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Therapeutic Jurisprudence and the Treatment of People with Mental Illness in Eastern Europe: Construing International Human Rights Law*

*Bruce J. Winick***

I. Introduction

The plight of mental patients in Eastern Europe, and in Hungary in particular, was the subject of a recent conference at New York Law School. A variety of abusive practices were documented by some of the speakers, some of whom were Eastern Europeans themselves, and some of whom were lawyers seeking to protect the rights of patients in these areas.[1] These abuses include the use of locked bed cages in Hungarian psychiatric facilities, also known as net beds, in which patients are restrained at night, and perhaps for periods during the day.[2] They include the use of unmodified electroconvulsive therapy administered for punitive purposes.[3] They also include the isolation of patients in overcrowded social care homes located in rural areas, thereby cutting off patients from people in their communities.[4] They include as well abusive practices by guardians, who instead of seeking to promote the best interests of their wards, commit them to these isolated social care facilities on a "voluntary" basis.[5]

Many facilities offer unsanitary living conditions containing rooms that smell of urine and feces.[6] Patients lack privacy, living in rooms that are inca-

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** Professor of Law, University of Miami School of Law. The author would like to thank Michael Perlin for inviting him to think about these issues, Halina Cegielski, a December, 2002, University of Miami School of Law graduate who herself grew up in Eastern Europe, for her able research assistance, and Edgardo Rotman, the University of Miami School of Law International Law Librarian, for his assistance with international materials.

1. *See generally* Symposium, International Human Rights Law and the Institutional Treatment of Persons with Mental Disabilities: The Case of Hungary, 21 N.Y.L. Sch. J. Int'l & Comp. L. 339 (2002) [hereinafter Symposium Transcript].

2. One of the net beds was found at Ludanyhalaszi Care Home with a patient living inside. The cage was 2.08 m by 0.93 m, covered with net, and set on a metal construction 1.26 m in height. Gabor Gombos et al., Hungary: The Social Care Home Report, *id.* at 361.

3. Symposium Transcript, *supra* note 1, at —; *see also* Personal communication from Michael L. Perlin to Bruce J. Winick, Sept. 27, 2002 (on file with the author).

4. Gombos et al., *supra* note 2. According to the Ministry of Health Regulations, every patient should have an area of 6 square meters and there should be no more than four patients in a room. *Id.* In reality, there are social care homes providing patients with a space of 2.5 square meters and that have rooms with 12 or more beds.

5. Remarks of Michael L. Perlin, Symposium Transcript, *supra* note 1, at 340-348.

6. Gombos et al., *supra* note 2.

pable of being locked.[7] They lack conjugal rights.[8] Their ability to communicate with those outside is highly restricted or forbidden altogether, and both incoming and outgoing mail is opened by facility staff.[9] Phone calls are either limited or not permitted.[10] These facilities do not offer adequate medical or dental care for their patients.[11] Patients frequently remain uninformed concerning their rights and often lack the ability to complain about their treatment.[12] Over-medication of patients and lack of appropriate medication has been reported in other parts of Eastern Europe. This might occur in Hungary as well.[13] Many diagnosed as mentally disabled are permanently institutionalized in Hungarian psychiatric facilities, although perhaps 50% of them could live safely in the community with suitable care.[14]

These abuses are reminiscent of the state of American mental health facilities thirty-five or more years ago. As we ponder the abuses in Eastern Europe and wonder what can be done to put an end to them, it may be useful to remind ourselves about the American experience. Prior to the mid-1960s the abuses existing in many state mental hospitals in America remained largely invisible, and the courts took a "hands off" approach to scrutinizing civil commitment issues.[15] Up until the modern era, mental hospitals were run by medical superintendents with little interference by the courts.[16] Before the 1960s, commitment was based on a physician's certificate of need.[17]

Commitment at this time was based on a medical model, but a legal model of civil commitment was beginning to emerge.[18] The civil rights struggle of the 1950s and 1960s produced a new generation of lawyers dedicated to pursuing the constitutional rights of racial minorities and other disadvantaged

7. *Id.*

8. *Id.*

9. *Id.*

10. *Id.*

11. *Id.*

12. *Id.*

13. Debra Benko & Brittany Benowitz, *The Application of Universal Human Rights Law to People with Mental Disabilities*, 9 HUM. RTS. BR. 9, 10 (2001).

14. *Id.* at 9.

15. *See* Alexander D. Brooks & Bruce J. Winick, *Foreword: Mental Disability Law Comes of Age*, 39 RUTGERS L. REV. 235, 236 (1987); Procunier v. Martinez, 416 U.S. 396 (1974); JAMES B. JACOBS, INDIVIDUAL RIGHTS AND INSTITUTIONAL AUTHORITIES: PRISONS, MENTAL HOSPITALS, SCHOOLS AND MILITARY xxiv (1979).

16. Paul. S. Appelbaum & Kathleen N. Kemp, *The Evolution of Commitment Law in the Nineteenth Century: A Reinterpretation*, 6 LAW & HUM. BEHAV. 343, 344 (1982).

17. Bruce J. Winick, *A Therapeutic Jurisprudence Model for Civil Commitment, in* INVOLUNTARY DETENTION AND CIVIL COMMITMENT: INTERNATIONAL PERSPECTIVES (Ian Freckleton & Kate Diesfeld eds., forthcoming 2003) [hereinafter *TJ Model*]; Bruce J. Winick, *Therapeutic Jurisprudence and the Civil Commitment Hearing*, 10 J. CONTEMP. LEGAL ISSUES 37, 39 (1999) [hereinafter *Civil Commitment Hearing*]; Sumner J. Sydeman et al., *Procedural Justice in the Context of Civil Commitment: A Critique of Tyler's Analysis*, 3 PSYCHOL. PUB. POL'Y & L. 207, 207 (1997).

18. Winick, *TJ Model, supra* note 17.

populations.[19] Public interest lawyers soon championed the rights of those with mental illness, filing lawsuits challenging the conditions at state mental hospitals.[20] These cases dramatized and brought to public attention the abysmal conditions and lack of treatment that characterized the institutions of the time.[21] Legislation tightened up civil commitment standards and provided for procedural due process hearings to determine whether they were satisfied.[22] The legal model for civil commitment thus replaced the medical model.[23]

In some ways, the American experience is now being replicated in Eastern Europe. Organizations, such as Mental Disability Rights International, are championing the rights of those with mental illness in these countries, dramatizing the existence of abuses and asserting their rights in the courts.[24] Thus, we are seeing the beginning of a transformation of mental health law in Eastern Europe from a medical to a legal model.

As the new legal model takes shape, many questions will emerge concerning the legal rights of patients in Eastern Europe. A variety of international human rights provisions and principles will guide the direction of reform, and there will be increasing interest in the meaning of these provisions. Since many are vaguely worded, courts will be called upon to construe them. This process will roughly parallel the American experience in which American courts were called upon to interpret the similarly vague constitu-

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19. Brooks & Winick, *supra* note 15, at 236.

20. *Id.; see also* Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971), *enforced*, 334 F. Supp. 1341 (M.D. Ala. 1971), 344 F. Supp. 373 (M.D. Ala. 1972), *aff'd in part, rev'd in part, and remanded in part sub nom;* Wyatt v. Aderholt, 503 F.2d 1305, 1309 (5th Cir. 1974); David Rothman, *The Courts and Social Reform: A Postprogressive Outlook*, 6 LAW & HUM. BEHAV. 113 (1982); Patricia Wald & Paul Friedman, *The Politics of Mental Health Advocacy in the United States*, 1 INT'L J.L. & PSYCHIATRY 137, 147 (1978).

21. Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971), *enforced*, 334 F. Supp. 1341 (M.D. Ala. 1971), 344 F. Supp. 373 (M.D. Ala. 1972), *aff'd in part, rev'd in part, and remanded in part sub nom*; Wyatt v. Aderholt, 503 F.2d 1305, 1309 (5th Cir. 1974) (due process imposes on mental disability institutions the following minimum standards: "(1) a humane psychological and physical environment, (2) qualified staff in numbers sufficient to administer adequate treatment and (3) individualized treatment plans."); New York State Ass'n for Retarded Children v. Carey, 393 F. Supp. 715 (E.D.N.Y. 1975), *aff'd*, 596 F.2d 27 (2d Cir.), *cert. denied*, 444 U.S. 836 (1979) (rights in institutions for the mentally retarded); Halderman v. Pennhurst State School & Hosp., 446 F. Supp. 1295 (E.D.Pa. 1977), *aff'd in part*, 612 F.2d 84 (3d Cir. 1979), *rev'd*, 451 U.S. 1 (1981), *previous judgment aff'd*, 673 F.2d 647 (3d Cir. 1982), *rev'd on other grounds*, 465 U.S. 89 (1984); Welsch v. Likens, 373 F. Supp. 487 (D. Minn. 1974), *aff'd in part and remanded*, 550 F.2d 1122 (8th Cir. 1977).

22. Winick, *Civil Commitment Hearing*, *supra* note 17, at 39. Substantive and procedural limits on commitment were also imposed by the courts. *E.g.*, Lessard v. Schmidt, 349 F. Supp. 1078, 1103 (E.D. Wis. 1972), *vacated and remanded on other grounds*, 414 U.S. 473 (1974), *on remand*, 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated and remanded on other grounds*, 421 U.S. 957 (1975), *reinstated*, 413 F. Supp. 1318 (E.D. Wis 1976).

23. Winick, *Civil Commitment Hearing*, *supra* note 17, at 39-40.

24. Mental Disability Rights International ("MDRI"), established in 1993, is a non-governmental organization, devoted to the enforcement and international recognition of the rights of people with mental disabilities. MDRI documents and publishes reports about human rights abuses in Eastern Europe and Latin America. *See* http://www.mdri.org (last visited Nov. 15, 2002).

tional rights of those with mental illness.[25] In America, the constitutionalization of much of mental health law occurred in the 1960s and 1970s. By the late 1980s, as the Supreme Court grew more conservative, it was clear that mental health law had reached a point in its development when the Constitution would no longer be its driving force.[26] Mental health law needed a new paradigm, and as a result, therapeutic jurisprudence was born.[27] In the past fifteen years, mental health law in America has begun to shift from a legal to a therapeutic jurisprudence model that seeks to strike an appropriate balance between the legal rights and therapeutic needs of patients.[28]

If developments in mental health law in Eastern Europe follow the path of the American experience, the task of construing the various international human rights provisions that place limits on how those with mental illness are treated will be guided by principles of therapeutic jurisprudence. After describing the approach of therapeutic jurisprudence, this Article will suggest how its principles can be used in the effort to end abuses in the mental health system in Eastern Europe and to reshape international human rights law and practice in this area.

II. A THERAPEUTIC JURISPRUDENCE MODEL FOR CIVIL COMMITMENT

Therapeutic jurisprudence grew out of the scholarly work in mental health law that David Wexler and I each had been doing during the 1970s and 1980s. In our individual work, Wexler and I often criticized American mental health law doctrines and cases, not only using the usual tools of legal scholarship — case analysis and statutory and constitutional construction — but also insights from psychiatry, psychology, and sociology to condemn their antitherapeutic effects, and to suggest reforms that would improve the mental health of the individuals affected.[29] We were concerned that mental health law scholarship, as it was then being practiced, was insufficiently interdisciplinary in character, and that mental health law, as it then existed, was too doctrinal, constitutional, and rights-oriented.[30] American mental health law from the 1960s to the 1980s had largely focused on an attempt to apply to people with mental illness the constitutional rights that had been extended to criminal defendants and prisoners by the U.S. Supreme Court during the period when Earl

25. Brooks & Winick, *supra* note 15, at 237.

26. DAVID B. WEXLER & BRUCE J. WINICK, ESSAYS IN THERAPEUTIC JURISPRUDENCE 5 (1991) [hereinafter ESSAYS].

27. *Id.* at 7-8; DAVID B. WEXLER, THERAPEUTIC JURISPRUDENCE: THE LAW AS A THERAPEUTIC AGENT (David B. Wexler ed., 1990) [hereinafter THERAPEUTIC AGENT].

