KATARZYNA WIDLAS-KLIMSIAK

The ECtHR and Mental Health Jurisprudence: Progressive Interpretation or Doctrinal Stagnation?

Abstract

This paper asks whether the European Court of Human Rights (ECtHR) has driven a rights-based transformation of mental-health law, or merely refined a paternalistic status quo. Using doctrinal analysis of the ECHR and close reading of leading judgments, it situates Strasbourg case law within the Council of Europe's normative framework (European Social Charter, Oviedo Convention) and soft-law developments, read against the CRPD. Three core findings emerge. First, the Court has thickened procedural protections under Articles 5 and 3, tightening admission standards, extending review to informal and social-care placements, and recognising therapeutic neglect as ill-treatment, while Article 8 jurisprudence increasingly foregrounds bodily integrity and participation. Second, non-consensual treatment is still treated largely as an incident of lawful detention, with deference to clinical expertise and risk-based reasoning; autonomy and equal legal capacity remain weak constraints. Third, Council of Europe soft law and equality norms outpace binding doctrine, endorsing deinstitutionalisation, informed consent, and supported decision-making. The paper prescribes recalibration: analytically decoupling detention from treatment, with capacity-sensitive review under Articles 3 and 8; enforcing rigorous least-restrictive-alternative tests, and integrating Article 14 scrutiny to expose structural discrimination.

KEYWORDS: Council of Europe, mental health law, human rights, coercion, legal capacity, European Court of Human Rights, CRPD, psychiatric detention

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1 Introduction

The protection of the rights of persons with mental disorders has emerged as a critical issue in contemporary human rights discourse. In European context, this this debate transcends the boundaries of health law, touching upon fundamental questions of liberty, equality, and human dignity. Unlike many other groups, persons with mental disorders or psychosocial disabilities continue to experience systemic violations of their rights, often justified through paternalistic frameworks or consideration of public safety. These patterns persist, despite a growing international consensus, embodied in the United Nations Convention on the Rights of Persons with Disabilities (CRPD),[1] that autonomy, legal capacity, and full participation in society must replace medicalized models of control.[2]

The significance of this problem lies not only in its normative dimension but also in its profound social and practical implications. Mental health law constitutes one of the last areas in which many European states still rely on coercive measures such as involuntary hospitalization, substituted decision-making, and forced treatment.[3] These practices reveal a fundamental tension between traditional doctrines of psychiatry[4] and evolving standards of international human rights law.[5] Addressing this tension

1 Along with CRPD General Comments and CRPD Committee's Concluding Observations.

2 Tina Minkowitz, "The United Nations Convention on the Rights of Persons with Disabilities and the Right to Be Free from Nonconsensual Psychiatric Interventions," *Syracuse Journal of International Law and Commerce*, No. 2 (2007): 405; Anna Bruce, Gerard Quinn, Theresia Degener, Catherine Burke, Shivaun Quinlivan, Joshua Castellino, Padraic Kenna, Ursula Kilkelly, *Human Rights and Disability: The Current Use and Future Potential of United Nations Human Rights Instruments in the Context of Disability* (Geneva: United Nations, 2002).

3 Oyine Aluh Deborah, Tella Lantta, Tânia Lourenço, Søren Fryd Birkeland, Giulio Castelpietra, Jovo Dedovic, José Miguel Caldas-de-Almeida, Jorun Rugkåsa, "Legislation and Policy for Involuntary Mental Healthcare Across Countries in the FOSTREN Network: Rationale, Development of Mapping Survey and Protocol" *BJPsych Open*, No. 5 (2024): e154. Legislation and policy for involuntary mental healthcare across countries in the FOSTREN network: rationale, development of mapping survey and protocol.

4 Term used to refer especially to risk-based mandatory treatment, substituted decision-making, institutionalization, and a strong biomedical model.

5 World Health Organization, Mental Health, Human Rights and Legislation: Guidance and Practice (Geneva: WHO, 2023). https://www.who.int/publications/i/item/9789240080737. World Health Organization, New WHO Guidance Calls for Urgent Transformation of Mental Health Policies. 25 March 2025. https://www.

is indispensable for ensuring that the European human rights system responds adequately to the lived realities of millions of persons suffering from mental disorders and psychosocial disabilities.

Within this landscape, the European human rights architecture, particularly that of the Council of Europe (CoE), plays a pivotal role in addressing these challenges by setting legal standards and adjudicating individual complaints through the European Court of Human Rights (ECtHR). The dual function of the CoE as both a standard-setting institution and the institutional seat of the ECtHR makes it a uniquely influential actor in shaping national laws and policies on mental health.[6] Key binding legal acts adopted by CoE, such as the European Convention on Human Rights, Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine (Convention on Bioethics,[7] Oviedo Convention),[8] the European Social Charter (ESC) – the Revised Social Charter (RESC) – and numerous soft-law Recommendations of the Committee of Ministers, Resolutions by the Parliamentary Assembly, as well as other guidelines contribute to the normative environment in which mental health-related rights are interpreted and applied.[9]

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who.int/news/item/25-03-2025-new-who-guidance-calls-for-urgent-transformation-of-mental-health-policies; Michelle Funk, Natalie Drew, Celine Cole, Peter McGovern, Maria Francesca Moro, "A New WHO Roadmap for Mental Health Policy Reform" *International Journal of Mental Health Systems*, (2025): 441-442. https://pmc.ncbi.nlm.nih.gov/articles/PMC12434360/; Jan-Christoph Bublitz, "Disability Human Rights Standards before the European Court: Legal Capacity" *Human Rights Law Review* (2025); European Disability Forum. Human Rights Report 2024: Legal Capacity – Personal Decision-Making and Protection. Brussels: EDF, 2024. https://www.edf-feph.org/publications/human-rights-report-2024-legal-capacity/; Quinn Gerard, Anna Arstein-Kerslake, "Promoting Autonomy in Adult Guardianship Measures: Comparative Analysis of CRPD and ECHR Human Rights Requirements in 28 European Jurisdictions" *International Journal of Law and Psychiatry*, (2024).

6 Peter Bartlett, "The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law" *Modern Law Review*, No. 3 (2007): 415-433.

7 The name is in a sense a misnomer, since its substance is considerably broader than that name implies.

8 Council of Europe, Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine, European Treaty Series no. 164, concluded April 4, 1997, https://rm.coe.int/168007cf98.

9 Council of Europe, European Convention on Human Rights, *as amended;* Convention on Human Rights and Biomedicine (Oviedo Convention), *ETS No. 164 (1997);* Revised European Social Charter, *ETS No. 163 (1996);* Recommendation

This article seeks to critically examine whether the ECtHR's jurisprudence in the fields of mental health represents a progressive trajectory towards the CRPD's autonomy-based paradigm or whether it perpetuates a paternalistic, risk-focused model.[10] The central research question is therefore twofold: (1) does the Court's case law strengthen the rights of persons with mental disorders and/or psychosocial disabilities in line with the CRPD,[11] or (2) does it entrench doctrines that justify coercive practices? To address this problem, the article advances several sub-theses: first, that the Court has developed robust procedural safeguards under Articles 5 and 6 ECHR; second, that substantive protections under Articles 3, 8, and 14 remain comparatively underdeveloped; and third, that this imbalance reveals both progress and stagnation in Strasbourg's approach.

Rec(2004)10 of the Committee of Ministers to Member States concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder.

10 Several authors assessed the relevance of the CRPD for the ECtHR and its potential to affect the latter's standards in, among others, the area of mental health law: Francesco Seatzu, "The Convention on the Rights of Persons with Disabilities and International Human Rights Law" *International Human Rights Law Review*, 1 (2018): 82-102; Silvia Favalli, "The United Nations Convention on the Rights of Persons with Disabilities in the case law of the European Court of Human Rights and in the Council of Europe Disability Strategy 2017–2023: «From Zero to Hero»" *Human Rights Law Review*, 3 (2018): 517-538; Olivier Lewis, Ann Campbell, "Violence and Abuse Against People with Disabilities: A Comparison of the Approaches of the European Court of Human Rights and the United Nations Committee on the Rights of Persons with Disabilities" *International Journal of Law and Psychiatry*, 53 (2017): 45-58; Andrea Broderick, "The United Nations Convention on the Rights of Persons with Disabilities and the European Convention on Human Rights: A Tale of Two Halves or a Potentially Unified Vision of Human Rights?" *Cambridge International Law Journal*, 2 (2018): 199-224; Olivier Lewis, "Council of Europe," [in:] *The UN Convention on the Rights of Persons with Disabilities in Practice: A Comparative Analysis of the Role of Courts*, ed. Lisa Waddington, Anna Lawson (Oxford: Oxford University Press, 2018), 89-130; Anna Nilsson, *Compulsory Mental Health Interventions and the CRPD: Minding Equality* (Oxford: Hart, 2021); Philip Fennell, Urfan Khaliq, "Conflicting or Complementary Obligations? The UN Disability Rights Convention, the European Convention on Human Rights and English Law" *European Human Rights Law Review*, 6 (2011): 662-674; Peter Bartlett, "The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law" *The Modern Law Review*, 5 (2012): 752-778.

