Compilation of statements opposing the draft protocol to the Oviedo Convention of the Council of Europe

(dated 3 June 2019)

This compilation is not exhaustive and provide the most recent submissions and declarations related to the opposition to the draft additional protocol to the Oviedo Convention.

Coalition of organisations of persons with disabilities and service providers

- Open letter to the Council of Europe’s Secretary General regarding the draft additional protocol to the Oviedo Convention (2018)

Human Rights Watch (2018)

- “Council of Europe: A Threat to Rights of People With Disabilities”
- Human Rights Watch Letter to Mr. Jagland on the Additional Protocol to the Oviedo Convention

National Human Rights Institutions (NHRIs) / Equality bodies

- Statement of the European Network of NHRIs against the draft additional protocol to the Oviedo Convention (2018)
- The opinion of the French Ombudsman (Défenseurs des droits) on the draft Additional Protocol to the Oviedo Convention (2018) - Avis 18-29 du 5 décembre 2018 portant sur le projet de protocole additionnel à la Convention sur la protection des droits de l’homme et la dignité des personnes atteintes de troubles mentaux en matière de placement et de traitement involontaires (Convention d’Oviedo)
- Equality and Anti-Discrimination Ombud of Norway (2015)
European Union Agency for Fundamental Rights (FRA) (2015)

Council of Europe

- Commissioner for Human Rights
  - Comments by Dunja Mijatović, Council of Europe Commissioner for Human Rights on the draft Additional Protocol to the Convention on Human Rights and Biomedicine concerning the Protection of Human Rights and Dignity of Persons with Mental Disorder with regard to Involuntary Placement and Involuntary Treatment (2018)
  - Speech at PACE’s joint hearing on protecting the rights of people with psychosocial disabilities with regard to involuntary measures in psychiatry (2018)

- Parliamentary Assembly (PACE)
  - Draft resolution and recommendation on ending coercion in mental health: the need for a human rights-based approach (2019) - for discussion in PACE plenary in June 2019
  - Comments on the draft Additional Protocol to the Oviedo Convention, concerning the protection of human rights and dignity of persons with mental disorder with regard to involuntary placement and involuntary treatment (2018): Committee on Equality and Non-Discrimination; Committee on Social Affairs, Health and Sustainable Development

United Nations

- Statement by the UN Committee on the Rights of Persons with Disabilities (2018)
- Speech of the UN Special Rapporteur on the Rights of Persons with Disabilities at PACE’s joint hearing on protecting the rights of people with psychosocial disabilities with regard to involuntary measures in psychiatry (2018)
- Letter to the Council of Europe Secretary General on the draft additional protocol to the Oviedo Convention from mandates of the Working Group on Arbitrary Detention; the Chair of the Committee on the Rights of Person with Disabilities; the Special Rapporteur on the rights of persons with disabilities and the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (2017)
- OHCHR-ROE (2015)
#WITHDRAWOVIEDO

FORCED TREATMENT AND PLACEMENT VIOLATE RIGHTS OF PEOPLE WITH DISABILITIES AND THE UN CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES

Since 2014, under the mandate received from member states of the Council of Europe, the DH-BIO Committee of the Council of Europe has been working on a draft additional protocol to the Oviedo Convention concerning the protection of human rights and dignity of “persons with mental disorders”.

If adopted, this protocol would greatly undermine the rights of persons with disabilities:

- **Its text and spirit violate the UN Convention on the Rights of Persons with Disabilities (CRPD),** that has been ratified by 46 of the 47 Member States of the Council of Europe, including all the Member States of the European Union (see statement of the experts of the UN Committee on the Rights of Persons with Disabilities attached).

- **It would lead to further institutionalisation and forced treatment.** These practices are condemned by the UN Committee on the Rights of Persons with Disabilities and the UN Special Rapporteur on the Rights of Persons with Disabilities.

- **It would create a legal conflict between the obligations of States at the regional level (Council of Europe) and at the international level (United Nations).**

We, organisations of persons with disabilities, call for the **immediate withdrawal of the draft additional protocol to the Oviedo Convention.** We urge States to focus on and develop alternative measures to forced treatment and institutionalisation, in collaboration with organisations of persons with disabilities.
Our opposition to the draft additional protocol is supported by international experts, such as:

- Commissioner of Human Rights of the Council of Europe
- Parliamentary Assembly of the Council of Europe
- UN Committee on the Rights of Persons with Disabilities
- UN Special Rapporteur on the right to health
- UN Special Rapporteur on the rights of persons with disabilities
- UN Working Group on Arbitrary Detention

We welcome the opposition expressed by the States of Bulgaria, Portugal and the Former Yugoslav Republic of Macedonia and remain available to provide further information to Council of Europe member states on the discriminatory nature of this draft protocol and the many alternatives possible in compliance with the CRPD.