28. Winick, *TJ Model*, *supra* note 17; Bruce J Winick, *Outpatient Commitment: A Therapeutic Jurisprudence Analysis*, 9 PSYCHOL. PUB. POL. & L. (forthcoming 2003).

29. WEXLER & WINICK, ESSAYS, *supra* note 26, at x; *e.g.*, David B. Wexler, *Criminal Commitment Contingency Structures*, *in* PERSPECTIVES IN LAW AND PSYCHOLOGY: THE CRIMINAL JUSTICE SYSTEM 121 (Bruce D. Sales ed., 1977); Bruce J. Winick, *Psychotropic Medication and Competence to Stand Trial*, 1977 AM. B. FOUND RES. J. 769.

30. WEXLER & WINICK, ESSAYS, *supra* note 26, at 3.

Warren was chief justice.[31] American mental health law at that point was part of a civil liberties revolution that had started in the civil rights struggle of the 1960s.[32] It had developed principally to correct the abuses of state psychiatric power that then existed.[33] As originally conceptualized, civil commitment was based on a medical model in which deference was given to the expertise of psychiatrists or other physicians, who without effective judicial review, were authorized to commit patients based upon an assessment of whether their best interests required care and treatment in a psychiatric hospital.[34] This medical model granted too much deference to physicians to make the essentially legal determination of when an individual's fundamental liberty could be taken away. Perhaps predictably, it had produced arbitrary and sometimes-unnecessary deprivations of liberty for unnecessarily long periods of time. Patients were held, often indefinitely, in under-staffed and under-funded hospitals that functioned more as human warehouses than as treatment facilities.

Injecting the Constitution into the mental health system thus seemed an appropriate remedy to correct these abuses. But as the Supreme Court grew more conservative, mental health law scholarship and reform ran out of steam and seemed to lack direction.[35] David Wexler and I, therefore, thought that future reforms in mental health law required disentangling mental health law from its overwhelming dependence on American constitutional law.[36] We felt that it was time to put mental health back into mental health law.[37] A legal model of civil commitment had replaced the medical model, and it brought significant reforms. By severely restricting the standards for commitment and providing for hearings to increase the accuracy of their application, the legal model had already eliminated much of the arbitrariness of the medical model, significantly limited the category of individuals subject to hospitalization, and placed much needed emphasis on protecting the legal rights of the mentally disabled. The legal model had limited much of the restrictiveness of mental hospitals and the duration of commitment, protected the rights of patients within the institutions, limited the abuses of involuntary treatment, and brought public and judicial concerns to institutional abuses that resulted in their curtailment, and ultimately produced pressures that helped to lead to deinstitutionalization.[38]

The advances of converting civil commitment from a medical to a legal model had largely been achieved. Further reforms seemed unlikely to be obtainable through a scholarly and law reform approach that was exclusively

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31. *Id.* at 4.
32. *Id.* at 7.
33. *Id.*
34. Sydeman et al., *supra* note 17; Winick, *Civil Commitment Hearing*, *supra* note 17, at 39.
35. WEXLER & WINICK, ESSAYS, *supra* note 26, at 3-5.
36. *Id.* at 15.
37. *Id.* at 3.
38. Winick, *TJ Model*, *supra* note 17.

rights-based in its orientation. We saw the interdisciplinary approach that grew out of our own individual scholarship — which focused attention on the impact of mental health law on the psychological well-being of the patients it affected — as a new paradigm for mental health law scholarship and law reform.[39] We came to call this approach "therapeutic jurisprudence."

Therapeutic jurisprudence is an interdisciplinary approach to legal scholarship and law reform that sees law itself as a therapeutic agent.[40] Legal rules, legal practices, and the way legal actors (such as judges, lawyers, and expert witnesses testifying in court) play their roles impose inevitable consequences on the mental health and emotional well-being of those affected. Therapeutic jurisprudence advocates the study of these consequences with the tools of the behavioral sciences so that we can better understand law and how it applies, and can reshape it to minimize its anti-therapeutic effects and maximize its therapeutic potential. It is interdisciplinary in that it brings insights from psychology and the social sciences to bear on legal questions. It is empirical in that it calls for the testing of hypotheses concerning how the law functions and can be improved.

Therapeutic jurisprudence suggests that law should value psychological health, should strive to avoid imposing anti-therapeutic consequences whenever possible, and when consistent with other values served by law, should attempt to bring about psychological well-being. Unlike the medical model, it does not privilege therapeutic values over others. Rather, it seeks to ascertain whether the law's anti-therapeutic effects can be reduced and its therapeutic effects enhanced without subordinating due process and other justice values.[41] Therapeutic jurisprudence does not suggest that therapeutic considerations should outweigh other considerations. Law often serves other ends that are equally or more important. Therapeutic jurisprudence seeks convergence between therapeutic and other values, and suggests that such convergence is the path to true law reform.[42] When therapeutic and other values served by law conflict, therapeutic jurisprudence cannot resolve the conflict. Rather, therapeutic jurisprudence helps to make this conflict more visible and sharpens the issues for further debate. Sometimes therapeutic considerations may strongly outweigh other values, and thus point the way to law reform. Although the weighing of therapeutic against other values may be a task that some might describe as weighing apples and oranges, it is possible to weigh differing val-

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39. *See generally* WEXLER & WINICK, ESSAYS, *supra* note 26; BRUCE J. WINICK, THERAPEUTIC JURISPRUDENCE APPLIED: ESSAYS ON MENTAL HEALTH LAW (1997) [hereinafter JURISPRUDENCE APPLIED].

40. WEXLER &WINICK, ESSAYS, *supra* note 26; *see generally* LAW IN A THERAPEUTIC KEY: DEVELOPMENTS IN THERAPEUTIC JURISPRUDENCE (David B. Wexler & Bruce J. Winick eds., 1996) [hereinafter THERAPEUTIC KEY]; WINICK, JURISPRUDENCE APPLIED, *supra* note 39.

41. WEXLER & WINICK, ESSAYS, *supra* note 26; WEXLER & WINICK, THERAPEUTIC KEY, *supra* note 40; Bruce J. Winick, *The Jurisprudence of Therapeutic Jurisprudence*, 3 PSYCHOL. PUB. POL'Y & L. 184, 185 (1997).

42. *Id.*; WINICK, JURISPRUDENCE APPLIED, *supra* note 39.

ues, even those thought of as incommensurable.[43] When therapeutic and other normative values do not converge, creative solutions can often be found that permit maximized balancing among such values with a minimization of conflict.[44]

Therapeutic jurisprudence, therefore, is a scholarly approach for bringing mental health insights into the development and reshaping of law.[45]

Therapeutic jurisprudence has emerged as one of the most important influences on mental health law.[46] Since its inception in the late 1980s, it has gone considerably beyond mental health law and has spread across the legal landscape, emerging as a mental health approach to law generally.[47] Moreover, therapeutic jurisprudence has become increasingly international in character.[48]

Therapeutic jurisprudence thus examines legal rules, legal practices, and the roles of legal actors to assess their therapeutic impact and to see how they can be revamped to increase therapeutic outcomes.

As previously mentioned, the medical model of civil commitment has been replaced in America over the last fifty years with a legal model. Although grounded in paternalism and principles of beneficence, the medical model produced significant abuses. In societies that celebrate the value of individual liberty, the question of when it can be justifiably taken away must be regarded as a legal, rather than a medical, question.[49] Applying a medical model for civil commitment, therefore, was inappropriate. The legal model represents a significant advance, but it has its own limitations. Its exclusive focus on protecting the legal rights of patients sometimes prevents appropriate consideration of patient needs.[50] Therapeutic jurisprudence has been an attempt to remedy this deficiency by taking mental health law scholarship and law reform beyond an exclusively rights-based legal model. It calls for mental health laws and practices that not only respect patients' rights, but also their clinical and human needs. It seeks to strike an appropriate balance between

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43. Ken Kress, *Therapeutic Jurisprudence and the Resolution of Value Conflicts: What We can Realistically Expect, in Practice, from Theory*, 17 BEHAV. SCI. & L. 555, 566-87 (1999).

44. *Id.*; Bruce J. Winick, *Applying the Law Therapeutically in Domestic Violence Cases*, 69 U. MO.K.C. L. REV. 33, 79 (2000).

45. *See generally* Carrie J. Petrucci et al., *Therapeutic Jurisprudence: An Invitation to Social Scientists, in* THE HANDBOOK OF PSYCHOLOGY IN LEGAL CONTEXTS 579-601 (David Carson & Ray Bull eds., 2d ed. forthcoming 2003).

46. MICHAEL L. PERLIN, THE HIDDEN PREJUDICE: MENTAL DISABILITY ON TRIAL 261 (2000).

47. WEXLER & WINICK, ESSAYS, *supra* note 26.

48. *See* Symposium, *International Perspectives on Therapeutic Jurisprudence, Part I*, 17 BEHAV. SCI. & L. 553, 553-696 (Allan J. Tomkins & David Carson eds., 1999); *see also* Symposium, *International Perspectives on Therapeutic Jurisprudence, Part II*, 18 BEHAV. SCI. & L. 411-556 (Allan J. Tomkins & David Carson eds., 2000).

49. *See generally* WINICK, JURISPRUDENCE APPLIED, *supra* note 39, at ch. 4.

50. Winick, *TJ Model*, *supra* note 17.

legal and therapeutic considerations.[51] As a result, a therapeutic jurisprudence model for civil commitment has emerged, one that is more interdisciplinary in character and that seeks to reshape mental health law and apply it in ways that are more consonant with patient needs.[52]

III. CONSTRUING INTERNATIONAL HUMAN RIGHTS LAW THROUGH THE LENS OF THERAPEUTIC JURISPRUDENCE: RESOLVING VAGUENESS IN THE EUROPEAN CONVENTION FOR THE PROTECTION OF HUMAN RIGHTS AND FUNDAMENTAL FREEDOMS

The basic insight of a therapeutic jurisprudence model for civil commitment is that legal rules in the commitment area and how they are applied by judges, lawyers, and clinicians can have an important impact on the mental health and psychological well-being of the patient. Therapeutic jurisprudence considerations frequently will converge with many of the principles underlying international human rights protections for those with mental illness, such as the protection of liberty against arbitrary deprivation and a commitment to procedural fairness. When such convergence occurs, therapeutic jurisprudence can provide insights about how these principles should be applied. Even in areas in which international human rights law remains unsettled, therapeutic jurisprudence principles can point the way to law reform. By their nature, international human rights principles constitute somewhat vague commitments to shared values. This vagueness places the burden on international courts construing these international human rights provisions to spell out what they mean in particular circumstances. When it can be shown that a particular construction or application of an international human rights principle governing those with mental illness will have strong therapeutic advantages, in the absence of countervailing considerations that are highly valued by international law principles, international human rights law should move in the direction of being construed and applied so as to achieve therapeutic aims and avoid antitherapeutic effects.

A therapeutic jurisprudence model for civil commitment would raise several fundamental questions: What are the therapeutic consequences of defining civil commitment criteria in differing ways? What kinds of procedural rights should be accorded patients in the civil commitment process, and what is the impact of the civil commitment hearing on the mental health of those sought to be committed? Should those subjected to civil commitment enjoy a right to treatment? Should those subjected to civil commitment thereby be barred from exercising other rights, such as to manage their property or to vote during the period of their commitment? International human rights law should address these and other related questions, and should do so with a sensitivity

51. *Id.* at 5 (presenting a therapeutic jurisprudence analysis of mental health law that seeks convergence between legal and therapeutic values).

52. *Id.* at 4.

to the fact that its responses will have inevitable effects on the mental health of those affected.