11 United Nations, Convention on the Rights of Persons with Disabilities, adopted December 13, 2006, entered into force 3 May 2008, UNTS vol. 2515, p. 3; see also Council of Europe, PACE Recommendation 2158 (2019): Ending Coercion in Mental Health: The Need for a Human Rights-Based Approach.

This analysis adopts a doctrinal legal methodology, grounded in the interpretation of relevant provisions of the ECHR and the legal reasoning employed in leading cases. This is supplemented by a jurisprudential review tracing the evolution of the Court's approach over time[12]. Through this combined lens, the article seeks to clarify the Court's role in shaping European mental health law and to assess the implications of its jurisprudence for future reforms at both national and regional levels.

2 Normative Foundations in the Council of Europe Framework

2.1. The European Convention on Human Rights: Selected Articles

The ECHR[13] was the first treaty adopted by CoE and remains the cornerstone of human rights protection in Europe. Several of its provisions are directly relevant to the rights of persons with mental disorders, especially in contexts involving psychiatric detention, coercive treatment, and personal autonomy. The ECHR aims to protect human rights and fundamental freedoms "which are the foundation of justice and peace in the world and are best maintained on the one hand by an effective political democracy and on the other by a common understanding and observance of the Human Rights upon which they depend."[14]

Article 2 (right to life) imposes a positive obligation on states to protect the lives of individuals within their jurisdiction, including those detained in psychiatric institutions.[15] Failures to prevent suicide or neglect in care

12 Bartlett, "The United Nations Convention," 415-433; Brendan D. Kelly, "Human Rights in Psychiatric Practice: An Overview for Clinicians" *BJPsych Advances*, 21 (2015): 54-62.

13 "47 states are signatories of the European Convention on Human Rights – every country in Europe except Belarus and the Russian Federation, which ceased to be party to the European Convention on September 16, 2022," – European Implementation Network, "Countries Overview." https://www.einnetwork.org/countries-overview.

14 Council of Europe, *European Convention on Human Rights*, Preamble.

15 See further: European Court of Human Rights, Guide on Article 2 of the European Convention on Human Rights, https://ks.echr.coe.int/.

facilities may engage this provision.[16] Ironically, it seems to be successfully invoked almost exclusively when the victim is already dead: cases involving sufficiently substandard conditions that life is put at risk tend to be dealt with under other articles, if the victim is still alive.[17] Article 2 is nonetheless relevant because of the requirements in its jurisprudence to investigate deaths, particularly when those deaths occur in custody or in state institutional. environments. When an individual dies in a psychiatric institution, therefore, Article 2 requires a full and prompt investigation by the state into the death.

Article 3 (prohibition of torture and inhuman or degrading treatment) provides an absolute prohibition against ill-treatment, which has been applied in cases involving excessive restraint, neglect, and inadequate psychiatric care.[18] The ECtHR has consistently held that persons in vulnerable situations, such as those with mental disorders, are entitled to enhanced protection.[19] This is one of the articles that has the potential to provide substantive standards and protections relating to mental health care.[20] As with many of the articles of the ECHR, the acts or omissions complained of must reach a particular level of severity to engage the article. It has been held that for persons who are detained for punishment, this minimum threshold will be reached when more force is used than intrinsically necessary to achieve the purposes of the detention. It is certainly at least arguable that no higher threshold can apply to people in psychiatric facilities, who are after all not detained for punishment. While some use of force may be necessary, for example to protect people in institutions from violence from each other, any indication of violence beyond what is

16 Keenan v. the United Kingdom, App. No. 27229/95, ECHR 2001-III; Centre for Legal Resources on behalf of Valentin Câmpeanu v. Romania [GC], App. No. 47848/08, ECHR 2014.

17 The investigation must be public, and independent from those implicated in the death. The next of kin of the deceased must be able to be involved in the investigation. It must have the power to compel witnesses, and be able to apportion responsibility for the death, if that is warranted by the facts. – Peter Bartlett et al., "Introduction: The European Convention on Human Rights and Mental Disability," [in:] *Mental Disability and the European Convention on Human Rights*, ed. Peter Bartlett et al. (Leiden; Martinus Nijhoff, 2007), 17-18.

18 Herczegfalvy v. Austria, App. No. 10533/83, ECHR 1992; Bureš v. the Czech Republic, App. No. 37679/08, ECHR 2012.

19 Aerts v. Belgium, App. No. 25357/94, ECHR 1998-V.

20 See further: European Court of Human Rights, Guide on Article 3 of the Convention on Human Rights. https://ks.echr.coe.int/.

clearly necessary in institutions should be taken to engage Article 3. More problematic are questions of whether Article 3 is engaged by enforced treatment of people without their consent, and at what point physical conditions in institutions are sufficiently poor as to trigger Article 3.[21]

It is now widely acknowledged that the drafters of the Convention did not adequately anticipate the complexity of mental health-related rights. The only explicit reference to mental illness appears in Article 5(1)(e). This is a qualification of the right to liberty and security, which allows "the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind,[22] alcoholics or drug addicts or vagrants." The clause on its face seems more consistent with the deprivation of civil rights than with their protection. On this basis, it is unsurprising that the court did not decide its first case on the subject until 1979.[23] The Court has developed stringent criteria for assessing the lawfulness of psychiatric detention, starting with Winterwerp v. the Netherlands.[24] While States are required to meet the standards established by the ECHR, the ECtHR allows them considerable latitude (a wide "margin of appreciation") as to how they do so. For example, Winterwerp requires that a detention under Article 5 may occur only if the individual is affected by a mental disability of a "kind or degree warranting compulsory confinement."[25] Assuming this threshold is defined with sufficient clarity under domestic law, the ECtHR is unlikely to be perturbed by the particular terms of the definition.

Article 8 (right to respect for private and family life) has been interpreted to encompass protections for bodily integrity, personal autonomy, and the right to make decisions about medical treatment.[26] It forms a legal basis for challenging coercive interventions such as forced medication and various guardianship regimes. Article 8(1) specifies that "everyone has the right to respect for his private and family life, his home and his correspondence." ECtHR has examined the restrictions placed on psychiatric

21 Bartlett et al., "Introduction," 18.

22 On the notion of 'a person of unsound mind', please see: Marcin Szwed, "The Notion of «a Person of Unsound Mind» under Article 5 § 1 (e) of the European Convention on Human Rights" *Netherlands Quarterly of Human Rights*, 4 (2020): 283-301.

23 Bartlett et al., "Introduction," 17.

24 Winterwerp v. the Netherlands, App. No. 6301/73, ECHR 1979.

25 Ibidem, para. 39.

26 X v. Finland, *App.* No. 34806/04, ECHR 2012; K.C. v. Poland, App. No. 31199/12, ECHR 2014.

patients' "correspondence" in secure hospitals, and recognized that such interference must meet the test of legality, necessity and proportionality.[27] The scope of this article is exceptionally broad: it is engaged by any involuntary medical treatment;[28] and by the decisions removing legal capacity from individuals.[29] It provides a right to correspondence with loved ones. It provides rights to view medical records. The rights it provides are not however absolute.[30]

Article 14 (prohibition of discrimination), while not a standalone right,[31] prohibits unjustified differential treatment in the enjoyment of other Convention rights on grounds including. "any status." It is a guarantee that the Convention rights will be interpreted in a non-discriminatory fashion. This considerably reduces the usefulness of the Article. Although disability is not listed explicitly, the ECtHR has read it in by implication, especially in the context of mental disability.[32] Historically, the ECtHR has been cautious in applying Article 14 expansively in mental health cases, but its interpretive trajectory has evolved, particularly in light of the CRPD and increasing attention to intersectional discrimination. The Court has tended in the past either to find a violation of a Convention right (e.g. Article 3 or 5) without reference to Article 14, or to say that as there is no violation of the other convention right, Article 14 has nothing to add.[33] One of the most interesting elements of the ECHR, however, is the positive obligation that states appear to be under to protect, as opposed to simply

27 European Convention on Human Rights, art. 8(II); Mark Curtice, "Mental Health Law in the European Court of Human Rights," *Journal of Mental Health Law* (2009): 8-17

28 Y.F. v. Turkey, App. No. 24209/94, Judgment of July 22, 2003, EHRR 39 (2004): 34.

29 H.F. v. Slovakia, App. No. 54797/00, Judgment of November 8, 2005, para. 47. The Court did not examine the application of Article 8 in detail, and did not consider the scope and effect of Article 8(2) at all in that case.

30 . The second paragraph of Article 8 state any violation of an Article 8 right must be "in accordance with the [domestic] law": there must be a clear domestic legal standard that applies. Second, there must be a demonstrable connection between the prima facie infringement of Article 8 and the ground relied upon under Article 8(2). Finally, the infringement of the Article 8 interest must be "necessary in a democratic society," and proportionate to the benefit achieved – Bartlett et al., "Introduction," 20.