Autism-Europe
Disability Rights International
European Disability Forum
European Network of (ex)-Users and Survivors of Psychiatry
European Association of Service Providers for Persons with Disabilities
Inclusion Europe
International Disability Alliance
Mental Health Europe
Validity

More information is available on our websites:


European Disability Forum: http://www.edf-feph.org/withdraw-additional-protocol-oviedo-convention


Inclusion Europe: http://inclusion-europe.eu/?p=6848

Mental Health Europe: https://mhe-sme.org/drop-draft-oviedo-convention/
To:
Secretary General
Council of Europe
Avenue de l'Europe
F-67075 Strasbourg Cedex, France

CC:
Committee on Bioethics of the Council of Europe
Human Rights Commissioner of the Council of Europe

Brussels, 14 May 2018
Ref. EDF-018-19-YV

RE: Open letter to the Council of Europe’s Secretary General regarding the draft additional protocol to the Oviedo Convention

Dear Members of the Committee on Bioethics of the Council of Europe,

Foreseeing the session of the 13th plenary meeting of the Committee on Bioethics that will focus on the re-examination of the draft additional protocol concerning the “protection of human rights and dignity of persons with mental disorder with regard to involuntary placement and involuntary treatment” with a view to a decision to send it for opinion to other Council of Europe bodies/committees we, the European Disability Forum, European Network of (ex-) Users and Survivors of Psychiatry, Autism Europe, Inclusion Europe, Mental Health Europe and the International Disability Alliance continue to convey our deepest concerns and opposition to its adoption.

Despite opposition from the UN CRPD Committee, the Special Rapporteur on the rights of persons with disabilities, the Special Rapporteur on the right to everyone to the enjoyment of the highest attainable standard of physical and mental health, the Working Group on arbitrary detention, and organizations of persons with disabilities, including in particular those organizations representing persons with psychosocial and intellectual disabilities themselves which would suffer the most impact, the draft additional protocol continues to neglect both the letter and the spirit of the UN Convention on the Rights of Persons with Disabilities, to date ratified by 46 of the 47 Member States of the Council of Europe. Any authorization of involuntary treatment and institutionalisation of persons with disabilities constitutes a violation of the CRPD, in particular of articles 14 (liberty and security of the person), 15 (freedom from torture or cruel, inhumane or degrading treatment or punishment), 17 (protecting the integrity of the person) and 25 (right to health) of the Convention. Moreover, by going ahead with the draft, the Council of Europe disregards the concerns raised by its own Parliamentary Assembly, which stated that: “Ignoring the interpretation of the CRPD by its monitoring body established under international law would not only undermine the Council of Europe’s credibility as a regional human rights organisation, but would also risk creating an explicit conflict between international norms at the global and European levels.”

The Council of Europe Disability Strategy 2017-2023 recognises freedom from exploitation, violence and abuse as a priority area and calls for a mainstreaming of rights of people with disabilities in activities and work of the Council bodies, including the Oviedo Convention.
Therefore, the current draft additional protocol does not reflect the Strategy by disregarding people with disabilities’ rights.

Finally, in terms of the consequences, the adoption of the draft additional protocol instead of helping would create two conflicting tracks of human rights legislation causing much confusion and jeopardizing reforms already started in many countries.

In these circumstances, we are obliged to reiterate our position stated in the joint letter to the Committee on Bioethics of 14 November 2015, written together with European Network of (ex-)Users and Survivors of Psychiatry, Mental Health Europe, Autism Europe, the Europe Office of the UNHCHR, Mental Disability Advocacy Centre, the Centre for Disability Law & Policy National University of Ireland Galway and urge you to withdraw the draft proposal.

We also take this opportunity to mention that our organizations will not attend the upcoming meeting on Thursday 24 May 2018. Despite our previous active engagement in these meetings, our inputs have been systematically ignored and the process has not been fully transparent, as we, civil society, never endorsed any aspects of this draft additional protocol. It is very concerning that organizations of persons with disabilities are not consulted in a meaningful way in this process, in line with article 4.3 of the UN CRPD regarding “decision-making processes concerning issues relating to persons with disabilities.”