In this section, I will examine these questions through an analysis of the most important international human rights decision in the area of mental health law in Europe, the 1979 decision of the European Court of Human Rights in *Winterwerp v. The Netherlands*.[53] There are, of course, a variety of other important civil commitment issues that could be analyzed through the lens of therapeutic jurisprudence,[54] but this Article will be limited to an analysis of the above questions, which were dealt with, at least preliminarily, in the *Winterwerp* decision. Let us, then, turn to a consideration of the *Winterwerp* case, the most important decision construing the European Convention for the Protection of Human Rights and Fundamental Freedoms' provisions dealing with the rights of those with mental illness.

A. *The Factual Background of* Winterwerp v. The Netherlands

In 1968, Fritz Winterwerp, a resident of The Netherlands, was committed to a psychiatric hospital pursuant to an emergency commitment procedure.[55] Six weeks later, the local court continued his hospitalization based on an application for commitment filed by his wife.[56] The reviewing court renewed the commitment order from year to year as a result of his wife's further applications and those of the public prosecutor, basing its actions on medical reports from the doctors who treated him. Winterwerp never received a hearing on these recommitment decisions, nor notice of the court orders, and never received legal assistance.[57]

Indeed, Dutch law at the time did not require that patients be notified of requests for their commitment, of physicians' applications in support of their need for hospitalization, or of the proceedings relating thereto.[58] Apart from being required to hear the public prosecutor, an administrative official, the court, and the reviewing court, were not required to follow any particular procedure.[59] Although it could have called for evidence or witnesses, heard the patient, granted him or her legal assistance, and consulted experts, the court need not have done any of these.[60] The court's decision, which need not have been furnished to the individual committed, did not need to occur at a public

53. 2 Eur. Ct. H.R. (ser. A) 387 (1979).

54. For a consideration of other such issues, including the medical appropriateness principle, the least restrictive alternative principle, conditional release, voluntary hospitalization, the right to refuse treatment, the use of advance directive instruments for those with mental illness, and outpatient commitment, among others, *see* Winick, *TJ Model, supra* note 17.

55. *Winterwerp*, 2 Eur. Ct. H.R. (ser. A) 387, 391.

56. *Id.*

57. *Id.*

58. *Id.* at 395.

59. *Id.*

60. *Id.*

hearing and was not subject to appeal.[61] Notification to the patient was left entirely to the discretion of the hospital and treated as a medical question.[62]

The law at the time allowed the patient to petition for release or partial release, and the public prosecutor, with the agreement of the doctor in charge of the institution, could order the patient's discharge if continued confinement was deemed unnecessary.[63] If the doctor disagreed with the patient's request for release, the public prosecutor could refer the matter to court.[64] At the expiration of the period covered by the commitment order, the hospital was required to inform the public prosecutor, who could request continued commitment based on a certification by the doctor in charge of the institution, that the patient's release would present a danger to public order.[65] Under the law at the time, an individual committed to a psychiatric hospital would automatically lose the legal capacity to administer his or her property.[66] As a result, the individual could no longer contract, transfer property, or otherwise manage his or her assets.[67] Legal capacity to manage property was restored only following discharge.[68] During the period of confinement, the court could appoint a guardian to manage the patient's property.[69]

Less than a year prior to his commitment, Winterwerp had received approximately six months of voluntary treatment at a psychiatric hospital, apparently as a result of brain damage he had previously sustained in an accident.[70] The events precipitating his commitment involved his detention by the police for stealing documents from a governmental office and his being found naked in a bed in a police cell.[71] The doctor's application accompanying his wife's petition alleged that he was "'a schizophrene, suffering from imaginary and Utopian ideas, who has for a fairly long time been destroying himself as well as his family' and that he 'is unaware of his morbid condition.'"[72] The court, in response, authorized Winterwerp's provisional detention without holding a hearing or seeking any expert advice.[73]

His commitment was extended from year to year, again without a hearing, based on medical records from Winterwerp's treating physicians stating that he suffered from "schizophrenic and paranoiac reactions" and had in the past performed irresponsible acts "without appreciating their consequences."[74]

61. *Id.*
62. *Id.*
63. *Id.* at 396.
64. *Id.*
65. *Id.*
66. *Id.* at 397.
67. *Id.*
68. *Id.*
69. *Id.*
70. *Id.*
71. *Id.*
72. *Id.* at 398.
73. *Id.*
74. *Id.* at 397-399.

Winterwerp had made several requests for discharge, the first of which the public prosecutor referred to the court, giving him a hearing at the hospital before denying his request.[75] Thereafter, his subsequent requests were denied after meetings with the public prosecutor.[76] In his requests for discharge, Winterwerp had asserted that he was "not mentally deranged, that he had been falsely accused of misdemeanors and that he did not constitute a danger to himself or to others."[77]

During his nine years of hospitalization, Winterwerp was allowed a number of leaves of absence from the hospital for periods of several months on an experimental basis.[78] Each time he was readmitted to the hospital, apparently because he had failed to take his medication.[79]

In addition to asserting that his commitment was arbitrary and without procedural regularity, Winterwerp alleged denial of "the right to appropriate treatment in order to ensure that he is not detained longer than absolutely necessary."[80] He asserted that, at the hospital his meetings with the psychiatrist were "too short and infrequent and that the medication administered to him was unduly made up of tranquilizers."[81] He also claimed that his automatic loss of capacity to administer his property constituted a determination of a civil right without an appropriate judicial procedure.[82]

B. *The Meaning of "Unsound Mind" as a Justifying Condition for Civil Commitment*

Winterwerp asserted that he had been deprived of his liberty in violation of the European Convention for the Protection of Human Rights and Fundamental Freedoms.[83] Article 5 of the European Convention is a broad protection of the liberty and security of the person.[84] Section 5(1) restricts the circumstances under which a government may deprive a person of liberty.[85] Subsection 5 (1)(e) authorizes detention of persons for the purpose of preventing the spread of infectious disease, of persons with "unsound mind," of alcoholics or drug addicts, or of vagrants.[86] The Convention does not define the term "unsound mind," and the Winterwerp court noted that the "term is not

75. *Id.* at 399.
76. *Id.*
77. *Id.*
78. *Id.* at 400.
79. *Id.*
80. *Id.* at 406.
81. *Id.*
82. *Id.* at 412.
83. European Convention for the Protection of Human Rights and Fundamental Freedoms, Sept. 3, 1953, 213 U.N.T.S. 222, amended by Protocols 3, 5 and 8, entered into force on Sept. 21 1970, Dec. 20, 1971 and Jan. 1, 1990 respectively [hereinafter Convention].
84. *Id.* § 5; *see generally* Lawrence O. Gostin, *Human Rights of Persons with Mental Disabilities*, 23 INT'L J.L. & PSYCHIATRY 125 (2000).
85. Convention, *supra* note 83 § 5(1).
86. *Id.* § 5 (1)(e).

one that can be given a definitive interpretation."[87] Rather, the court stated, "it is a term whose meaning is continually evolving as research in psychiatry progresses, an increasing flexibility in treatment is developing and society's attitudes to mental illness change . . . ."[88] The court, however, provided some clarification. The term, the court found, could not justify "the detention of a person simply because his views or behavior deviate from the norms prevailing in a particular society."[89] The term, the court noted, should be given a "narrow interpretation," in a manner that would achieve the Covenant's purpose, to prevent deprivations of liberty "in an arbitrary fashion."[90]

The court rejected Winterwerp's contention that his commitment had been arbitrary. Dutch law at the time had authorized civil commitment based upon a medical declaration that the patient is in a state of "mental illness" (a term not defined), and that it is necessary or desirable to treat him or her in a psychiatric hospital.[91] In addition, the court noted that under the practice then followed, commitment was authorized only if the individual's mental disorder was "of such a kind or of such gravity as to make him an actual danger to himself or to others."[92] In principle, therefore, the court found that Netherlands' law was in conformity with the Convention.[93] Turning to the facts of Winterwerp's case, the court agreed that "no one may be confined as 'a person of unsound mind' in the absence of medical evidence establishing that his mental state is such as to justify his compulsory hospitalization," and that this calls for "objective medical expertise" finding that the mental disorder is "of a kind or degree warranting compulsory confinement."[94] Furthermore, the court concluded that "the validity of continued confinement depends upon the persistence of such a disorder."[95] Finding no reason to question the "objectivity and reliability of the medical evidence" showing that Winterwerp had suffered from "schizophrenic and paranoiac reactions" of which he was unaware, and that on several occasions he had committed "some fairly serious acts without appreciating their consequences," the court rejected his contention that his confinement failed to meet the "unsound mind" requirement of the Convention.[96] Moreover, because it found that "gradual rehabilitation into society had failed," the court concluded that his continued confinement did not violate Article 5(1)(e).[97]

87. Winterwerp v. The Netherlands, 2 Eur. Ct. H.R. (ser. A) 387, 387, ¶37 (1979).
88. *Id.*
89. *Id.*
90. *Id.* at 401-402.
91. *Id.* at 392.
92. *Id.* at 402.
93. *Id.* at 405.
94. *Id.* at 402-403.
95. *Id.*
96. *Id.* at 404.
97. *Id.*

Although the European Court of Human Rights thus provided some clarification concerning the meaning of the term "unsound mind," its analysis could have gone considerably further. There must be mental illness objectively diagnosed, we are told, and it must be "of a kind or degree warranting compulsory confinement." The implication is that mental illness, although a necessary condition for civil commitment, is not a sufficient one. However, the court provided little guidance concerning when such illness is "of a kind or degree warranting compulsory confinement." Although mental illness causing the individual to be a danger to himself or others, the requirement under Dutch law at the time, would meet the test, the court did not clearly require that this standard be met in order to satisfy Article 5 (1)(e). The court's *Winterwerp* decision, therefore, leaves the contours of "unsound mind" substantially unexplored, and subsequent decisions of the European Court of Human Rights have shed little light on the question.[98]

The term "unsound mind" seems rather archaic, but we must recall that this language was chosen for use as a limitation on deprivations of liberty in 1953, when the European Convention for the Protection of Human Rights and Fundamental Freedoms was adopted.[99] What was the common understanding of the term "unsound mind" at that time? *Winterwerp* tells us that the meaning of the term is not frozen, but can change over time with advances in psychiatry,[100] and this is a most significant insight. But the inquiry should start with the question of what "unsound mind" must have been understood to mean in the early 1950s and earlier, when those who drafted and negotiated the European Convention for the Protection of Human Rights and Fundamental Freedoms developed their own ideas about the kind of mental disorder that would justify involuntary hospitalization. The term is found in Article 341 of the English Lunacy Act of 1890, which authorized the commitment of a person who was a "lunatic," defined as "an idiot or person of unsound mind."[101] Law dictionaries of the time shed considerable light on what may have been the common understanding of the term "unsound mind." Byrne's DICTIONARY OF ENGLISH LAW, published in 1927, defined "unsound mind" by referring the reader to "idiocy, insanity, lunacy, lunatic, mental deficiency, and non-compos

98. In *X v. United Kingdom*, 4 Eur. Ct. H.R. 188, 202 (1982), the court declared: "In its Winterwerp judgment, the court stated three minimum conditions which have to be satisfied in order for there to be 'the lawful detention of a person of unsound mind' within the meaning of Article 5 (1) (e): except in emergency cases, the individual concerned must be reliably shown to be of unsound mind, that is to say, a true mental disorder must be established before a competent authority on the basis of objective medical expertise; the mental disorder must be of a kind or degree warranting compulsory confinement; and the validity of continued confinement depends upon the persistence of such a disorder."

99. Convention, *supra* note 83.

100. Winterwerp v. The Netherlands, 2 Eur. Ct. H.R. (ser. A) 387, 401 (1979).

101. Lunacy Act of 1890, art. 341, XXVII THE LAW REPORTS (STATUTES) 106 (1890). A leading dictionary of English law in the period, cites the Lunacy Act of 1890 definition of "lunatic" in its definition of the term "unsound mind." W. J. BYRNE, DICTIONARY OF ENGLISH LAW 551 (1923, 1990).