31 Such a free-standing right would be introduced by Protocol 12., Ibidem, 20.

32 Alajos Kiss v. Hungary, App. No. 38832/06, Judgment of May 20, 2010, para. 42.

33 Stanev v. Bulgaria, App. No. 36760/06, Judgment of January 17, 2012, para. 245.

not to violate, ECHR rights.[34] That said, the article has strong normative potential, especially when read in conjunction with the Court's recognition of positive obligations on states not only to refrain from interference but to actively secure effective enjoyment of Convention rights by all persons, including those with psychosocial disabilities.[35]

2.2. The European Social Charter

In doctrinal analysis, ESC constitutes a treaty covering economic, social and cultural right and it is the point for understanding the human right to health within the CoE system.[36] The rights enshrined therein are of a universal nature and establish the minimum standards for social and economic protection, including health-related entitlements.[37] In the ESC, the right to health is articulated "in a partially different wording" than in other regional systems.[38] Article 11 guarantees the right to protection of health, encompassing broader obligations concerning the prevention of illness, the promotion of public health, and the improvement of environmental conditions affecting health.[39] Article 15 affirms the right of persons with disabilities to independence, social integration, and participation in

34 Brendan D. Kelly, "Human Rights in Psychiatric Practice: An Overview for Clinicians" *BJPsych Advances*, 21 (2015): 56.

35 Oliver Lewis, "Advancing Legal Capacity Jurisprudence" *European Human Rights Law Review*, 6 (2011): 700-714.

36 Eibe Riedel, "The Human Right to Health: Conceptual Foundations," [in:] *Realizing the Right to Health*, ed. Andrew Clapham, Mary Robinson (Zurich: Rüffer & Rub, 2009).

37 Council of Europe member states have recognized the entitlements of individuals, including those directly related to health status, under the basic or revised Charter.

38 Charter of Fundamental Rights of the European Union, art. 35; see also: Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador), art. 10; African Charter on Human and Peoples' Rights (Banjul Charter), art. 16; Protocol to the African Charter on the Rights of Women in Africa (Maputo Protocol), art. 14; African Charter on the Rights and Welfare of the Child, art. 14; Revised Arab Charter on Human Rights, art. 39. – for further references regarding the right to health, see Jacek Barcik, *Międzynarodowe prawo zdrowia publicznego* (Warszawa: C.H. Beck, 2013).; In the final version of the ESC text, direct references to health as a component of the substantive content of the analysed right appear twelve times.

39 Revised European Social Charter (RESC), art. 11.

community life.[40] The RESC also emphasises a range of complementary rights with clear implications for health protections.[41] It ensures the right to the highest attainable standard of health[42] and the right to social security for workers and their dependents.[43] It also guarantees access to social and medical assistance.[44] Finally, it provides for the right to safe and hygienic working conditions through a common policy on occupational safety and health, along with mechanisms for control.[45]

2.3. Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine

Among legal acts adopted by the Council of Europe in the field of health (mental health) and human rights, the Oviedo Convention,[46] represents the most significant regional legal framework addressing the intersection of medical ethics, personal autonomy, and state obligations. The Convention

40 Ibidem, art. 15. The European Committee of Social Rights (ECSR) the monitoring body established under the Charter – has interpreted these provisions as imposing obligations on states to ensure the availability, accessibility, acceptability, and quality of mental health services, along with a duty to promote social inclusion and non-discrimination in all aspects of health and social policy – European Committee of Social Rights (ECSR), Mental Health in Europe: Achievements and Challenges, Conclusions XXI-2 (2017), General Introduction.

41 It emphasizes the right to safe and hygienic working conditions and fair working conditions, which includes the determination of appropriate working hours and the removal of all risks associated with dangerous or hazardous work. – RESC, part I, point 3; art. 3; see also: ECSR, Conclusions 2009: France, 12–16; ibidem, art. 2.

42 Ibidem, part I, point 11; art. 11; see also: ECSR, European Roma Rights Centre v. Ireland, Complaint No. 100/2013, Decision on the Merits, December 1, 2015.

43 Ibidem, part I, point 12; art. 12.

44 Ibidem, part I, point 13, art. 13.

45 Ibidem, art. 3 (3).

46 Supplemented by the related Protocol concerning Biomedical Research Council of Europe, Additional Protocol to the Convention on Human Rights and Biomedicine, Concerning Biomedical Research, ETS No. 195, 25 January 2005. https://www.coe.int/en/web/conventions/full-list?module=treaty-detail&treatynum=195. Apart from this Additional Protocol, there have been other Additional Protocols adopted so far: Additional Protocol on the Prohibition of Cloning Human Beings (2001), Additional Protocol concerning Transplantation of Organs and Tissues of

stands out not only for its binding legal force in ratifying states but also for its comprehensive scope, extending beyond civil and political rights to include fundamental ethical protections in the context of biomedical practice.[47] It also, importantly, has a set of rules determining when research may be carried out on people who are unable to consent.[48] The Convention underscores the principle of equitable access to health care of appropriate quality. It requires states to take measures ensuring that all individuals, including those with mental disorders, have fair access to health services that meet professional standards.[49] This provision reinforces the notion of health care as a fundamental right that must be equally available to all, regardless of disability or other status. Also, the Oviedo Convention establishes a fundamental rule that no medical intervention may be carried out without the free and informed consent of the person concerned. Informed consent requires that the individual receive sufficient information about the purpose, nature, consequences, and risks of the proposed intervention.[50] It addresses the situation of minors and adults who lack the capacity to provide informed consent. It stipulates that medical interventions on such individuals must be based on the consent of their legal representative or an authority designated by law.[51] Moreover, the Convention provides specific safeguards for medical interventions intended to treat mental disorders. It permits involuntary treatment only when

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Human Origin (2006), Additional Protocol concerning Biomedical Research (2007), Additional Protocol concerning Genetic Testing for Health Purposes (2008).

47 Unlike to soft-law recommendations, the Oviedo Convention is a treaty. It therefore has more gravitas than the Council of Ministers' recommendations in countries where it has been signed and ratified, but no formal legal effect in countries that have not done so. It provides some protections to individuals' right to consent to treatment, although not necessarily as strong a right as that contained in the Council of Ministers' Recommendations.

48 It does deal with a number of circumstances not expressly considered by those recommendations, however, standards are provided for consent to organ removal, and when this may be done on a patient who lacks capacity to consent. It also, importantly, has a set of rules determining when research may be carried out on people who are unable to consent. – Oviedo Convention, arts. 5, 6, 7, 17, 20.

49 Ibidem, art. 3.

50 It also includes the right to freely withdraw consent at any time, reinforcing the patient's autonomy and the centrality of personal decision-making in health care. – ibidem, art. 5.

51 Furthermore, it requires that the previously expressed wishes of the person concerned be taken into account, reflecting a commitment to respecting the autonomy and will of persons with disabilities – ibidem, art. 6.

the absence of intervention poses a serious risk of substantial harm to the individual's health. In such cases, the intervention must comply with the conditions prescribed by law, including adequate supervision, control, and appeal mechanisms. These safeguards aim to ensure that involuntary treatment is strictly limited to therapeutic necessity and subject to robust procedural protections.[52]

Taken together, these provisions of the Oviedo Convention reflect a nuanced approach to mental health care that balances therapeutic needs with the autonomy, dignity, and legal safeguards of the individual. They reinforce the broader CoE's commitment to upholding human rights in the context of mental health care, while also highlighting the need for legal clarity and oversight when medical interventions infringe upon personal liberty. In the field of mental health, its provisions operate as a minimum rights-based standard, complementing the jurisprudence of the ECtHR. Rights and resonating with the emerging international consensus reflected in the CRPD. However, its continued reliance on substituted decision-making models and conditional acceptance of involuntary treatment positions it in partial tension with the CRPD's paradigm of supported autonomy, prompting critical reflection on the need for future reform and interpretive convergence.

2.4. The Soft-Law: Four Stages of Development

The Council of Europe (CoE) is governed by the Committee of Ministers (composed of the foreign ministers of member states or their representatives) which serves as its principal decision-making body. Complementing it are the Parliamentary Assembly, representing national parliaments, and assemblies for local and regional authorities. In keeping with its mission to protect human dignity and fundamental rights, the CoE has long engaged with the protection of persons with mental disorders and psychosocial disabilities. Beyond the binding framework of the ECHR, it has produced a series of soft-law instruments, such as recommendations, resolutions, and guidelines, that progressively articulate evolving standards in mental health care. Although not legally binding, these instruments have exerted considerable normative influence: they shape national legislation, inform policy reforms, and are increasingly cited by the ECtHR in its jurisprudence

52 Ibidem, art. 7.

concerning psychiatric detention and treatment. The CoE's engagement in this field has evolved through four key stages, marking a gradual shift from a medically paternalistic paradigm toward a rights-based approach consistent with the CRPD.