Finally, we note and deeply regret the generalized decrease of the Council of Europe’s commitment to respect, protect and advance the rights of persons with disabilities, as reflected in the Committee of Ministers’ recent decision to suspend all work and activities of the Ad Hoc Committee of experts on the Rights of Persons with Disabilities.

Yours sincerely,

Yannis Vardakastanis, President
European Disability Forum
www.edf-feph.org

Olga Kalina, Chair
European Network of (Ex)-Users and Survivors of Psychiatry (ENUSP)
www.enusp.org

Jan Berndsen, President
Mental Health Europe
www.mhe-sme.org

Maureen Piggot, President
Inclusion Europe
www.inclusion-europe.eu

Zsuzsanna Szilvasy, President
Autism-Europe
www.autismeurope.org

Colin Allen, Chair
International Disability Alliance
www.internationaldisabilityalliance.org
November 21, 2018 12:01AM EST

Available In   English   Français

Council of Europe: A Threat to Rights of People With Disabilities

Oppose Protocol for Detention, Forced Treatment; Provide Alternatives

The headquarters of the Council of Europe in Strasbourg. © 2018 Human Rights Watch

(Brussels) – Council of Europe member states should oppose new proposed standards regulating the detention and forced treatment of people with disabilities, Human Rights Watch said today. The body in charge of developing the standards, the Council of Europe’s Committee on Bioethics (DH-BIO), consisting of experts from each member state, is to meet on November 21, 2018 in Strasbourg.
and treatment of people with so-called “mental disorder” in Europe. The Council of Europe is an inter-governmental human rights organization consisting of 47 member countries, including the 28 European Union states.

“The Council of Europe prides itself in promoting the highest human rights standards, but the draft Additional Protocol to the Oviedo Convention goes against decades of hard-fought progress towards equal rights for people with disabilities.” said Lea Labaki, of the Disability Rights Division at Human Rights Watch. “European governments should publicly oppose the protocol and stop its further development.”

The UN Convention on the Rights of Persons with Disabilities (CRPD), which 46 out of 47 Council of Europe member states have ratified, guarantees people with disabilities, including people with psychosocial disabilities, or mental health conditions, equal rights to liberty and health care based on informed consent. The draft Additional Protocol risks undermining the human rights protections guaranteed in the CRPD and could lead to serious violations of the rights of people with disabilities, Human Rights Watch said.

Beginning in September, Human Rights Watch sent letters to Council of Europe member countries and key Council of Europe bodies calling on them to oppose the Additional Protocol and insist on its withdrawal. Six countries responded, all saying that they are considering their position.

Organizations representing people with disabilities, the UN Committee on the Rights of Persons with Disabilities, the UN special rapporteurs on health and disability and the Council of Europe’s own Parliamentary Assembly and Commissioner for Human Rights have called for withdrawing the draft Additional Protocol. Bulgaria, Portugal and the former Yugoslav Republic of Macedonia have publicly opposed it.

Involuntary detention on grounds of disability and particularly involuntary treatment of people with psychosocial disabilities inherently violates the rights of those subjected to them, including non-discrimination, liberty and security of the person, and the right to health. Such treatment may also violate the prohibition on torture and inhuman or degrading treatment.

Protection from discrimination, unlawful detention, and ill-treatment as well as the right to health are also established in the European Convention on Human Rights (ECHR).

To address abuses against people with psychosocial disabilities, the Council of Europe should instead encourage its member states to move away from coercive measures and provide them with guidance on rights-respecting alternatives to involuntary placement and treatment based on informed consent.
“By creating a framework for involuntary placement and forced treatment, the Additional Protocol undermines the fundamental rights and dignity of people with disabilities,” Labaki said. “Council of Europe members have a chance to stop this dangerous trajectory and instead lead on promoting the rights of people with disabilities with alternatives to force and coercion.”
Human Rights Watch Letter to Mr. Jagland on the Additional Protocol to the Oviedo Convention

September 4, 2018

Re: Additional Protocol to the Oviedo Convention

Dear Mr. Jagland,

We are writing to express our serious concern about the draft Additional Protocol to the Oviedo Convention concerning “the protection of human rights and dignity of persons with mental disorder with regard to involuntary placement and involuntary treatment,” currently being prepared by the Council of Europe.

We urge you to oppose the further development or adoption of the draft Additional Protocol.

