rights international instrument (the CRPD) tackles the problematic on its origin. This fact should be seen as a big step forward on the human rights field.

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