The first stage started with the Parliamentary Assembly's Recommendation 818 (1977)[53] on the situation of the mentally ill, which marked a pivotal step in European mental health governance. It urged member states to abandon outdated notions such as "dangerousness" as the sole justification for confinement and to end indeterminate detention. The Recommendation introduced crucial procedural safeguards: the establishment of independent psychiatric tribunals, the right of appeal, protection of correspondence and medical data, and the right to legal defence for individuals facing criminal charges.[54] It also recognized the right of persons with mental disorders to civic participation, including the right to vote, and emphasized the importance of professional training and community involvement in rehabilitation.[55] By linking mental health with privacy, data protection, and social reintegration, the 1977 Recommendation began to reframe mental illness not merely as a clinical condition but as a matter of autonomy and social inclusion. Building on these foundations, the Committee of Ministers' Recommendation R(83)2 concerning the legal protection of persons suffering from mental disorder placed as involuntary patients (1983)[56] introduced a more detailed framework of judicial and procedural safeguards. It required that any deprivation of liberty be ordered by a competent authority based on objective medical evidence, and only when necessary for therapeutic purposes. It also established the principle of the least restrictive alternative, periodic review of placement, and the right of appeal. Importantly, it clarified that involuntary hospitalization should not entail the automatic loss of legal capacity – anticipating later CRPD standards.[57] These provisions signalled a shift toward

53 Council of Europe, Recommendation 818 (1977) on the Situation of the Mentally Ill, https://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-en.asp?fileid=14852.

54 Ibidem, paras 6-10.

55 Ibidem, paras. 13–18.

56 Council of Europe, Committee of Ministers, Recommendation No. R(83)2 concerning the Legal Protection of Persons Suffering from Mental Disorder Placed as Involuntary Patients, https://search.coe.int/cm?i=09000016804fe027.

57 Ibidem, art. 6.

proportionality and individualized assessment, laying the groundwork for future human-rights-based reforms in psychiatric law.

The second stage might be reflected in the Parliamentary Assembly's Recommendation 1235 (1994)[58] on psychiatry and human rights, which marked a major advance in integrating autonomy and bodily integrity into mental health regulation. This document articulates key principles aimed at ensuring procedural and substantive safeguards in psychiatric care, reflecting a commitment to human dignity and autonomy that has shaped European mental health policy for decades.[59] It reaffirmed that placement decisions must be judicial, time-limited, and regularly reviewed, with access to appeal and legal counsel.[60] Above all, it enshrined the principle of informed consent as a cornerstone of ethical psychiatric practice and prohibited coercive measures such as non-consensual sterilization or medical research conducted against a patient's will.[61] The Recommendation also promoted individualized care through accurate medical documentation, ethical oversight, and the training of qualified personnel.[62] By distinguishing between mental illness and intellectual disability, it fostered a rights-based, non-discriminatory approach.[63] These provisions underscore the Council of Europe's holistic approach to mental health care: one that balances the need for therapeutic treatment with the unwavering protection of fundamental rights, dignity, and autonomy – principles that later found full articulation in the CRPD.

The third stage would include the Committee of Ministers' Recommendation Rec(2004)10[64] concerning the protection of the human rights and

58 Council of Europe, Parliamentary Assembly, Recommendation 1235 (1994) on Psychiatry and Human Rights, https://pace.coe.int/en/files/15269/html.

59 See also: David Kingdon, et al., "Protecting the Human Rights of People with Mental Disorder: New Recommendations Emerging from the Council of Europe" *British Journal of Psychiatry*, 185 (2004): 277-279.

60 Ibidem, art. 7(1)(b) – (d). Also,. the right to information is essential to empowering patients and safeguarding their ability to challenge or consent to treatment decisions.

61 Ibidem, art. 7(2)(b). This safeguard aligns closely with modern international standards, including the CRPD, by emphasizing the autonomy and will of the individual.

62 Ibidem, art. 7(2)(c)-(d).

63 Ibidem art. 7(2)(a).

64 Council of Europe, Recommendation Rec(2004)10 of the Committee of Ministers to Member States Concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder and Its Explanatory Memorandum. https://rm.coe.int/rec-2004-10-em-e/168066c7e1.

dignity of persons with mental disorder consolidated this trajectory into a comprehensive, person-centred framework. It explicitly prohibited discrimination on grounds of mental disorder, mandated respect for civil and political rights, and emphasized the principles of free and informed consent and deinstitutionalization.[65] The Recommendation urged the development of community-based alternatives to coercion and required that mental health services meet appropriate quality and human rights standards.[66] It thus represents the CoE's most systematic attempt to align mental health care with autonomy, dignity, and social inclusion, anticipating principles later codified in the CRPD. This proactive approach aims to combat stigma and ensure that mental health is understood as an integral component of public health and human rights.

The fourth stage was marked by Resolution 2291[67] (2019) and Recommendation 2158[68] (2019), where the Parliamentary Assembly (PACE) advanced the CoE's most progressive position to date. These documents criticized the "culture of confinement," acknowledged the harm and trauma caused by coercive practices, and called for a complete paradigm shift toward voluntary, rights-based care grounded in free and informed consent. They also rejected proposals for a new binding convention on involuntary measures, arguing that such an instrument would be incompatible with the CRPD's transformative vision. Instead, they urged member states to develop national strategies to end coercion, invest in community-based services, and actively involve persons with lived experience in policy formation.[69]

In comparative perspective, all the abovementioned soft law documents reveal a clear trajectory. Early texts (1977, 1983) focused on procedural safeguards and minimum protections within a medicalized framework. The 1994 Recommendation began to address substantive rights such as informed consent and bodily integrity, but still operated within a paradigm of permissible coercion. By 2004, the Council of Europe articulated

65 Ibidem, arts.3, 4, 7, 10 (ii), 12.

66 Ibidem arts. 3, 6, 9, 10(i).

67 Council of Europe, Parliamentary Assembly, Resolution 2291 (2019): Ending Coercion in Mental Health: The Need for a Human Rights-Based Approach, https://pace.coe.int/en/files/28038/html.

68 Council of Europe, Recommendation 2158 (2019): Ending Coercion in Mental Health: The Need for a Human Rights-Based Approach, https://pace.coe.int/pdf/47ef3a7e88bb49490558bb6a7894d059deb8ce900356e2bbd721d0b0ebc5024e/rec.%202158.pdf.

69 Resolution 2291 (2019), para. 5,6, 7(1)-(7); Recommendation 2158 (2019), paras. 2-4

a holistic, non-discriminatory, person-centred framework that explicitly integrated social rights and deinstitutionalisation. Finally, the 2019 Resolution and Recommendation pushed further, openly calling for the abolition of coercion and aligning most closely with the CRPD.

This progression illustrates both the normative potential and the limitations of soft law: while these instruments have gradually expanded the rights discourse, they also highlight the persistent gap between aspirational standards and binding Strasbourg jurisprudence. The Council of Europe's own soft-law consensus now often outpaces the ECtHR, whose case law remains anchored in the acceptability of psychiatric confinement rather than its abolition.

2.4.1. CoE's Commissioner for Human Rights' Thematic Reports, Issue Papers, and Speeches

Finally, the Council of Europe Commissioner for Human Rights has published a series of thematic reports, issue papers, and speeches that underscore the pressing need for comprehensive, rights-based reforms in mental health care systems across Europe. Notably, they call for a paradigm shift away from coercive psychiatric practices and towards voluntary, community-based mental health services that uphold the dignity, autonomy, and participation of individuals with psychosocial disabilities.[70] Earlier, in 2012 critically examined the widespread practice of substituted decision-making, advocating instead for models of supported decision-making that respect the will and preferences of the individual.[71] In her 2019 address to the Parliamentary Assembly of the Council of Europe, the Commissioner forcefully condemned the overreliance on coercion within mental health systems, highlighting how such measures often stem not from clinical necessity but from entrenched practices, social stigma, and the absence of adequate alternatives.[72] They argued that coercion in mental health

70 Council of Europe Commissioner for Human Rights, The Right to Health: A Human Rights-Based Approach to Health in Europe, Issue Paper (2021)1. https://www.coe.int/en/web/commissioner/-/the-right-to-health-a-human-rights-based-approach-to-health-in-europe.

71 Council of Europe Commissioner for Human Rights, Who Gets to Decide? Right to Legal Capacity for Persons with Intellectual and Psychosocial Disabilities, Issue Paper (2012). https://rm.coe.int/16806da2e2.

72 Council of Europe Commissioner for Human Rights, Ending Coercion in Mental Health: The Need for a Human Rights-Based Approach (PACE Debate),

care perpetuates human rights violations and contributes to the social marginalization of those affected, calling for a fundamental reorientation towards human rights-based practices that ensure meaningful participation and self-determination for persons with psychosocial disabilities. Furthermore, the Commissioner has been an outspoken critic of the draft Additional Protocol to the Oviedo Convention, warning that its provisions risk entrenching outdated, coercive approaches to mental health care and creating legal uncertainty that could erode human rights protections.[73] In her formal comments on the Protocol, she emphasized the need to redirect efforts towards developing and implementing clear guidelines for the abolition of coercion in mental health services, reinforcing the primacy of dignity, choice, and legal capacity.

Together, these instruments demonstrate the Council of Europe's evolving commitment to protecting the rights of persons with mental disorders. While tensions remain between security-based and autonomy-based approaches, the normative trend increasingly favours deinstitutionalisation, legal capacity, and human dignity.[74]

3 Jurisprudence of the European Court of Human Rights

The European Court of Human Rights (ECtHR) in Strasbourg is established in Article 19 of the ECHR and was set up in 1959.[75] It has played a pivotal role in interpreting the rights of persons with mental disorders under

Speech (2019). https://rm.coe.int/commdh-speech-2019-7-pace-debate-on-ending-coercion-in-mental-health-/168095114a.