"mentis."[102] Moreover, "idiot" is defined as a person "who from his birth, by a perpetual or incurable infirmity, is of unsound mind."[103] Today we would use the term "mental retardation" instead of "idiot." According to this dictionary, the term "lunatic" was used in law in three senses. It denoted "a person who has attacks of intermittent insanity separated by lucid intervals, or suffers from delusion."[104] It also referred to a person "who from unsoundness of mind is incapable of managing himself or his affairs . . . ."[105] In addition, it referred to "a person detained in an asylum on account of unsoundness of mind."[106]

STROUD'S JUDICIAL DICTIONARY OF WORDS AND PHRASES, published in England in 1953, defined "unsound mind" as "depravity of reason, or want of it."[107] THE DICTIONARY OF ENGLISH LAW, published in 1959, defined "persons of unsound mind" as persons afflicted with a mental illness affecting their reason . . . , as distinguished from idiots, imbeciles, feeble minded persons, and moral defectives . . . ."[108] Finally, let us examine an American entry of the period, the edition of BLACK'S LAW DICTIONARY published in 1957, which defined a "person of unsound mind" as "one from whom infirmity of mind is incapable of managing himself and his affairs," one who is "incapable of understanding and acting with discretion in the ordinary affairs of life."[109]

These dictionary definitions suggest a concept of "unsound mind" that equates with mental illness of a variety of kinds, and that produces functional impairment. Increasingly, the concept seems to be mental illness impairing the individual's ability to manage his property or affairs, or impairing his reasoning ability. Functional impairment might not have been an essential component of the term "unsound mind" in the 19th Century, but it was increasingly thought to be so by the middle of the 20th Century. Nineteenth Century thinking about mental illness was based on the belief that mental illness automatically destroys decision-making capacity.[110] At that time, people suffering from mental illness were regarded as globally incompetent, cognitively impaired in every area of functioning.[111]

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102. BYRNE, *supra* note 101, at 902.

103. *Id.* at 454.

104. *Id.* at 551.

105. *Id.*

106. *Id.*

107. STROUD'S JUDICIAL DICTIONARY OF WORDS AND PHRASES, 316 (John Burke ed., 1953).

108. THE DICTIONARY OF ENGLISH LAW 1335 (Earl Jowitts & Clifford Walsh eds., 1959).

109. BLACK'S LAW DICTIONARY 1708 (4th ed. 1957).

110. *E.g.*, Paul S. Appelbaum & Thomas Grisso, *The MacArthur Treatment Competence Study I: Mental Illness and Competence to Consent to Treatment*, 19 LAW & HUM. BEHAV. 105, 107, 108 (1995); Issac Ray, *American Legislation on Insanity*, 21 AM. J. INSANITY 21 (1864-5); Bruce J. Winick, *The MacArthur Treatment Competence Study: Legal and Therapeutic Implications,* 2 PSYCHOL. PUB. POL'Y & L. 137, 140 (1996) [hereinafter *MacArthur Study*]. The U.S. Supreme Court's review of the historical origins of the competency to stand trial doctrine in the criminal process cites several early 19th-century cases equating "insanity" with incompetence to stand trial. Cooper v. Oklahoma, 517 U.S. 348, 360-361 (1996).

111. Winick, *MacArthur Study, supra* note 110, at 140.

However, in the 20th Century, the law began to reject the notion that mental illness produces an automatic and generalized incompetence, moving instead in the direction of a presumption in favor of competence, even for those with mental illness, and requiring an adjudication of incompetence to perform a particular task or play a particular role before an individual could be deemed incompetent to engage in the conduct in question.[112] Under the modern conception, incompetency is not equated with mental illness, and is regarded as a functional and highly contextualized inquiry.[113] Indeed, in 1952, just prior to the adoption of the European Convention for the Protection of Human Rights and Fundamental Freedoms, the American National Institute of Mental Health proposed a draft Act Governing the Hospitalization of the Mentally Ill, that conceptualized incompetency to consent to mental hospitalization as loss of the power to make choices or confusion that renders the individual unable to make a decision having any relation to the factors bearing on hospitalization.[114]

Thus, the conception of mental illness that was emerging at the time of the adoption of the European Convention for the Protection of Human Rights and Fundamental Freedoms regarded mental illness not as a uniform phenomenon that always produced a generalized functional incapacity, but rather as a condition that sometimes does — but sometimes does not — impair functioning, and when it does so, often does not do so in a global fashion. "Unsound mind," the archaic language used in the Convention, therefore cannot be equated with mental illness, but seems to require a degree of functional impairment as well. When the *Winterwerp* court defined "unsound mind" as mental illness "of a kind or degree warranting compulsory confinement,"[115] it arguably was not simply delegating to psychiatrists the determination in individual cases of whether hospitalization was warranted. Rather, it was noting that not all mental illness warrants compulsory confinement, but only that of a certain "kind or degree," *i.e.*, producing functional impairment that bears on the need for hospitalization.

But what kind of functional impairment bears on the need for hospitalization? This question remains unexamined in *Winterwerp*. Yet it is the crucial question in determining the "nature or degree" of unsoundness of mind that would warrant hospitalization.

More recent developments in international human rights law begin to answer this question. In 1991, the United Nations adopted the *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental*

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112. *Id.* at 151-53.

113. *Id.* at 152 & n.86.

114. NAT'L. INST. MENTAL HEALTH, DRAFT ACT GOVERNING HOSPITALIZATION OF THE MENTALLY ILL (1952) (commentary), *cited in* Note, *Developments in the Law: Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1201, 1217 (1974).

115. Winterwerp v. The Netherlands, 2 Eur. Ct. H.R. (ser. A) 387, 403 (1979).

Health Care ("MI Principles").[116] The MI Principles were adopted by a resolution of the U.N. General Assembly, and as such, are not directly binding on member states.[117] However, they have strong persuasive force, representing, as they do, the most detailed and comprehensive statement of international principles governing the rights of those with mental illness.[118]

MI Principle 16 deals with involuntary commitment.[119] It limits involuntary hospitalization to people who have a mental illness diagnosed under internationally accepted medical standards.[120] In addition, it requires that there be a serious likelihood of immediate harm to the person or others, or if the person is severely mentally ill and has impaired judgment, a finding that there will be serious impairment of the individual's condition is required.[121] The MI Principles thus seek to limit commitment to those whose mental illness presents an imminent risk of serious harm to themselves or to others, or results in seriously impaired judgment that, without hospitalization, would lead to a serious impairment in their condition. In short, the MI Principles authorize two differing kinds of commitment grounded in two different governmental purposes – the police power interest in preventing harm to others,[122] and the *parens patriae* interest in preventing harm to an individual who is incompetent to protect himself or herself.[123]

When "unsound mind" or mental illness is the justification for depriving the individual of liberty through involuntary commitment, it should be of such a nature that it threatens public safety or produces significant functional impairment in ways that prevent the individual from exercising autonomy.[124] To suffice, the mental illness should be required to produce some resulting func-

116. *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*, G.A. Res. 119, U.N. GAOR, 46th Sess., Supp. No. 49, Annex, at 188-92, U.N. Doc. A/46/49 (1991) [hereinafter *MI Principles*].

117. Benko & Benowitz, *supra* note 13, at 9; Eric Rosenthal & Leonard S. Rubenstein, *International Human Rights Advocacy under the "Principles for the Protection of Persons with Mental Illness,"* 16 INT'L J.L. & PSYCHIATRY 257, 268 (1993).

118. Rosenthal & Rubenstein, *supra* note 117, at 259.

119. *MI Principles*, *supra* note 116, Principle 16.

120. *Id.*

121. *Id.*

122. The state's police power allows interventions to protect the public health and safety. Winick, *TJ Model, supra* note 17; Winick, *MacArthur Study, supra* note 110, at 138; *see* Note, *Developments in the Law: Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1222-28 (1974).

123. *See* Mills v. Rogers, 457 U.S. 291, 296 (1982); *see also* JOEL FEINBERG, HARM TO SELF 6 (1986) (analyzing *parens patriae* power); Winick, *TJ Model, supra* note 17; Winick, *MacArthur Study, supra* note 110, at 138-39; Bruce J. Winick, *Competency to Consent to Treatment: The Distinction Between Assent and Objection*, 28 HOUS. L. REV. 15, 16 & n.3 (1991) (discussing scope of government's *parens patriae* power); Bruce J. Winick, *Legal Limitations on Correctional Therapy and Research*, 65 MINN. L. REV. 331, 374 (1981) (examining government's *parens patriae* power to make decisions for those who are unable to make decisions for themselves); Note, *supra* note 114, at 1207-22.

124. Bruce J. Winick, *Ambiguities in the Legal Meaning and Significance of Mental Illness*, 1 PSYCHOL. PUB. POL'Y & L. 534, 567 (1995) [hereinafter *Ambiguities*].

tional impairment in a way that relates to the justifications for involuntary hospitalization.[125] The major mental illnesses that typically serve to justify involuntary hospitalization — schizophrenia, major affective depression, and bipolar disorder — would satisfy this condition.[126] They may render patients incompetent to appreciate the need for hospitalization and to engage in rational decision making about the question.[127] They may also prevent patients from controlling their conduct in ways that endanger themselves or others.[128]

Schizophrenia is a thought disorder that frequently produces hallucinations and delusions that distort reality and seriously interfere with rational decision-making.[129] Major depression and bipolar disorder produce alterations in mood that may also seriously impair rational decision-making.[130] In addition, those with schizophrenia, major affective depression, and bipolar disorder may be unable to control their behavior, thus endangering themselves or others.[131] Not all individuals suffering from these major mental illnesses will, of course, be rendered cognitively or volitionally impaired in ways that justify commitment.[132] The extent of functional impairment produced by these disorders differs widely within each diagnostic category, with the result that assignment of a particular diagnosis does not imply a specified level of impairment or disability.[133] In making diagnoses, clinicians are expected to conduct a separate inquiry into the patient's functional impairment.[134] These major

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125. *Id.* at 568.

126. *Id.*

127. *Id.*

128. *Id.*

129. "Schizophrenia . . . includes at least 1 month of active-phase symptoms (*i.e.*, two [or more] of the following: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior . . . ." AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 645 (4th ed. rev 1994) [hereinafter DSM-IV]; "At some phase of the illness Schizophrenia always involves delusions, hallucinations, or certain characteristic disturbances in affect and the form of thought." AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 343 (3d ed. rev 1987).

130. Major depression is defined as one or more major depressive episodes, which involves depressed mood for a period of at least two weeks accompanied by serious interference in functioning. DSM-IV, *supra* note 129, at 339. Bipolar disorder is defined as one or more manic episodes, characterized by elevated, expansive, or irritable mood, usually accompanied by one or more major depressive episodes, accompanied by serious interference in functioning. *Id.* at 350-51.

131. Some evidence suggests that the frequency of violent acts in schizophrenia may be greater than in the general population. *Id.* at 280. Suicide attempts are greater for those suffering from major depression. *Id.* at 322. Mania may cause "marked impairment" requiring hospitalization "to protect the individual" or others. *Id.* at 329.

132. *See* PAUL S. APPELBAUM & THOMAS G. GUTHEIL, CLINICAL HANDBOOK OF PSYCHIATRY AND THE LAW 218 (1991) ("The mere presence of psychosis, dementia, mental retardation, or some other form of mental illness or disability is insufficient to constitute incompetence."); Stephen J. Morse, *Crazy Behavior, Morals and Science: An Analysis of Mental Health Law*, 51 S. CAL. L. REV. 527, 578 (1978); Winick, *Ambiguties, supra* note 124, at 569.