Human Rights Watch is an independent international nongovernmental organization dedicated to defending and promoting human rights in more than 90 countries around the world. We have done extensive research on disability rights issues, particularly the rights of persons with psychosocial disabilities (mental health conditions) in countries around the world, including in Europe.

We strongly believe that the draft Additional Protocol to the Oviedo Convention is not only unnecessary but potentially very harmful to the protection of the rights of persons with psychosocial disabilities, as higher, pre-existing standards for their protection already exist, in particular, in the UN Convention on the Rights of Persons with Disabilities (CRPD), to which 177 states are party, including 46 out of 47 Council of Europe member states.
The CRPD, which has already been in force for a decade (since May 3, 2008), is the most comprehensive instrument protecting the rights of persons with disabilities. It is also one of the most widely ratified UN treaties. It constitutes the authoritative framework on the rights of persons with disabilities, including people with psychosocial disabilities, whom the draft Additional Protocol disturbingly refers to as persons with “mental disorder.”

The draft Additional Protocol to the Oviedo Convention contradicts and undermines the human rights standards set by the CRPD, insofar as it accepts and seeks to regulate involuntary treatment and involuntary placement of people with disabilities.

At the heart of the clash between the draft Additional Protocol and the CRPD are articles 12, 14 and 25 of the CRPD on equal recognition before the law, liberty and security of the person, and the right to health, respectively.

The CRPD provides that involuntary placement and treatment of people with disabilities is a violation of the right to equal recognition before the law and informed consent should be the basis of any healthcare provided to people with disabilities. In addition, the CRPD explicitly prohibits deprivation of liberty on the basis of disability. Under article 14, any involuntary placement of a person with “mental disorder” based on that “disorder” constitutes arbitrary and discriminatory deprivation of liberty, as only people with disabilities can be subject to it. Therefore, while the CRPD prohibits discrimination based on disability, the draft Additional Protocol facilitates it by diminishing protection for the category of persons with psychosocial disabilities. The draft Additional Protocol is proposing standards in direct contradiction to Council of Europe member states’ existing human rights obligations, creating an unnecessary and unhelpful conflict.

We understand the concerns that prompted the Committee of Ministers to call for the development of the draft Additional Protocol, noting the wide variation in practices across the Council of Europe region and number of cases brought before the European Court of Human Rights as a result of involuntary measures. Indeed, involuntary placement and involuntary treatment cause human rights violations in many countries around the world. Human Rights Watch has documented these abuses in many countries.

The cause of such human rights violations, however, is not a lack of standards or safeguards for the use of involuntary measures. Involuntary placement and particularly involuntary treatment of people with psychosocial disabilities inherently violate the rights of those subjected to them, including nondiscrimination, liberty and security of the person, right to health and may also violate the prohibition on torture and inhuman or degrading treatment. These protections are established in the European Convention on Human Rights (ECHR) and developed in the European Court of Human Rights’ jurisprudence. By creating a framework to facilitate involuntary placement and treatment, the Additional Protocol would sanction serious violations of these rights of people with disabilities.
To address abuses against people with psychosocial disabilities, states should develop alternatives to involuntary placement and treatment based on informed consent, that respect the rights guaranteed under the ECHR, and are in line with their obligations under the CRPD. Such alternatives already exist and can grow through information exchange and the sharing of good practices between member states.

Although the draft Additional Protocol supports promoting the use of alternatives to involuntary placement and involuntary treatment, it is not sufficient for human rights protection to have such measures operating in parallel while involuntary placement and involuntary treatment are allowed to continue in violation of human rights standards.

As we have noted the scope of issues identified in the draft Additional Protocol is already covered by the CRPD. Promotion of consistency of international human rights standards should be a goal with the adoption new human rights instruments, not as with the Additional Protocol, the creation of regressive, conflicting legal standards that provide weaker protections. As 46 Council of Europe member states are already parties to the CRPD, a far more constructive and productive route would be to adopt measures that reinforce positive changes underway to implement the CRPD.

We strongly urge you to oppose the draft Additional Protocol to the Oviedo Convention. By objecting to the draft Additional Protocol, you can be a leader for the rights of people with psychosocial disabilities in Europe and promote the development of alternatives to involuntary measures for people with psychosocial disabilities. We stand ready to collaborate and support you in this effort.