73 Council of Europe Commissioner for Human Rights, Comments on the Draft Additional Protocol to the Oviedo Convention. https://rm.coe.int/commhr-comments-on-the-draft-additional-protocol-to-oviedoconvention/1680a2e452.

74 Additionally, the Council of Europe, Compendium Report on Good Practices in Promoting Voluntary Measures in Mental Health (2019) showcases promising initiatives such as crisis response services, advance directives, and peer-support networks, all of which offer alternatives to coercion and highlight the potential for truly person-centred mental health care – retrieved from:

75 All 47 of Europe member states have ratified the Convention and recognise the ECtHR's jurisdiction.

the European Convention on Human Rights (ECHR). Through its evolving case law, the Court has shaped legal standards in areas such as involuntary placement, coercive treatment, legal capacity, and the conditions of psychiatric care. This section analyses key judgments to trace the development of the Court's jurisprudence and assess its responsiveness to the changing international human rights landscape, particularly in light of the Convention on the Rights of Persons with Disabilities (CRPD).[76] There is now a substantial body of jurisprudence in relation to mental illness and the ECHR, relating chiefly to involuntary detention owing to mental illness, conditions while detained, and mechanisms for reviews and appeal.[77] This reflects the fact that the key provisions of the ECHR in relation to psychiatry concern involuntary detention rather than economic and social rights. Fortunately, the Court has taken the view that its jurisprudence is a "living tree."[78] The approach of the Court is not frozen in time, but developing with a view to progressing attitudes to human rights. The Court has in recent years made considerable progress in the protection of the rights of people with mental disabilities, and as the core of this book shows, there is potential for a good deal more. While certainly not wishing to undercut that trend, a note of caution is appropriate. The "living tree" approach goes only so far. In the end, the Court must be governed by the terms of the ECHR itself, and there will in the future no doubt be worthy cases where the language of the ECHR cannot adequately fashion a remedy.[79]

3.1. Deprivation of Liberty and Procedural Safeguards

The cornerstone of the ECtHR's mental health jurisprudence is Article 5(1)(e) ECHR, which permits the lawful detention of persons of "unsound mind." In Winterwerp v. the Netherlands (1979), the Court established three

76 In Enver Sahin v. Turkey, the Court opined that the CRPD should be taken into consideration in interpreting the ECHR "to achieve harmony with other rules of international law of which it forms part" – Enver Sahin v. Turkey, App. No. 23065/12, Judgment of 30 January 2018, para. 53.

77 Peter Bartlett, "The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law" *The Modern Law Review*, No. 5 (2012): 752–778; Michael L. Perlin, *International Human Rights and Mental Disability Law* (Washington, DC: American Society of International Law, 2006).

78 Tyrer v. the United Kingdom, App. No. 5856/72, Judgment of 25 April 1978, Series A no. 26.

79 Bartlett et al., "Introduction,"17.

cumulative criteria for such detention: (1) reliable evidence of a mental disorder; (2) a disorder of a kind or degree warranting compulsory confinement; and (3) continued detention justified only as long as the disorder persists.[80] These standards have formed the foundation of the Court's approach, providing a framework intended to balance individual liberty with the state's interests in protection and treatment. Importantly, the Court has consistently perceived involuntary treatment as component of involuntary hospitalisation under Article 5. If hospitalisation is deemed lawful, any medical treatment administered during the detention is presumed justified and does not require separate judicial scrutiny.[81] This applies even when individuals with full legal capacity refuse treatment but are forcibly medicated while lawfully detained.[82] In such circumstance, the Court does not apply separate criteria, such as lack of capacity, to assess the permissibility of treatment. Under Article 5, the Court has only held that if the purpose of detention is treatment, it must take place in an appropriate institution, such as a hospital[83]. The Court moved closer to distinguishing between detention and treatment in Pleso v. Hungary (2010), where it on X v. Finland (2012) to emphasize that involuntary hospitalisation often entails forced medication, which interferes with the right to physical integrity.[84] This recognition marked an initial step towards separating the legal assessment of detention from that of forced treatment and highlighting the role of capacity and consent.

Subsequent case law has progressively refined these safeguards. In Luberti v. Italy (1984), the Court confirmed that medical evidence justifying detention must be objective and reliable.[85] In Ashingdane v. the United Kingdom (1985) and Storck v. Germany (2005), it expanded the concept of "deprivation of liberty" to encompass not only formal hospital admissions but also placements in social care or private psychiatric

80 Winterwerp v. the Netherlands, App. No. 6301/73, Judgment of 24 October 1979.

81 Ibidem, para. 51.

82 Grare v. France, App. No. 18835/91, Decision of 2 December 1992.

83 Aerts v. Belgium, App. No. 25357/94, Judgment of 30 July 1998, para. 46. A few attempts to separate detention from treatment appeared in the European Court's jurisprudence. In X. v. Finland, the Court found a separate violation of the right to private life under Article 8 of the ECHR for the applicant's involuntary treatment, because the domestic law had no procedure to regulate decision-making over treatment. See also Sýkora v. the Czech Republic, op. cit., Ples´o v. Hungary, op. cit.

84 Id., para 65.

85 Luberti v. Italy, App. No. 9019/80, Judgment of 23 February 1984, paras. 30–35.

institutions where genuine consent and oversight were absent. Crucially, the ECtHR has stressed that detention must serve a genuine therapeutic purpose and cannot be justified by a psychiatric diagnosis alone.[86] A significant development occurred in Shtukaturov v. Russia (2008),[87] where the Court held that "the existence of a mental disorder, even a serious one, cannot be the sole reason to justify full incapacitation," emphasizing that any measure must be tailored to the person's circumstances[88]. In Pleso, the Court underlined that for the particularly vulnerable group of psychiatric patients, "very weighty reasons" are required to restrict Convention rights, and any interference must reflect a fair balance between society's duty to provide appropriate health care and the individual's inalienable right to self-determination.[89] In Rooman v. Belgium (2019), detention without individualized therapeutic aims or culturally appropriate treatment was found to violate Articles 3 but, surprisingly, the Court found only the partial violation of Article 5[90] , as the applicant was detained in an appropriate institution.[91] Similarly, in *Bergmann v. Germany* (2016) and Ilnseher v. Germany (2018), the Court held that detention in prison-like environments lacking therapeutic justification breaches Article 5, even if authorized under domestic law[92], while in S. v. Germany (2012) and Kallweit v. Germany (2011) it underscored the requirement that post-sentence preventive detention must involve appropriate therapeutic care.[93]

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86 Ashingdane v. the United Kingdom, App. No. 8225/78, Judgment of 28 May 1985, para. 50; see also the dissenting opinion of Judge Pettiti; Storck v. Germany, App. No. 61603/00, Judgment of 16 June 2005, paras. 103, 111, 147, 152.

87 Shtukaturov v. Russia, App. No. 44009/05, Judgment, of 27 March 2008 – The case concerning concerning the placement under guardianship of a relatively independent young man with mental health problems on the proposal of his mother. The Court found a violation, noting that the procedure had failed to adequately establish the applicant's condition and circumstances.

88 Ibidem paras. 94-96.

89 Plesó v. Hungary, App. No. 41242/08, Judgment of 2 January 2013.

90 The Grand Chamber corrected this course, and found a partial violation of the right to liberty, but not for the period when some form of psychological consultation was offered to the applicant.

91 Rooman v. Belgium, App. No. 18052/11, Judgment of 31 January 2019, para. 130.

92 Bergmann v. Germany, App. No. 23279/14, Judgment of 7 January 2016, paras. 170–175; Ilnseher v. Germany, Apps. Nos. 10211/12 and 27505/14, Judgment of 4 December 2018; see also dissenting opinion of Judge Pinto de Albuquerque joined by Judge Dedov.

93 S. v. Germany, App. No. 3300/10, Judgment of 28 June 2012, paras. 86-88, 90, 95-87; Kallweit v. Germany, App. No. 17792/07, Judgment of 13 January 2011,

The ECtHR has also recognized that informal psychiatric admissions may amount to deprivation of liberty if the individual is not genuinely free to leave. In H.L. v. the United Kingdom (2004), it ruled that even "informal" detentions must meet the same procedural safeguards as formal ones.[94] This principle was extended in Sýkora v. the Czech Republic (2012), where the Court found a that a guardian's consent was insufficient to make hospitalisation voluntary;[95] and Stanev v. Bulgaria (2012), which extended the protection of Article 5 to placements in long-term social care institutions.[96] More recently, in Miranda Magro v. Portugal (2024), the Court reaffirmed that detention must remain therapeutic and be accompanied by individualized psychiatric care, even in prison hospitals.[97] The ECtHR has consistently emphasized that deprivation of liberty must be accompanied by robust procedural guarantees. In Megyeri v. Germany (1992), it emphasized that detainees have an effective opportunity to be heard and to contest the lawfulness of their detention.[98] Rakevich v. Russia (2003) and Morsink v. the Netherlands (2004) confirmed the indispensability of effective and independent judicial review,[99] while Matter v. Slovakia (2009) underscored the importance of legal representation and prompt hearings.[100] In X v. Finland (2012), the Court elaborated on the necessity of accessible and effective safeguards for individuals unable to express their wishes regarding hospitalization or treatment.[101]

A particularly insightful observation by the ECtHR highlights the difficulty of defining "a person of unsound mind." It acknowledged that the notion is "continually evolving as research in psychiatry progresses and increasing flexibility in treatment is developing." At the same time, it

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paras. 47–59.