133. DSM-IV, *supra* note 129, at XXIII.

134. *See id.* at 30 (Axis V permits the clinician to rate a person's psychological, social, and occupational functioning on a scale, the Global Assessment of Functioning ("GAF scale"), that assesses mental health-illness).

mental illnesses, in particular cases at least, may produce gross impairment of functioning, which may justify involuntary commitment.[135]

How "unsound" must an individual's mind be to justify civil commitment under the European Convention for the Protection of Human Rights and Fundamental Freedoms? When is mental illness "of a kind or degree" that would warrant compulsory confinement? These questions, left substantially unresolved by the European Court of Human Rights in its *Winterwerp* decision, can now be resolved if we take into account the civil commitment standards set forth in the MI Principles and our present understanding about the nature and effects of mental illness. To warrant compulsory confinement based on mental illness or "unsound mind," it should be required that the individual suffer from a condition that produces cognitive or volitional impairment that renders the patient incompetent in ways that serve as one of the two justifications for involuntary commitment, *i.e.*, that substantially impairs the patient's self-control in a manner that creates an imminent risk of harm to the patient or others, or that substantially impairs his or her ability to make rational decisions about the need for care and treatment. Such a circumscribed conception of "unsound mind" within the meaning of Article 5 (1)(e) of the European Convention for the Protection of Human Rights and Fundamental Freedoms would strike an appropriate balance between the values of individual liberty, beneficence, and societal protection.

Such a circumscribed conception of the mental illness that would justify involuntary hospitalization also is supported by principles of therapeutic jurisprudence. Hospitalization, although it can be beneficial for many suffering from the major mental illnesses, is not beneficial for all of them, even many who are severely mentally ill. The benefits that mental health treatment frequently produce can be provided in community facilities where the individual can develop and practice the community living skills that are needed to accomplish the restoration to functional capacity that is the goal of any enlightened system of mental hospitalization.

Moreover, mental hospitalization, particularly if for a lengthy period, can produce negative effects. For many patients, even those with serious mental illness, hospitalization can be iatrogenic, creating an institutional dependency that such facilities often condition in their inmates[136] and a form of learned

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135. Winick, *Ambiguities, supra* note 124, at 569.

136. *See* ERVING GOFFMAN, ASYLUMS: ESSAYS ON THE SOCIAL SITUATION OF MENTAL PATIENTS AND OTHER INMATES 3 (1961) (discussing the phenomenon of institutional dependence); Bruce A. Arrigo, *Paternalism, Civil Commitment and Illness Politics: Assessing the Current Debate and Outlining Future Direction*, 7 J.L. & HEALTH 131, 139 (1992-93) (civil commitment statutes); Richard Cole, *Patients' Rights vs. Doctors' Rights: Which Should Take Precedent?, in* REFUSING TREATMENT IN MENTAL INSTITUTIONS: VALUES IN CONFLICT 59 (A. Edward Doudera & Judith P. Swazey eds., 1982); Edmund G. Doherty, *Labeling Effects in Psychiatric Hospitalization: A Study of Diverging Patterns of Inpatient Self-Labeling Process*, 32 ARCHIVES GEN. PSYCHIATRY 562-63 (1975); Catherine K. Riessman et al., *Brief Versus Standard Psychiatric Hospitalization*, 2 COMMUNITY MENTAL HEALTH REV. 1, 9 (1977); *see also* Johnson v. Solomon, 484 F. Supp. 278, 308 (D. Md. 1979) ("Inappropriate and excessive hospi-

helplessness that debilitates motivation and effective functioning and produces a form of clinical depression.[137] Involuntary hospitalization in a psychiatric facility is also seriously stigmatizing, causing not only lasting social and occupational disadvantages for the patient,[138] but also affecting his or her self-concept in ways that reinforce feelings of incompetency and that undermine functioning and psychological well-being.[139]

These anti-therapeutic effects of involuntary psychiatric hospitalization would be augmented for individuals subjected to involuntary commitment who did not suffer from one of the major mental illnesses such as schizophrenia, major affective depression, or bipolar disorder. Although a psychiatric hospital would be medically appropriate for some people suffering from the major mental illnesses, it would offer scarce little therapeutic benefit for individuals with behavioral problems or "conditions" that fell outside of these categories.[140] Several forms of mental health treatment — counseling, behavioral therapy, cognitive behavioral therapy, and psychotherapy — may be helpful for people with behavioral problems. However, such treatment typically can be provided in community facilities on an outpatient basis, and does not require inpatient hospitalization.[141]

People with such behavioral problems may act in ways we disapprove of, and sometimes will cause harm to others. But, unless they also suffer from a

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talization fosters deterioration, institutionalization, and possible regression."); Winick, *Ambiguities, supra* note 124, at 583.

137. *See* MARTIN E.P. SELIGMAN, HELPLESSNESS: ON DEPRESSION, DEVELOPMENT, AND DEATH (1975); MARTIN E.P. SELIGMAN, HUMAN HELPLESSNESS: THEORY AND APPLICATIONS (1980); Lynn Y. Abramson et al., *Learned Helplessness in Humans: Critique and Reformulation*, 87 J. ABNORMAL PSYCHOL. 49 (1978); Robert F. DeVellis, *Learned Helplessness in Institutions*, 15 MENTAL RETARDATION 10 (1977); Steven F. Maier & Martin E. P. Seligman, *Learned Helplessness: Theory and Evidence*, 105 J. EXPERIMENTAL PSYCHOL. 33 (1976); J. Bruce Overmier & Martin E. Seligman, *Effects of Inescapable Shock Upon Subsequent Escape and Avoidance Responding*, 63 J. COMP. & PHYSIOLOGICAL PSYCHOL. 28 (1967); Martin E. P. Seligman, *Learned Helplessness*, 23 ANN. REV. MED. 407 (1972); *see also* SHARON S. BREHM & JACK W. BREHM, PSYCHOLOGICAL REACTANCE: A THEORY OF FREEDOM AND CONTROL 378 (1981) (discussing learned helplessness theory); LENORE WALKER, THE BATTERED WOMAN (1979) (applying learned helplessness theory to the battered woman syndrome); Christopher Peterson & Lisa M. Bossio, *Learned Helplessness*, *in* SELF-DEFEATING BEHAVIORS: EXPERIMENTAL RESEARCH, CLINICAL IMPRESSIONS, AND PRACTICAL IIMPLICATIONS 235 (1989); Jerry W. Thornton & Paul D. Jacobs, *Learned Helplessness in Human Subjects*, 87 J. EXPERIMENTAL PSYCHOL. 367 (1971); Winick, *Ambiguties, supra* note 124, at 584.

138. *See* Vitek v. Jones, 445 U.S. 480, 492 (1980); *Report of the Task Panel on Public Attitudes and Use of Media for Promotion of Mental Health*, *in* IV TASK PANEL REPORTS SUBMITTED TO THE PRESIDENT'S COMMISSION ON MENTAL HEALTH 864, 1870 (1978); Winick, *Ambiguities, supra* note 124, at 584.

139. *See* Kelly E. Piner & Lynn R. Kable, *Adapting to the Stigmatizing Label of Mental Illness: Foregone but not Forgotten*, 47 J. PERSONALITY & SOC. PSYCHOL. 805, 806 (1984); Bruce J. Winick, *The Side Effects of Incompetency Labeling and the Implications for Mental Health Law*, 1 PSYCHOL. PUB. POL'Y & L. 6, 13-23 (1995) [hereinafter *Incompetency Labeling*]; *see also* Albert Bandura, *Self-Efficacy Mechanisms in Human Agency*, 37 AM. PSYCHOLOGIST 122 (1982); Winick, *Ambiguities, supra* note 124, at 584

140. Winick, *Ambiguities, supra* note 124, at 558-60, 562-66.

141. *Id.* at 575-77.

major mental illness, their "condition" will not render them incompetent to engage in rational decision-making about the value of choosing to engage in mental health treatment.[142] They may have behavioral problems, but those problems will not produce cognitive impairment, at least of a serious kind. In short, they should not be deemed to be of "unsound mind."

To the extent there are police power reasons justifying an intrusion on their liberty to protect the safety of others, this purpose should be accomplished by means other than civil commitment to a psychiatric hospital. Because they do not suffer from mental illnesses that prevent them from controlling their behavior,[143] we should deal with their antisocial conduct through the criminal law. Unless the individual suffers from a condition of the kind that would make psychiatric hospitalization clinically appropriate, the prevention of conduct dangerous to others should not justify confinement in a psychiatric facility. Use of the mental hospital to isolate individuals from society for the purposes of community protection, or to warehouse those whose conduct or appearance is perceived as offensive or threatening to others, should be deemed inappropriate unless supported by a genuine therapeutic justification. Mental hospitals should not be used as prisons or as facilities for the confinement of dangerous individuals. Rather, their use should be limited to individuals suffering from mental illness, defined narrowly, who are able to experience the medical benefits such hospitals can provide. Moreover, requiring hospitals to house individuals who are not mentally ill in this sense can drain away scarce clinical resources from those who could most benefit from them, disrupt the treatment of other patients, and have a strongly antitherapeutic effect on the staff of such facilities, discouraging good clinicians from choosing to work there.

A narrower conception of the nature and degree of mental illness that would warrant involuntary hospitalization would not only protect liberty from arbitrary deprivation — the purpose of Article 5 of the European Convention for the Protection of Human Rights and Fundamental Freedoms — but also would seem therapeutically beneficial. Involuntary hospitalization should be reserved for those who are seriously, mentally ill and could benefit from psychiatric hospitalization and treatment. Those who are not mentally ill in this sense, but are given a variety of labels because of their antisocial or maladaptive behavior, are simply not appropriate for mental hospitalization.[144]

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142. *Id.* at 569.

143. *See* ROBERT D. HARE, WITHOUT CONSCIENCE: THE DISTURBING WORLD OF THE PSYCHOPATHS AMOUNG US 60 (1993) (discussing psychopaths); Winick, *Ambiguities, supra* note 124, at 568-69 (discussing antisocial personality disorder); *id.* at 579-82 (discussing personality disorders, conditions once labeled neurosis, and the impulse control and sexual disorders).

144. *Contra* Anderson v. The Scottish Ministers, PC (31st July 2000) [2001] UKPC D5. In this case, several convicted murderers were committed pursuant to an amendment to Scotland's Mental Health Law authorizing civil commitment of persons with "psychopathic personality disorder." Without analysis, the Judicial Committee of the Privy Council assumed that this

The *Winterwerp* case can be seen as beginning a movement in this direction, but the limits it placed on the concept of "unsound mind" did not go far enough. Developing international human rights law should go further and impose additional restrictions on civil commitment. The MI Principles point the way, and should be used to construe the vague concept of "unsound mind" in the European Convention for the Protection of Human Rights and Fundamental Freedoms.

C. *Procedural Requirements for Civil Commitment*

Article 5 (1)(e) of the European Convention for the Protection of Human Rights and Fundamental Freedoms also requires that civil commitment must occur "in accordance with the procedures prescribed by law."[145] In addition, Article 5(4) provides that a person "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."[146] Winterwerp challenged his detention under both of these provisions.

In construing Article 5 (1) (e), the court noted that the phrase "procedure prescribed by law" refers to the procedures required by domestic law, and that the provision simply requires compliance with that law.[147] Although the European Court of Human Rights has the jurisdiction to review whether domestic law has been followed, the proper interpretation of domestic law is a matter for the domestic courts.[148] Deferring to the interpretation of its law by the Netherlands courts in several respects, the *Winterwerp* court rejected several of his procedural claims and found that he was detained "in accordance with the procedure prescribed by law."[149]

Winterwerp also raised several procedural claims under Article 5 (4).[150] He argued that neither the official who made the initial decision to detain him, nor the public prosecutor who repeatedly continued his detention, possessed the characteristics of a court, as required by Article 5 (4).[151] The European Court of Human Rights agreed that these administrative officials were not courts within the meaning of the Convention, which contemplated bodies that are "independent both of the executive and of the parties to the case."[152] Even though the reviewing courts that approved his continued detention were courts in this sense, the *Winterwerp* court noted that Article 5 (4) would be satisfied

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condition constituted "unsound mind," and rejected their contention that their commitment violated Article 5(1)(e) of the Convention.