94 H.L. v. the United Kingdom, App. No. 45508/99, Judgment of 5 October 2004, paras. 89-125.

95 Sýkora v. the Czech Republic, App. No., Judgment of, para. – This case displayed the notion that the Court did not reject involuntary hospitalisation as such, only in the circumstances of the specific case.

96 Stanev v. Bulgaria, op. cit.

97 Miranda Magro v. Portugal, App. No. 72077/14, Judgment of 23 April 2024, paras. 75-96.

98 Megyeri v. Germany, App. No. 13770/88, Judgment of 12 May 1992, paras. 21-27.

99 Rakevich v. Russia, App. No. 58973/00, Judgment of 28 October 2003, paras. 43-47; Morsink v. the Netherlands, App. No. 48865/99, Judgment of 11 May 2004, paras. 67, 69, 72.

100 Matter v. Slovakia, App. No. 31534/96, Judgment of 5 July 1999, para. 59.

101 X v. Finland, App. No. 34806/04, Judgment of 3 July 2012, paras. 183-184, 218.

insisted on definitional limits, stressing that detention cannot be justified merely "because his or her views or behaviour deviate from established norms."[102] Despite these advances, the Court's jurisprudence reveals an enduring reliance on a risk-based paradigm, often framing persons with mental disorders or psychosocial disabilities largely in terms of dangerousness or vulnerability, rather than as autonomous rights-holders. As Szwed observes, the Court has been "relatively good on procedural justice, but not nearly so strong on substance."[103] In several subsequent cases concerning Article 5, the Court referenced the CRPD, but did not elaborate on its significance for its own standards.[104] Where it found violations, it did so because the Winterwerp criteria were not properly applied;[105] when they were met, the Court accepted hospitalisation without addressing the CRPD.[106] In Ruiz Rivera v. Switzerland (2014), Judge Sajo's concurring opinion explicitly highlighted the CRPD's relevance for detention of persons of "unsound mind", yet the majority remained silent.[107]

This pattern illustrates the Court's cautious stance: while Winterwerp and its progeny articulate detailed procedural safeguards for lawful detention, they do not fundamentally question the legitimacy of psychiatric confinement itself. The result seems to be significant procedural progress but substantive stagnation in the protection of liberty and autonomy for persons with mental disorders or psychosocial disabilities.

3.2. Inhuman or Degrading Treatment

The ECtHR has long recognized that persons with mental disorders or psychosocial disabilities are particularly vulnerable to inhuman or degrading treatment while detained. In Herczegfalvy v. Austria (1992), the Court

102 Winterwerp v. the Netherlands, para. 37; see also Szwed, "The Notion of «a Person of Unsound Mind» under Article 5 § 1 (e) of the European Convention on Human Rights," 1-19.

103 Szwed, "The Notion of «a Person of Unsound Mind» under Article 5 § 1 (e) of the European Convention on Human Rights," 18.

104 See, for example, Koroviny v. Russia, App. No. 31974/11, Judgment of 27 May 2014; Kuttner v. Austria, App. No. 7997/08, Judgment of 16 July 2015; Hadzimejlic and Others v. Bosnia and Herzegovina, App. No. 3427/13, Judgment of 3 February 2016.

105 For example, Blokhin v. Russia, App. No. 47152/06, Judgment of 23 March 2016.

106 For example, Haidn v. Germany, App. No. 6587/04, Judgment of 13 April 2011.

107 Ruiz Rivera v. Switzerland, App. No. 8300/06, Judgment of 18 February 2014, Concurring Opinion of Judge Sajo.

accepted that medical necessity might justify certain restrictive practices in psychiatry but cautioned that such interventions must remain strictly proportionate to avoid breaching Article 3.[108] This cautionary approach has gradually evolved into an increasingly rigorous standard of review. Later judgments have subjected psychiatric interventions to closer scrutiny. In Bureš v. the Czech Republic (2012), the ECtHR found that the prolonged use of mechanical restraints without urgent necessity violated Article 3.[109] In Rooman, the Court held that the failure to provide specialized psychiatric care to a forensic patient in detention amounted to inhuman treatment.[110] Similarly, in Strazimiri v. Albania (2020), the Court reaffirmed that therapeutic neglect within prison-based psychiatric units can itself violate Article 3, underscoring that even where detention is initially lawful, the continuing failure to provide adequate treatment can render it inhuman or degrading.[111] In Gajcsi v. Hungary (2006), the Court illustrated that involuntary treatment within social care settings must also be justified by therapeutic necessity.[112]

The Court has further emphasized that these obligations extend to the continuous review of the necessity and proportionality of psychiatric detention. In Miranda Magrol, it reinforced this trajectory by holding that placement in a prison hospital without individualized psychiatric care breached both substantive and procedural aspects of Articles 3 and 5 ECHR, confirming that deprivation of liberty must be genuinely therapeutic rather than merely custodial.[113] Similarly, in Claes v. Belgium (2013) the ECtHR stressed that the lack of appropriate treatment can itself constitute inhuman or degrading treatment.[114] In cases concerning the expulsion

108 Herczegfalvy v. Austria, App. No. 10533/83, Judgment of 24 September 1992, paras. 79-84.

109 Bureš v. the Czech Republic, App. No. 37679/08, Judgment of 18 October 2012, paras. 83-86, 88 -106.

110 Rooman v. Belgium, App. No. 18052/11, Judgment of 31 January 2019, paras. 141–48, 153–59; partly dissenting opinion of Judge Nussberger; joint partly dissenting opinion of Judges Turković, Dedov, Motoc, Ranzoni, Bošnjak, and Chanturia; partly dissenting opinion of Judge Serghides.

111 Strazimiri v. Albania, App. No. 34602/16, Judgment of 21 January 2020, paras. 103-112.

112 Gajcsi v. Hungary, App. No. 34503/03, Judgment of 3 October 2006, paras. 20-21.

113 Miranda Magro v. Portugal, App. No. 72077/14, Judgment of 23 April 2024, paras. 75–96.

114 Claes v. Belgium, App. No. 43418/09, Judgment of 10 January 2013, paras. 95, 101.

or extradition of a person with mental illness, such as in Bensaid v. the United Kingdom (2001), the Court found no violation of Articles 3, 8 or 13, but nevertheless stressed that "the preservation of mental stability is an indispensable precondition to effective enjoyment of the right to respect for private life."[115]

Importantly, the ECtHR has clarified that the state's positive obligations under Article 2 cannot justify involuntary hospitalisation of individuals who retain full decision-making capacity. Indeed, the Court has warned that such an interpretation would be excessively paternalistic, stating that "the positive obligations under Article 2 should not be unduly impaired by paternalistic interpretations, bearing in mind that the notion of personal autonomy is an important principle underlying the Convention guarantees."[116] This rejection of paternalistic overreach signals an important shift in the Court's case law, affirming that therapeutic necessity – not mere medical or social convenience – must guide all psychiatric interventions that interfere with personal liberty and dignity.

Nevertheless, the ECtHR has remained reluctant in finding an involuntary treatment to constitute torture in cases involving persons with mental disorders or psychosocial disabilities. In Shtukaturov, it held that the applicant had shown "no evidence that the medication in question had the unpleasant effects he was complaining of," and that his health had 'not deteriorated as a result of such treatment."[117] This reasoning sets an evidentiary threshold that is nearly impossible for most psychiatric patients to meet. The Court has shown similar caution regarding restraints in institutions;[118] in its leading case, Herczegfalvy, where it upheld the use of such measures under a standard of medical necessity, has never been formally overruled. In Shtukaturov, the applicant raised the question of restraints under Article 3, the Court declined to examine it in detail, despite finding multiple other violations.[119] A modest step forward came in Bures,

115 Bensaid v. the United Kingdom, App. No. 44599/98, Judgement of 1 February 2001; Contrary to that, in the case of Aswat v. the United Kingdom, App. No. 17922/12, Judgement of 16 April 2013, the Court, in the light of the severity of applicant's mental illness and the unknown conditions of his detention in the other country, held that an extradition would violate Article 3.

116 Herczegfalvy v. Austria, para. 82.

117 Shtukaturov v. Russia, op. cit., para. 128.

118 Bernadette McSherry, "Regulating Seclusion and Restraint in Health-Care Settings: The Promise of the Convention on the Rights of Persons with Disabilities" *International Journal of Law and Psychiatry*, 53 (2017): 39-44.

119 Shtukaturov v. Russia, op. cit., paras. 126–129.

where the applicant was strapped to a bed in a psychiatric centre and sustained severe injuries.[120] The Court declared the restraints as constituting ill-treatment, and found a violation of the procedural limb of Article 3 due to the authorities' failure to investigate. Substantively, this judgement partially departed from Herczegfalvy without explicitly overruling it so, while extending the obligation to investigate under Article 3 – well established in the prison[121] and police violence[122] contexts – into the field of psychiatric care.

Collectively, these cases demonstrate the ECtHR's growing insistence that detention and treatment of persons with mental disorders must be genuinely therapeutic, respectful of personal autonomy, and never solely custodial. They also reveal the ongoing tension in the Court's approach: while procedural safeguards are robustly protected, a degree of deference to medical expertise and national practices that may limit the substantive review of coercive measures.

3.3. Right to Private Life and Legal Capacity

Article 8 of the ECHR guarantees the right to respect for private and family life, encompassing bodily and psychological integrity, as well as personal autonomy. In mental health contexts, the ECtHR has recognized that forced treatment, restrictions on family life, and plenary guardianship regimes can seriously intrude upon these fundamental rights.

In X v. Finland (2012), the Court held that forced psychiatric treatment administered without the patient's meaningful involvement amounted to an unjustified interference with Article 8.[123] Similarly, in Alajos Kiss v. Hungary (2010), the Court applied strict scrutiny to an automatic voting ban imposed on persons under guardianship. It held that any disability-based restriction on civil rights requires "very weighty reasons," emphasizing that such blanket restrictions demand exceptional justification.[124] Also, by this very judgement, the Court recognized persons with mental disabilities as a historically disadvantaged group, against whom any restrictions

120 Bureˇs v. the Czech Republic, App No. 37679/08, Judgment of 18 October 2012.
121 Selmouni v. France [GC], App. No. 25803/94, Judgment of 28 July 1999.
122 Assenov v. Bulgaria, App. No. 24760/94, Judgment of 28 October 1998.
123 X v. Finland, App. No. 34806/04, Judgment of 3 July 2012, paras. 212-223.
124 Alajos Kiss v. Hungary, App. No. 38832/06, Judgment of 20 May 2010, paras. 41-44.

should be reviewed with strict scrutiny.[125] The ECtHR's standards in this area continue to evolve, and the CRPD has become an important reference point for highlighting the shortcomings in national mental health systems, as seen in Pleso, where applicants invoked the CRPD to challenge the necessity of involuntary hospitalization and to argue for the existence of less restrictive alternatives.[126] Further cases, such as Riviere v. France (2006) and K.C. v. Poland (2014), have sought to balance personal autonomy with clinical considerations – particularly in situations involving self-harm – while reaffirming the importance of respecting the individual's will and preferences where capacity is retained.[127] In S.S. v. Slovenia (2018), the Court stressed that "perpetrators of criminal acts who suffer from mental disorders and are placed in psychiatric facilities are in a fundamentally different situation than other detainees."[128]

Collectively, these judgements reflect the ECtHR's growing appreciation of the need to safeguard not only the physical safety of persons with mental disorders or psychosocial disabilities but also their personal autonomy, dignity, and capacity for social participation. Despite this progress, the Court's approach to legal capacity remains cautious. It continues to operate within a medicalized framework that tends to treat persons with mental disorders or psychosocial disabilities as objects of clinical control rather than as rights-holders with inherent agency and equality. As Bartlett[129] has argued, this cautious stance reveals an enduring tension within Strasbourg jurisprudence: while procedural safeguards and dignity-based principles are increasingly recognized, the Court has yet to fully embrace a social model of disability that prioritizes empowerment, autonomy, and equal recognition before the law.

125 Ibidem, para. 42. See also: Adam Bodnar, „Międzynarodowe standardy praw człowieka a prawa wyborcze osób z niepełnosprawnościami intelektualnymi lub psychicznymi," [in:] *Prawa osób z niepełnosprawnością intelektualną lub psychiczną*, ed. Dorota Pudzianowska (Warszawa: Wolters Kluwer, 2014), 213-245.

126 The patient has the right to be ill.

127 Riviere v. France, App. No. 33834/03, Judgment of 11 July 2006, paras. 59-77 and cases cited therein; K.C. v. Poland, *App. No.* 31199/12, Judgment of 10 July 2014, paras. 63-71.

128 S.S. v. Slovenia, App. No. 40938/16, Judgment of 30 October 2018, para 29.

129 Peter Bartlett, "The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law," *Modern Law Review*, No. 5 (2012): 752–778., https://doi.org/10.1111/j.1468-2230.2012.00923.x.

3.4. Intersection with Non-Discrimination

Article 14 of the ECHR, which prohibits discrimination in the enjoyment of Convention rights, has historically played a secondary role in the ECtHR's jurisprudence concerning persons with mental disorders or psychosocial disabilities. Its relevance in mental health cases, however, is gradually gaining recognition[130]. In Alajos Kiss, the Court acknowledged the particular vulnerability of persons with mental disorders or psychosocial disabilities to discrimination and subjected restriction on their rights to strict scrutiny[131]. This judgement marked a pivotal step towards recognizing persons as a suspect or quasi-suspect class under the Convention framework. In Cînța v. Romania (2020), the ECtHR found a violation of Article 8 in conjunction with Article 14 , holding that while mental illness might be a relevant factor when assessing parental capacity, reliance on it as the decisive – or even a contributing– element may amount to discrimination, when, in the specific circumstances, the illness has no bearing on the parent's ability to care for the child.[132] By contrast, in other landmark judgments such as Storck v. Germany (2005) and Strazimiri v. Albania (2020), Article 14 was either not invoked or received minimal judicial attention. In those cases, the Court focused primarily on the lawfulness, proportionality, and conditions of deprivation of liberty under Articles 3 and 5. Considerations of discrimination, particularly those linked to systemic exclusion, structural violence, or stigma, were largely sidelined. This pattern reflects a persistent doctrinal gap: while the Court has developed strong procedural safeguards, the substantive dimension of equality remains underdeveloped in the mental-health context. Moreover, the ECtHR tends to defer heavily to the expertise of national medical authorities, rarely challenging psychiatric assessments or national determinations of "unsound mind," even when these serve as the legal basis for coercive interventions.[133] Yet, it applies a more exacting standard when evaluating whether individuals deprived of liberty were afforded procedural guarantees such as timely review, legal representation, or access to remedies. This asymmetry has drawn criticism from scholars. As Bartlett has aptly noted, "[i]n dealing with cases

130 Ibidem, 752–778

131 Alajos Kiss v. Hungary, App No. 38832/06, ECHR 2010, paras. 40–44.

132 Cînța v. Romania, App. No. 3891/19, Judment of 18 February 2020,

133 *Strazimiri v. Albania*, no. 34602/16, ECHR 2020, paras. 103–112; *Storck v. Germany*, no. 61603/00, ECHR 2005, paras. 111–152.

of persons with mental disabilities, the ECHR has been relatively good on procedural justice, but not nearly so strong on substance."[134] The same point is echoed by Szwed, who emphasizes that the Court has done little to confront the structural marginalization of persons with mental disabilities within the broader disability rights framework. Despite advances in recognizing vulnerability, the Court's jurisprudence still lacks a fully developed non-discrimination lens that would address the intersectional and systemic nature of rights violations in psychiatric settings.

At the same time, the Court has addressed related issues, in a series of cases against Germany concerning preventive detention. Germany is one of the few European states that have adopted a preventive-detention measure not directly based on mental disorder.[135] It applies to persons deemed dangerous who have committed serious criminal acts, served their time, and do not satisfy the criteria for involuntary psychiatric hospitalisation.[136] Preventive detention is difficult to justify under Article 5, which contains a closed list of permissible grounds for deprivation of liberty, and mere dangerousness is not among them. Scholars,[137] including Kanter, have argued that preventive detention is not compatible with the ECHR.[138] Nevertheless, the Court accepted preventive detention in Bergmann v. Germany[139], and reaffirmed this holding in two subsequent cases.[140] The Grand Chamber ultimately upheld the measure in Ilnseher v. Germany.[141] Because the applicant did not fulfil the criteria for involuntary

134 Bartlett, "The United Nations Convention," 778.

135 Michel Van der Wolf, "Legal Control on Social Control of Sex Offenders in the Community: A European Comparative and Human Rights Perspective" *Erasmus Law Review*, 2, (2016): 39-54.

136 Szwed, "The notion of 'a person of unsound mind' under Article 5 § 1 (e) of the European Convention on Human Rights," 283-301, 289.

137 Fennell, Khaliq, "Conflicting or Complementary Obligations? The UN Disability Rights Convention, the European Convention on Human Rights and English Law," 839.

138 Ariene S. Kanter, *The Development of Disability Rights under International Law: From Charity to Human Rights* (London: Routledge, 2014), 148.

139 Bergmann v. Germany, App. No. 23279/14, judgment of 7 January 2016.

140 Blühdorn v. Germany, App. No. 62054/12, Judgment of 18 February 2016; Klinkenbuss v. Germany, App. No. 53157/11, Judgment of 25 February 2016.