145. Gostin, *supra* note 84, at 140.

146. Convention, *supra* note 83, at § 5(4).

147. *Id.*

148. Winterwerp v. The Netherlands, 2 Eur. Ct. H.R. (ser. A) 387, 405 (1979).

149. *Id.*

150. Convention, *supra* note 83, at § 5(4).

151. *Id.*

152. *Winterwerp*, 2 Eur. Ct. H.R. (ser. A) at 405.

only if "the procedure followed has a judicial character and gives to the individual concerned guarantees appropriate to the kind of deprivation of liberty in question."[153]

The court concluded that "it is essential that the person concerned should have access to a court and the opportunity be heard either in person or, where necessary, through some form of representation, failing which he will not be afforded 'the fundamental guarantees of procedure applied in matters of deprivation of liberty.'"[154] The court noted that "mental illness may entail restricting or modifying the manner of exercise of such a right, but it cannot justify impairing the very essence of the right."[155] Because neither the district nor the reviewing courts, under the domestic law in force at the time, were obliged to hear the individual detained, and because Winterwerp was never notified of the proceedings nor of their outcome, and was not heard by these courts, the court found that Article 5 (4) was not satisfied.[156] Although Winterwerp was provided a hearing before the reviewing court on his initial application for release in 1969, his subsequent requests for release in 1971, 1972, and 1973, were rejected by the public prosecutor as without merit and not forwarded to the regional court.[157] While the public prosecutor gave Winterwerp a hearing at these points, these could not qualify as decisions taken by a court within the mandate of Article 5 (4).[158]

The *Winterwerp* court thus took seriously the Convention's commitment to a fair judicial process for determining the need for detention on the basis of mental illness. But *Winterwerp* was an easy case in this regard. It involved the total deprivation of a judicial hearing and of notice of the application for continued detention. The case, therefore, did not provide the court with an opportunity to specify what further details, if any, such a hearing would need to provide. Plainly, the hearing would need to comply with whatever domestic law requires in this regard. But is more required? This is left to developing principles of international human rights law.

Some further guidance on this point is provided by MI Principle 16, which specifies that involuntary detention or retention shall be for a short period of observation and treatment, as specified by domestic law, "pending review of the detention or retention by the review body."[159] MI Principle 16 also provides that "the grounds for the admission shall be communicated to the patient without delay and the fact of the admission and the grounds for it shall

153. *Id.* at 408.

154. *Id.* at 409.

155. *Id.*

156. *Id.* at 409-410.

157. *Id.* at 399-400.

158. The court also rejected the government's contention that, because Winterwerp had the opportunity to consult with counsel at various intervals, but never applied to the court through counsel, he cannot complain that he was denied the opportunity to take proceedings before a court. *Id.* at 411.

159. *MI Principles*, *supra* note 116.

also be communicated promptly and in detail to the review body."[160] Although it specifies additional details concerning the type of notice that is required and the promptness with which the hearing must be held, the MI Principles tell us little about other safeguards that the hearing must provide.

In the 1981 case of *X v. United Kingdom*, the European Court of Human Rights reiterated Article 5 (4)'s requirement of judicial review, noting that even when domestic law does not authorize periodic judicial review of continued detention, an individual detained is entitled "to take proceedings at intervals before a reviewing court to put in issue the 'lawfulness' of his detention."[161] In so doing, the court noted, "[I]t is not within the province of the court to enquire into what would be the best or most appropriate system of judicial review in this sphere, for the Contracting States are free to choose different methods of performing their obligations."[162] Declaring that to be a "court" within this requirement, the body in question must be independent of the executive and the parties to the case, the court noted that it need not be "a court of law of the classic kind," as long as it exhibits "the guarantees ('appropriate to the kind of deprivation of liberty in question') of [a] judicial procedure, the forms of which may vary from one domain to another."[163] One of these essential safeguards is notice, and the *X* court held that to satisfy the requirement, the individual must be "promptly and adequately informed of the facts and legal authority relied on to deprive him of his liberty."[164]

Article 5, therefore, contemplates that the individual be accorded adequate notice, a fair hearing before an independent court designed to ascertain whether the criteria under domestic law for involuntary hospitalization have been satisfied, and an opportunity for periodic judicial review of continued commitment. The specific safeguards provided at the hearing will, in the first instance, be a matter of domestic law. Until the European Court of Human Rights provides further clarification concerning the essential features of procedural fairness required, it will be up to domestic law to specify such details as whether the individual is provided the right to counsel, to present evidence and cross-examine adverse witnesses, and how the burden of proof will be allocated. The requirement of a civil commitment hearing is designed to minimize the risk of arbitrary deprivations of liberty, but also serves therapeutic ends.[165] Analysis of the procedural fairness of the commitment hearing, therefore, should also be concerned with the impact on the individual's mental health of the various safeguards provided at the hearing and how they are applied by the judge, attorneys, and expert witnesses involved in it.

160. *Id.*

161. X v. United Kingdom, 4 Eur. Ct. H.R. 188, 207 (1982).

162. *Id.* ¶ 53.

163. *Id.*

164. *Id.* ¶ 66.

165. *See generally* Tom R. Tyler, *The Psychological Consequences of Judicial Procedures: Implications for Civil Commitment Hearings*, 46 SMU L. REV. 433-45 (1992); Winick, *Civil Commitment Hearing*, *supra* note 17, at 38.

An important therapeutic jurisprudence insight is that, if properly conducted, the hearing can fulfill the individual's participatory or dignitary interest in ways that a body of literature on the psychology of procedural justice suggests would increase the efficacy of any hospitalization and treatment that is ordered.[166] If domestic law provides for a series of procedural safeguards, but they are applied in only a formal way by judges that rubberstamp the conclusions of the clinical experts and by attorneys that relax their adversary role in ways that make them appear to act in concert with the judge and clinical experts to facilitate commitment, the effects on the patient may be strongly antitherapeutic.[167] Practices of this kind can make the commitment hearing appear to the patient to be a farce and a mockery, a feeling that can undermine the participatory or dignitary value of the hearing. Patients subjected to such a sham ritual will loose trust and confidence in the judge, lawyers, and clinicians involved in the hearing, and will become suspicious of the genuineness of their purportedly benevolent intentions. Hearings of this kind can violate the need of patients to be treated with respect, politeness, and dignity, and to feel that their rights as citizens are acknowledged. These feelings can undermine their sense of self-esteem and self-efficacy, which can exacerbate their mental illness and foster a form of learned helplessness.[168] They may also have a significantly adverse impact on the ability of patients to respond successfully to hospitalization and treatment. By contrast, according patients a fair hearing that satisfies their need to be treated with dignity and respect can facilitate the goals of commitment, should it be ordered.

The literature on the psychology of procedural justice shows that such treatment increases litigant satisfaction and compliance with the outcome of the hearing.[169] Properly administered, the hearing can increase the patient's sense of trust and confidence in the judicial and mental health systems, and make it more likely that he or she will accept the outcome of the commitment hearing and respond more effectively to hospitalization. Properly performed, the hearing can also play an important educational role, and provide the patient with a degree of information control, facilitating his or her ability to deal with the stress of the commitment hearing and hospitalization.[170] The information given at the hearing can provide individuals with an opportunity to comprehend what is happening to them, enabling them to understand the reasons for commitment and the positive expectations that the judge and clinicians testifying at the hearing have concerning the outcome of hospitalization. Moreover, subjecting patients to a sham hearing at which they feel betrayed by their own lawyers and the judge can increase the feeling that they are being coerced. By contrast, treating them with dignity and respect and recognizing their need for

166. *Id.*
167. *Id.* at 43.
168. *Id.* at 45.
169. Tyler, *supra* note 165.
170. Winick, *Civil Commitment Hearing, supra* note 17, at 58.

voice, the ability to tell their stories, and validation, the feeling that what they have to say is being taken seriously, may enable them to avoid the negative effects of coercion and even allow them to feel that they have voluntarily chosen hospitalization.[171] This conclusion is supported by research conducted by the MacArthur Research Network on Mental Health and the Law, which found that patient perceptions of coercion are strongly associated with a degree to which the process accorded was seen to be characterized by procedural justice.[172] This research found that people feel they have not been coerced, even in coercive situations like civil commitment, when they perceive the intentions of governmental actors to be benevolent and they are treated with dignity and respect.

This research is especially significant when considered in connection with a body of theoretical work on the psychology of choice that suggests people perform more effectively and with greater motivation when they choose voluntarily to do something, and perform less effectively, with poor motivation and sometimes with psychological reactance, when they feel coerced into doing it.[173] Principles of cognitive and social psychology, including the goal setting effect, expectancy theory, intrinsic motivation, psychology of commitment, and cognitive dissonance in general, support the positive value of choice and the negative effects of perceived coercion. Recent empirical work confirms the conclusion that patients will respond more effectively to hospitalization if accorded the benefits of procedural justice.[174]

In light of the therapeutic value of according patients procedural justice at the commitment hearing, therapeutic jurisprudence would suggest the need for restructuring the role of the various actors at the hearing. Judges, lawyers, and clinicians need to understand the potential they have for applying the law therapeutically, and should restructure their behavior in order to realize this potential. They need to heed the lessons of the MacArthur work on coercion, and reframe their practices in ways that produce in the patient feelings of non-coercion. They need to make patients feel that they are being treated fairly, with dignity and respect, and accord to them a greater sense of voice and validation.

The role of counsel, in particular, needs to be played with sensitivity to these therapeutic considerations. Lawyers need to be aware of the literature on the psychology of procedural justice, the MacArthur research on coercion, and the literature on the psychology of choice. They also need to understand the

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171. *Id.* at 45.

172. Charles W. Lidz et al., *Perceived Coercion in Mental Hospital Admission: Pressures and Process*, 52 ARCHIVES GEN. PSYCHIATRY 1034, 1034-39 (1995); Bruce J. Winick, *Coercion and Mental Health Treatment*, 74 DENV. U. L. REV. 1145, 1158 (1997) [hereinafter *Coercion*].

173. *See* Winick, *Civil Commitment Hearing, supra* note 17, at 48; BRUCE J. WINICK, THE RIGHT TO REFUSE MENTAL HEALTH TREATMENT ch. 17 (1997); Winick, *Coercion, supra* note 172, at 1161.

174. Michele Cascardi et al., *Procedural Justice in the Context of Civil Commitment: An Analogy Study*, 18 BEHAV. SCI. & L. 731-40 (2000).

work of the MacArthur Research Network on Mental Health and the Law on competency, which demonstrates that many people with mental illness, even schizophrenia, are capable of decision-making about mental health treatment within a relatively normal range.[175] Attorneys, therefore, should play the adversarial role that procedural requirements contemplate, familiarizing themselves fully with the facts of the case before the hearing, interviewing the client and other witnesses, exploring available alternatives to commitment, counseling the client about possible dispositions, attempting to negotiate an alternative to commitment, protecting the client's rights at the hearing, and engaging in advocacy at the hearing in accordance with whatever the client's expressed wishes may be.[176]

As long as the client can evidence a consistent choice concerning hospitalization, and can justify it in ways that are not obviously irrational or otherwise the product of mental illness, the attorney should consider the client to be competent and should respect his or her decision either to accept voluntary admission or to oppose hospitalization. If the attorney believes that, under the circumstances, commitment is likely to be ordered by the court and would be appropriate for the client, he or she should recommend that course to the client. When the client agrees, the attorney should negotiate a form of voluntary or non-protesting admission in lieu of commitment, when it is available. When the client opposes admission, on the other hand, the attorney should play the adversarial role contemplated by the right of the patient to protest commitment, helping the client to achieve full participatory value from the hearing process.

Judges and clinicians also need training to sensitize them to the potential of the therapeutic roles they play so that their conduct can also enhance the therapeutic potential of the commitment hearing.[177] Judges play an especially important symbolic role. The literature on the psychology of procedural justice shows that people place a high value on how they are treated by legal authorities. Patients should be permitted to dress appropriately for the hearing, rather than in hospital garb, as sometimes occurs. The judge should treat the patient with respect and convey to the patient that the commitment process is designed for his or her welfare and that he or she will be treated with fairness and dignity.