141 The case concerned a young offender who had been found criminally responsible and sentenced but was placed in preventive detention after serving his sentence. Yet later, when he served his sentence, instead of releasing him he was spectively placed in preventive detention – Ilnseher v. Germany [GC], App. No. 10211/12, Judgment of 4 December 2018.

hospitalisation, the domestic courts relief on a tenuous connection between his alleged personality disorder and past offenses to justify his detention as that of a person of "unsound mind," as no other justification was applicable to his situation.[142] Judge Pinto de Albuquerque warned that this reasoning dangerously expanded the meaning of person of "unsound mind," and the scope of permissible justifications under Article 5, effectively permitting detention based solely on a prediction of future dangerousness.[143]

Given the CRPD's influence and the evolving normative landscape, the ECtHR's approach appears increasingly outdated. A stronger integration of Article 14 with Articles 3, 5, and 8 could offer a more robust protection framework, one that not only scrutinizes procedural fairness but also affirms the equal dignity, autonomy, and legal agency of persons with mental disorders or psychosocial disabilities.

4 Conclusion

This article has evaluated whether the ECtHR's jurisprudence on mental health evidences progressive interpretation or doctrinal stagnation. The findings indicate a persistent bifurcation.

On the one hand, the Court has consolidated a sophisticated architecture of procedural safeguards under Articles 3, 5, 8 and 14 ECHR: the Winterwerp criteria have been clarified and applied across formal, informal and social-care placements; individualized therapeutic aims and ongoing judicial oversight have been required; and disability-based restrictions have attracted intensified review, notably in Alajos Kiss. On the other hand, the Court continues to accept involuntary hospitalization – and, by implication, forced treatment – as legitimate in principle where domestic thresholds are met. In practice, Strasbourg scrutinizes the fairness of coercion more than it interrogates coercion's normative premise. The case law surveyed illustrates this duality. Judgments such as Stanev, H.L., Rooman, X v. Finland, and Miranda Magro expand the reach of Article 5 and strengthen participation and review guarantees, yet the jurisprudence remains anchored

142 Id, para. 169.

143 Id., no. 10211/12, Judgment of 4 December 2018, Dissenting opinion of Judge Pinto de Albuquerque joined by Judge Dedov, para. 30.

in a risk-based, medicalized paradigm. The category of "unsound mind" functions as the doctrinal gateway to confinement; non-consensual interventions are frequently treated as incidents of lawful detention rather than as distinct interferences that require separate, capacity-sensitive justification under Articles 3 and 8; and deference to clinical expertise and national legislative choices persists in proportionality analysis. The result is procedural thickening without a commensurate substantive reorientation towards autonomy, equal legal capacity and freedom from disability-based coercion – core commitments of the CRPD.

The broader CoE's normative environment heightens this tension. Over five decades, soft-law instruments have moved from calibrating safeguards within a paternalistic model to advocating a rights-based, community-anchored paradigm centred on consent, supported decision-making and social inclusion. The European Social Charter and the Commissioner for Human Rights' thematic work similarly endorse an equality- and participation-oriented approach. Against this trajectory, the Court's jurisprudence appears comparatively conservative: it has refined standards of legality and review but has not articulated autonomous substantive limits on psychiatric coercion consistent with contemporary disability rights norms.

The Court's jurisprudence reveals a dual trajectory. On the one hand, Winterwerp and its progeny continue to anchor the Court's approach to involuntary hospitalization in a medical-certification model that entrenches paternalistic assumptions about incapacity and risk. On the other hand, more recent judgements, including Miranda Magro, demonstrate a willingness to scrutinize coercive practices more strictly, particularly where procedural safeguards are lacking. Rooman further indicates the Court's openness to linking deprivation of liberty with substantive rights such as rehabilitation and social reintegration. Yet, the lack of a clear doctrinal shift towards autonomy and non-coercion underscores a stagnation that contrasts with the CRPD's paradigm of equal legal capacity and supported decision-making. Since Winterwerp, the Court has found violations in dozens of cases, but it has never declared involuntary hospitalisation, as such, contrary to the ECHR. Rather, it has consistently accepted it as a legitimate measure in principle.[144] Critics argue that the Court has not

144 See Hutchison Reid v. the United Kingdom, App. No. 50272/99, Judgment of 20 February 2003, for an example of a case where the Court had to consider and accepted the legitimacy of hospitalisation in the case of a person who was not treatable.

succeeded in substantially limiting medical discretion.[145] While it has infused the framework with rights-based language, providing some protection to patients[146], it has not developed substantive criteria of its own concerning assessing the acceptability of coercive treatment. The Court continues to defer to domestic mental health laws, which typically justify confinement on the grounds of dangerousness to self or others, or the even vaguer "deterioration of conditions."[147] It has never rejected these substantive justifications, finding violations only when domestic criteria were not properly.[148] Nor has it ever questioned or overruled medical expertise.[149]

Looking ahead, the ECtHR faces the critical task of aligning its jurisprudence more fully with the transformative standards of the CRPD, which calls for a paradigm shift towards autonomy, legal capacity, and meaningful participation. While the Court has not yet fully incorporated the CRPD's vision, its evolving case law, coupled with CoE's soft-law instruments, points towards a growing recognition that mental health care must be grounded in respect for the dignity and autonomy of persons with psychosocial disabilities.

National practice corroborates the limited transformative impact of Strasbourg jurisprudence. No EU Member State fully complies with CRPD Article 12 on equal recognition before the law;[150] full deprivation of legal

145 Philip Fennell, "Institutionalising the Community: The Codification of Clinical Authority and the Limitations of Rights-Based Approaches," [in:] *Rethinking Rights-Based Mental Health Laws*, ed. Bernadette McSherry, Penelope Weller (Oxford: Hart, 2012).

146 Penelope Weller, "Lost in Translation: Human Rights and Mental Health Law," [in:] Rethinking rights-based mental health laws, ed. Bernadette McSherry, Penelope Weller (Oxford: Hart, 2012), 55.

147 See, for example, Sabeva v. Bulgaria, App. No. 44290/07, Judgment of 10 June 2010.

148 Jennifer Brown, "The Changing Purpose of Mental Health Law: From Medicalism to Legalism to New Legalism" *International Journal of Law and Psychiatry*, 47 (2016): 1-9; Szmukler George, Lawrence O. Gostin, "Mental Health Law: «Legalism» and «Medicalism» – Old and New," [in:] *Mind, State and Society*, ed. George Ikkos, Nick Bouras (Cambridge: Cambridge University Press, 2021).

149 Karen Reid, *A Practitioner's Guide to the European Convention on Human Rights*, 5th ed. (London: Sweet & Maxwell, 2015), 832.

150 European Disability Forum, Human Rights Report 2024: Legal Capacity—Personal Decision-Making and Protection (Brussels: EDF, 2024), p. 18. https://www.edf-feph.org/publications/human-rights-report-2024-legal-capacity/.

capacity remains permissible in several jurisdictions; and legal frameworks for involuntary placement and treatment persist, with indications of increasing reliance in some systems.[151] First-person accounts, including non-consensual electroconvulsive therapy, demonstrate the gap between formal safeguards and lived experience.[152] These dynamics suggest that the Court's procedural emphasis has not yet precipitated substantive legislative realignment: substituted decision-making and coercive measures endure notwithstanding incremental judicial developments.

Doctrinal recalibration is both feasible and normatively warranted. First, detention and treatment should be analytically decoupled. Forced medication and other non-consensual interventions should be assessed as separate interferences under Articles 3 and 8, with independent justification that engages decision-making capacity, will and preferences, and the availability of less restrictive alternatives. Second, the *Winterwerp* threshold should be tightened through rigorous least-restrictive-alternative analysis and evidence-based scrutiny of risk, resisting the conflation of diagnostic categorization with necessity. Third, Article 14 should be operationalized in tandem with Articles 3, 5 and 8 to expose and remedy structural discrimination, including the systemic use of "dangerousness" as a surrogate for disability-based exclusion. Finally, consistent with existing Convention doctrine, positive obligations should be interpreted to encompass the infrastructure of autonomy – effective supported decision-making regimes, crisis and community services that render coercion unnecessary, and safeguards ensuring access to care without trading away legal capacity. Remedial practice can evolve accordingly, moving beyond individualized relief to structured indications that guide legislative reform (e.g., decoupling guardianship from service access, eliminating blanket civil-rights restrictions, and auditing restraint practices).

In sum, the ECtHR's mental-health jurisprudence stands at a doctrinal inflection point. Continuing to refine procedures around coercion will consolidate a carefully managed paternalism; articulating substantive limits aligned with the CRPD would re-centre dignity, autonomy and equality as operative constraints on state power. Only the latter trajectory can

151 EDF, Human Rights Report 2024, p. 3; In Czechia, courts approve only about fifty supported decision-making agreements annually, while up to ten thousand people are newly restricted in their legal capacity each year. –p. 17.

152 EDF, Human Rights Report 2024, pp. 6, 13.

convert incremental procedural gains into genuine rights transformation for persons with mental disorders and psychosocial disabilities in Europe.

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