The judge and the expert witness can provide the patient with an important sense of information control. By carefully and understandably conveying to the patient information about the hearing process and what will occur at the hospital if commitment is ordered, the judge can diffuse much of the stress

175. Applebaum & Grisso, *supra* note 110; Thomas Grisso & Paul S. Appelbaum, *The MacArthur Treatment Competence Study III: Abilities of Patients to Consent to Psychiatric and MedicalTreatment*, 19 LAW & HUM. BEHAV. 149-174 (1995); Bruce J. Winick, *Civil Commitment Hearing*, *supra* note 17, at 48.

176. Winick, *Civil Commitment Hearing, supra* note 17, at 53-54.

177. *Id.* at 57.

that the commitment process itself might produce. The judge and clinicians should address the patient directly, and attempt to communicate in his or her language, rather than in professional jargon.

If the expert witnesses recommend commitment, the reasons why this is so should be explained in ways that are understandable and convincing to the patient. A sense of optimism should be conveyed to the patient. Although the clinician feels that the patient suffers from a mental illness, he or she should be told that such an illness is likely to respond effectively to hospital treatment within a reasonably brief period. The use of psychotropic medication and other forms of treatment should be explained to the patient in ways that are calculated to persuade him or her as to their value.

The judge should listen attentively to the patient and convey the impression that he or she is important and will be given full consideration. If the judge concludes that commitment should be ordered, his or her decision should be explained to the patient, and the patient should be given the opportunity to have any questions that he or she may have about hospitalization answered. Whenever possible, the treating clinician should not also function as the expert witness testifying in favor of the patient's commitment. When this happens, the patient can conclude that the clinician is an enemy, a feeling that can seriously undermine the effectiveness of the clinician's treatment role.

If the hearing can be conducted in these ways, with sensitivity by the judge, attorneys, and expert witnesses to these therapeutic considerations, it can significantly increase the patient's perceptions of fairness, participation, and dignity. According patients procedural justice can increase the likelihood that they will accept the outcome of the hearing, will view that outcome as being in their best interests, and will participate in the hospitalization and treatment process in ways that will bring about better therapeutic results. If hearings are held in this manner, they can more effectively achieve the goals of hospitalization when it is necessary. Understood in this way, the requirement that patients be accorded notice and a fair opportunity to contest their hospitalization can both minimize arbitrary deprivations of liberty and achieve considerable therapeutic value.

D. The Right to Appropriate Treatment

Winterwerp also asserted that Article 5 (1)(e) of the European Convention for the Protection of Human Rights and Fundamental Freedoms entails "the right to appropriate treatment in order to ensure that he is not detained longer than absolutely necessary."[178] Asserting that the psychiatric sessions he received at the hospital were "too short and infrequent," and that the medication administered "was unduly made up of tranquilizers," he claimed that his right to treatment was violated.[179] The *Winterwerp* court dismissed this con-

178. Winterwerp v. The Netherlands, 2 Eur. Ct. H.R. (ser. A) 387, 406 (1979).
179. *Id.*

tention without analysis, concluding that a right to appropriate treatment cannot be derived from Article 5.[180]

Should international human rights law recognize a right to treatment? Should an individual be permitted to be deprived of liberty based on mental illness and detained in the hospital that provides no treatment or inadequate treatment? Because the government in *Winterwerp* vigorously denied the patient's contention that he received inadequate treatment,[181] the court's statement rejecting the existence of such a right under the Convention is a broad dictum and may not constitute a rejection of a right to treatment on different facts — when it is clear that no such treatment has been provided, or that the treatment provided was inadequate.

The question of whether the European Convention for the Protection of Human Rights and Fundamental Freedoms should recognize a legally enforceable right to appropriate treatment, therefore, should be regarded as an open one, *Winterwerp* notwithstanding. Because the essential protection provided by Article 5 is a right against arbitrary deprivation of liberty, it should be read to require, at least for patients who are treatable, a minimum level of treatment tailored to their clinical needs. Otherwise, detention based upon mental illness alone would seem to be an unreasonable and arbitrary deprivation of their liberty. The MI Principles, which are persuasive but not binding, recognize a right to appropriate treatment. MI Principle 8, Standard of Care 1, provides that "[e]very patient shall have the right to receive such health and social care as is appropriate to his or her health needs . . . ."[182]

The purpose of civil commitment grounded in the government's *parens patriae* power is to promote the best interests of individuals who, by reason of their mental illness, are incompetent to make decisions about hospitalization and treatment on their own behalf.[183] As a result, hospitalization in a facility that provides no or inadequate treatment tailored to the patient's needs would frustrate this justification for commitment, rendering such commitment an arbitrary deprivation of liberty. When the patient can survive safely in the community, hospitalization based upon the patient's need for treatment in a facility that fails to meet this need would constitute an unjustified infringement on his or her liberty.[184]

When the justification for civil commitment is the government's police power interest in protecting the community from his or her dangerousness,[185] the rationale for detaining the patient in a psychiatric hospital rather than a prison or preventive detention facility also would seem to be the promise of

180. *Id.* at 406-407.

181. *Id.*

182. *MI Principles, supra* note 116, Principle 8, Standard of Care 1.

183. Winick, *TJ Model, supra* note 17.

184. *See generally* O'Connor v. Donaldson, 422 U.S. 563 (1975) (construing Due Process Clause of the 14th Amendment of the U.S. Constitution).

185. *See supra* note 122 and accompanying text.

treatment for the mental illness to reduce the risk of his or her dangerousness. Otherwise, the use of a psychiatric hospital for this purpose, rather than a prison or a humane detention facility, would impose unnecessary limits on the individual's liberty and unnecessary stigma on the individual himself. Because treatment designed to reduce dangerousness can decrease the need for further hospitalization, when treatment is available that would accomplish this purpose; the failure to provide it would make the use of a psychiatric hospital for this purpose an arbitrary deprivation of liberty.

Some American courts have recognized the existence of a right to treatment in the Due Process Clause of the 14th Amendment to the U.S. Constitution.[186] In addition, many American states have provided for such a right as a legislative matter.[187] The inclusion of a right to appropriate treatment in the MI Principles reflects the absorption of this right into customary international human rights law.

Recognition of such a right to appropriate treatment is also strongly supported by considerations of therapeutic jurisprudence. The mental health of those institutionalized because of their mental illness would be substantially improved by the provision of needed services. The mental illnesses typically resulting in civil commitment — schizophrenia, major affective depression, and bipolar disorder — respond effectively to the increasing variety of psychotropic medications,[188] particularly if used in conjunction with other therapeutic techniques, including individual and group therapy, cognitive behavioral therapy, and various types of counseling, as well as a variety of social interventions.

Depriving patients of these needed treatments when they can restore the patient to a degree of functioning that will allow a return to community life not only would make hospitalization an unjustified deprivation of their liberty, but it could exacerbate their mental illness. Detention in a psychiatric hospital without needed treatment that, if successful, would ameliorate suffering and restore functioning would seem to be punitive, both as a legal matter and as a matter of patient perception. Because those who have been subjected to civil commitment have not been convicted of crime, it would offend principles of justice to punish them. However, the perception of punishment that patients hospitalized against their will would experience can also limit feelings of self-

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186. *E.g.*, Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971), *enforced*, 334 F. Supp. 1341 (M.D. Ala. 1971), 344 F. Supp. 373 (M.D. Ala. 1972), *aff'd in part, rev'd in part, and remanded in part sub nom.* Wyatt v. Aderholt, 503 F.2d 1305, 1309 (5th Cir. 1974) (due process imposes on mental disability institutions the following minimum standards: "(1) a humane physical and psychological environment, (2) qualified staff in numbers sufficient to administer adequate treatment and (3) individualized treatment plans").

187. *E.g.*, FLA. STAT. ANN. § 394.459 (2002).

188. Winick, *Ambiguities*, *supra* note 124, at 559; Jack A. Grebb, *Biological Therapies: Introduction and Overview*, *in* 2 COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 1574, 1575 (Harold I. Kaplan & Benjamin J. Sadock eds., 5th ed. 1989) (table 31.1-1 showing use of psychotropic drugs for these diagnostic categories).

determination and self-efficacy that might be essential to mental health, and could produce learned helplessness,[189] and an institutionalized personality syndrome.[190] It can also increase feelings of cynicism, resentment, distrust, and other negative emotions associated with being coerced and unjustifiably imprisoned, which can compromise the ability of future treatment to be effective.

Any system of mental hospitalization must take as its goal the restoration of the patient to as high a degree of functional normality as may be possible in the circumstances. Institutionalization without needed treatment not only fails to achieve this goal, but it substantially frustrates it. Unless hospitals are to be converted into prisons or human warehouses, they must be provided with sufficient funding to enable a full range of adequate treatment interventions tailored to the patient's needs that can facilitate his or her improvement and release within a reasonable period of time. The massive curtailment of liberty that involuntary psychiatric hospitalization entails can be justified only if such hospitalization is beneficial and not harmful to the mental health of those subjected to it. Societies that establish mental hospitals do so for putatively benevolent purposes. They must match their good intentions regarding those with mental illness with the commitment of adequate resources to allow mental hospitals to provide their essential function — the treatment of the patient. If a psychiatric hospital lacks adequate resources to provide a sufficient level of treatment to patients in need, or denies available treatment resources to such patients, it cannot fulfill this essential purpose.

Therapeutic jurisprudence considerations thus converge with the value that international human rights law principles place upon liberty and justice to favor a right of institutionalized patients to appropriate treatment. While international human rights tribunals, such as the European Court of Human Rights, may not be able to order that more funds be spent to provide additional clinical resources at psychiatric hospitals which lack adequate levels of treatment services, they can and should adjudicate that patients detained in such facilities who are denied treatment have thereby suffered an arbitrary deprivation of their liberty, and therefore order their release. While the *Winterwerp* court declined to find such a right to treatment to be protected by the European Convention, at least on the facts before it, in an appropriately egregious case involving detention in a psychiatric hospital without treatment, it should not hesitate to do so.

E. Automatic Divestiture of Right to Administer Property upon Civil Commitment

Winterwerp's final contention was that the automatic divestiture of his right to administer his own property that he experienced under Dutch law upon

189. Winick, *Incompetency Labeling*, *supra* note 139.
190. GOFFMAN, *supra* note 136.

being civilly committed constituted a violation of his civil rights under Article 6 (1) of the European Convention for the Protection of Human Rights and Fundamental Freedoms.[191] Article 6 (1) provides: "In the determination of his civil rights and obligations or of any criminal charge against him, everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law."[192] The European Court of Human Rights agreed with this contention, finding that the "capacity to deal personally with one's property" is a civil right within the protection of Article 6 (1).[193] The Court noted that the civil commitment hearing given to Winterwerp following his initial detention was concerned solely with the deprivation of his liberty, and therefore, could not be deemed to meet the separate requirements of Article 6 (1) for a fair hearing "on the question of his civil capacity."[194]

The Court's decision constitutes a rejection of the conception that "unsound mind" or mental illness always and automatically renders an individual incompetent to engage in rational decision-making. This had been the conception of mental illness that prevailed in the 19th Century.[195] This conception has been rejected by our advancing understanding of the nature of mental illness and by the thrust of modern mental health law reform.[196]

Recent research on treatment competency conducted by the MacArthur Research Network on Mental Health and the Law demonstrates that the *Winterwerp* court's approach was correct.[197] The MacArthur study shows that, although the decision-making capacity of people with mental illness is sometimes severely impaired, they are not always incompetent to make rational treatment decisions, and by extension, other decisions as well. This research, the most sophisticated and thorough attempt to study the issue ever undertaken,[198] demonstrates the need for individualized determinations of the competency question, rather than across-the-board presumptions that mental illness equates with incompetency to make various kinds of decisions.

By requiring a separate hearing to address the question of a patient's competence to manage his property, rather than presuming incompetence in this regard based upon satisfaction of civil commitment criteria, the *Winterwerp* court struck a blow for individual autonomy. The court's approach in effect erects a presumption in favor of competency, and the ability of an individual with mental illness to manage his own property and otherwise

191. Winterwerp v. The Netherlands, 2 Eur. Ct. H.R. (ser. A) 387, 413-14 (1979).

192. *Id.* at 412.

193. *Id.* at 390.

194. *Id.* at 414.

195. *See supra* note 101 and accompanying text.

196. *See supra* note 175 and accompanying text; Winick, *MacArthur Study, supra* note 110, at 152.

197. *See supra* note 175 and accompanying text; Winick, *MacArthur Study, supra* note 110 (analyzing the study and its legal and policy implications).

198. Winick, *MacArthur Study, supra* note 110, at 158.

make decisions on his own behalf. Unless found to be incompetent, following a fair hearing to engage in the specific kind of decision-making in question, the patient may not be deprived of other civil rights. These include not only the right to manage one's own property, but also the right to contract, to make a will, to vote, to marry, and to have custody of one's children.

This approach, in addition to promoting individual liberty, is supported by principles of therapeutic jurisprudence. Psychiatric hospitals too often have conditioned passivity and helplessness in their patients by reinforcing it and by discouraging assertiveness and autonomous behavior.[199] Mental patients too often have been infantilized by the treatment they receive from institutional clinicians and staff.[200] Treating patients as incompetent objects of paternalism may strongly reinforce feelings of incompetence, hopelessness, and diminished self-esteem and self-efficacy, destroying intrinsic motivation and even producing the syndrome of learned helplessness.[201] When others make decisions that significantly affect the individual, such as the management of his or her own property without the individual's participation, the resulting disuse of decision-making powers may lead to further degeneration of existing capabilities and behaviors.[202] Treating even institutionalized patients as incompetent to make decisions in other areas of their lives can actually promote psychological dysfunction. Exercising self-determination is a basic human need.[203] Allowing individuals to make choices for themselves is intrinsically motivating, whereas denying choice undermines their motivation, learning, and general sense of well-being.[204] The approach reflected in the *Winterwerp* decision can, therefore, do much to limit these antitherapeutic and dysfunctional effects that mental patients have been subjected to for too long.

IV. CONCLUSION: APPLYING INTERNATIONAL HUMAN RIGHTS LAW THERAPEUTICALLY TO REMEDY ABUSES IN THE MENTAL HEALTH SYSTEM OF EASTERN EUROPE

Do the abuses in the mental health system of Hungary and other Eastern European nations discussed in the Introduction to this Article violate the European Convention for the Protection of Human Rights and Fundamental Freedoms? Do they violate the principles reflected in the *Winterwerp* case, the most important one construing the Convention? Can international human rights lawyers use these tools to attack these practices?

199. *Id.* at 160.

200. *Id.*

201. *Id.* n.129; *see also* ELLEN J. LANGER, MINDFULNESS 5 (1989); DeVellis, *supra* note 136; Winick, *Incompetency Labeling, supra* note 139.

202. Winick, *MacArthur Study, supra* note 110, at 161; Bruce D. Sales & Lynn R. Kahle, *Law and Attitudes Toward the Mentally Ill*, 3 INT'L J.L. & PSYCHIATRY 391, 392 (1980).

203. *Id.*; EDWARD L. DECI, THE PSYCHOLOGY OF SELF-DETERMINATION 208 (1980) (discussing intrinsic motivation).

204. *Id.* at 209 (discussing studies).

Locked bed cages would seem to constitute an arbitrary deprivation of liberty in violation of Article 5 (1) (e) of the Convention. Although patients committed to psychiatric hospitals or social care homes have already been deprived of their liberty generally, locking them up in bed cages constitutes an additional and especially severe deprivation of their liberty. If done every night without a particularized showing of need, it would seem to be highly arbitrary. Moreover, as a separate deprivation of liberty, this practice should be permitted, if at all, only following a fair hearing. Even if domestic law makes no provision for such an additional hearing, Article 5 (4) of the Convention would seem to require such a hearing before an independent court which would give the patient the opportunity to protest this added deprivation of liberty.

Locking patients up in bed cages should never be permitted. If a patient is acting violently toward other patients or staff the problem should be dealt with by appropriately trained hospital personnel, and in appropriate circumstances, through the use of a brief period of seclusion or restraint.[205] Insufficient staff should not justify the use of locked bed cages any more than it would justify the use of chains or excessive administration of psychotropic medication to tranquillize patients in order to make them more manageable. Not only are locked bed cages an arbitrary deprivation of liberty, they also are highly antitherapeutic. Patients locked up each night in this way for reasons unrelated to their conduct, will inevitably have feelings of powerlessness, lowered self-esteem and self-efficacy, and depression, and are likely to experience a form of learned helplessness. Treating people in this way also will likely produce feelings of resentment, anger, and distrust of hospital staff that can seriously undermine the effectiveness of whatever treatment they are offered.

Psychiatric facilities that, because of inadequate staff and clinical resources, use locked bed cages, unmodified electroconvulsive therapy as punishment, or excessive psychotropic medication for management purposes also would seem to violate the right to appropriate treatment that I have argued Article 5 of the European Convention for the Protection of Human Rights and Fundamental Freedoms should be read to protect.[206] Similarly, psychiatric facilities that provide unsanitary living conditions containing rooms that smell of urine and feces, overcrowded and inadequate living facilities that deprive patients of needed privacy, and inadequate or inappropriate psychotropic medication or other treatment should be deemed to violate their patients' right to

205. *See MI Principles, supra* note 116, Principle 11("[P]hysical restraint or involuntary seclusion of the patient shall not be employed except in accordance with the officially approved procedures of the mental health facility, and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose.").

206. *See supra* Part III.D; *see also MI Principles, supra* note 116, Principle 8, Standard of Care 1 (right to receive appropriate health and social care); *id.* at Principle 8, Standard of Care 2 ("Every patient shall be protected from harm, including unjustified medication . . . or other acts causing mental distress or physical discomfort.").

appropriate treatment. Facilities that are so underfunded and understaffed that they cannot meet the clinical needs of their patients and use abusive practices that can further exacerbate their mental illness and cause them psychological damage, cannot fulfill the therapeutic promise that serves as the justification for civil commitment. Detention of patients in such facilities, therefore, should be condemned as an arbitrary deprivation of their liberty in violation of Article 5 (1) of the European Convention for the Protection of Human Rights and Fundamental Freedoms.

In addition, the practice of appointing plenary guardians with the power to commit their wards to psychiatric hospitals or social care homes also should be considered to violate Article 5 (1) of the Convention. Unless such patients themselves voluntarily consent to their admission to such facilities and are competent to do so, such commitment by guardians would constitute a deprivation of their liberty. When domestic law sanctions this practice, it constitutes a governmental deprivation of liberty[207] that would need to be justified on the ground of "unsound mind" as that term was construed in *Winterwerp* and as developing principles of international human rights law may come to define it.[208]

The guardian alone should not be permitted to make the determination that the ward suffers from "unsound mind" of a kind or degree that would warrant involuntary detention; rather, in accordance with Articles 5(1)(e) and 5(4) of the Convention, this determination should be made by a court that provides the individual with a fair procedural opportunity to protest his or her detention. Even if domestic law authorizes such a guardianship process, and compliance with it is therefore deemed to satisfy the requirements of Article 5 (1) (e), the patient still would possess the right under Article 5 (4) to protest his detention at a hearing before an independent court. The guardianship process, producing the functionally identical deprivation of liberty as civil commitment, should not be permitted to circumvent Article 5's substantive and procedural requirements for such a deprivation of liberty. Let us recall that it was Winterwerp's wife who initially had him admitted to a mental hospital. As his wife, she presumably had his best interests at heart and was functioning as a sort of guardian. Yet, she alone could not effectuate his admission to a mental hospital, however justified that might have been. As the court held in *Winterwerp*, there also needed to be judicial review of the basis for his commitment and an opportunity for him to protest his admission at a fair hearing held before an independent court.[209] The guardian cannot be deemed to be an independent court within the meaning of Article 5. If appointed by the state, the guardian would be an administrative official who, like the public prosecu-

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207. Nielsen v. Denmark, 11 Eur. Ct. H.R. 175, 193 (1988) (hospitalization of a minor by his mother held not to implicate Article 5 (1) of the Convention, which is limited to deprivations of liberty by the authorities of the state).

208. *See supra* Part III.B.

209. *See supra* Part III.C.

tor in *Winterwerp*, would not be deemed sufficiently independent of the political process to be considered a court within the meaning of Article 5.[210] If appointed by the patient for some purpose other than commitment, perhaps through an advance directive instrument or irrevocable power, the guardian still would not meet the definition of a court within *Winterwerp's* construction of Article 5 because the guardian would not be independent of the parties, one of whom would be the patient.[211]

Even if the guardian was appointed by the court, as a result, for example, of the patient's incompetence to manage his or her property, this should not authorize the guardian to effectuate the patient's civil commitment without an additional judicial hearing. *Winterwerp's* holding that the automatic deprivation of the patient's right to manage his own property as a result of his civil commitment constituted a violation of Article 6 (1) of the Convention would seem applicable in this context.[212] The court's decision in this regard represents a rejection of the concept of total incompetency resulting from mental illness. A determination that an individual is incompetent to manage his own property and requires the appointment of a guardian to act on his behalf in this regard cannot, consistent with *Winterwerp*, constitute a determination that his or her mental illness is of such a nature or degree as to warrant involuntary detention. A determination that an individual lacks competency in one area of functioning does not justify a presumption that he or she also is incompetent in another regard. Under *Winterwerp*, there must be a separate hearing on the question. The concept of plenary guardianship thus seems wholly at odds with the approach of *Winterwerp*.

Allowing guardians to effectuate hospital admissions without a hearing therefore should be deemed to violate the procedural protections of Article 5 of the Convention. Moreover, this practice would frustrate the therapeutic jurisprudence need for participatory and dignitary values to be respected in the commitment process.[213] The patient will experience feelings of being sold out by the guardian, if the guardian is a trusted friend or relative, and even if the guardian is a public official appointed to act on the patient's behalf in furtherance of his or her best interests. This feeling will provoke a sense of distrust in the legal and mental health system, and increase feelings of coercion, both of which will undermine the potential efficacy of hospitalization and treatment.[214] Moreover, if the guardianship admission process is permitted to deprive the patient of the right to have a hearing to protest his or her detention, denying the patient the sense of "voice" and "validation" that seem essential to litigant satisfaction and compliance with judicial determinations, and creating the feeling that he or she has been dealt with unfairly, the potential for a suc-

210. *See id.*
211. *See id.*
212. *See supra* Part III.E.
213. *See supra* Part III.C.
214. *Id.*

cessful adjustment to hospitalization and response to hospital treatment can be seriously diminished. Being treated in this way can also exacerbate the patient's sense of self-esteem and self-efficacy and produce feelings of helplessness, hopelessness, and depression that can be psychologically damaging.

Thus, many of the abusive practices in the mental health system of Eastern Europe can be understood to violate the European Convention for the Protection of Human Rights and Fundamental Freedoms and other evolving principles of international human rights law. The *Winterwerp* case and the policies it reflects, properly understood, condemn these abuses. International human rights lawyers should attack these practices, bringing them to public attention and seeking judicial redress from both domestic courts and the European Court of Human Rights.

The remedy for the abuses in the mental health system of Hungary and other Eastern European nations is a healthy dose of international human rights law and therapeutic jurisprudence. As that region moves from a medical, to a legal, to a therapeutic jurisprudence model of civil commitment, we can expect to see reforms in mental health law and practice that will both protect individual liberty and promote improved mental health and psychological well-being. The European Convention for the Protection of Human Rights and Fundamental Freedoms and other evolving principles of international human rights law will do much to spur this movement toward reform. Bringing the rule of law to the mental hospital will do much to limit abuses, and bringing therapeutic jurisprudence to mental health law and practice in Eastern Europe and to our construction of international human rights principles will do much to reshape law and practice in this area into a more effective tool for promoting the mental health of patients. A therapeutic jurisprudence model for civil commitment can do much to convert the mental health system in Eastern Europe into a more humane and therapeutic one that can provide help to those suffering from mental illness without in the process harming them.