Yours sincerely,

Jane Buchanan
Deputy Disability Rights Director
Hugh Williamson
Europe and Central Asia Director

(Similar letters were sent by Human Rights Watch to a number of Council of Europe bodies and member states.)
## Statement of the European Network of National Human Rights Institutions (ENNHRI) on the Draft Additional Protocol to the Oviedo Convention

### The European Network of National Human Rights Institutions (ENNHRI):

- Calls upon the DH-BIO to withdraw the present version of draft Additional Protocol in view of the persisting concerns with the draft text, including those raised by the UNCRPD Committee, the Council of Europe’s Commissioner for Human Rights, the Council of Europe’s Parliamentary Assembly and its Committee on Equality and Non-Discrimination, and Committee on Social Affairs, Health and Sustainable Development.
- Calls upon Member States of the Council of Europe to ask for the withdrawal of the present version of the draft text and, if this draft is ultimately put to a vote, to oppose its adoption.
- Calls upon DH-BIO to ensure that any text relating to the deprivation of liberty of persons with disability includes the necessary procedural safeguards, and is subject to thorough, further consultations and dialogue with a broad range of stakeholders, including National Human Rights Institutions, disabled persons organisations and civil society at large.

In 2014, ENNHRI and its CRPD Working Group submitted its comments to the Council of Europe’s Committee on Bioethics (DH-BIO) on an earlier iteration of the draft Additional Protocol to the Convention on Human Rights and Biomedicine, also known as the “Oviedo Convention”. On that occasion, ENNHRI expressed a number of concerns about the overall form and approach of the draft, including that it was not coherent with the aims and wording of the UN Convention on the Rights of Persons with Disabilities.

Despite the notes of concerns from a broad range of stakeholders, including the Council of Europe’s Commissioner for Human Rights and the UN Committee on the Rights of Persons with Disabilities (UNCRPD Committee), DH-BIO has proceeded with working on the draft and is due to plan the finalisation of the draft Additional Protocol during its next meeting from 20-22 November 2018.

ENNHRI remains concerned about the current draft of the Additional Protocol. Particularly, we would like to point out that:

1. **The draft Additional Protocol creates the risk of a conflict between international norms at the global and European levels:** According to the UNCRPD Committee, the draft Additional Protocol still falls short of fully observing the spirit and provisions of the UN Convention on the Rights of Persons with Disabilities. The adoption of the Additional Protocol would result in fragmented, conflicting frameworks in the field of international human rights law for persons with disabilities. This lack of harmonised standards could hinder the efforts of Member States and bring confusion when implementing the necessary changes at the national level. This is particularly the case for those States who already engage in a constructive dialogue with the UNCRPD Committee. Finally, for National Human Rights Institutions (NHRIs) and disabled persons organisations (DPOs) the existence
of conflicting standards could debilitating their work for the promotion and protection of the human rights of persons with disabilities in Europe.

2. **As it stands, the draft Additional Protocol lacks clear, strong procedural safeguards to ensure respect for the rights of persons with disabilities:** As indicated by a number of stakeholders during the consultations on the draft Additional Protocol, including by the Council of Europe’s [Commissioner for Human Rights](mailto:info@ennhri.org), the draft does not adequately and sufficiently provide procedural safeguards to ensure respect for the rights of persons with disabilities in situations under the scope of the draft Additional Protocol. In addition, the draft as it stands lacks the necessary legal precision and, thus, risks undermining the already existing human rights standards at the regional and international levels.

3. **Different stakeholders have opposed the adoption of the draft, both at the level of the Council of Europe and the United Nations:** During the public consultation on the draft Additional Protocol, different voices within the Council of Europe have expressed their concerns about the draft, including the Commissioner for Human Rights. More recently, the Council of Europe Parliamentary Assembly’s Committee on Social Affairs, Health and Sustainable Development, and the Committee on Equality and Non-Discrimination, have expressed the view that the DH-BIO should “cease its work on the draft Additional Protocol”. At the UN level, the UNCRPD Committee’s Statement on the draft Additional Protocol strongly recommended States to oppose the adoption of the Additional Protocol.

**ENNHRI Recommendations**

ENNHRI is of the view that the drafting amendments are not sufficient to allay the fundamental concerns surrounding the Additional Protocol. The intention to move forward with the draft and finalise it in due time seems to contradict the prevalent, substantial criticism to the Additional Protocol, already explained in detail by a wide range of stakeholders during the consultation process.

ENNHRI is confident that the DH-BIO and all stakeholders share the same objective, that is, the promotion and protection of the human rights of persons with disabilities, including intellectual and psychosocial disabilities. Therefore, it encourages the DH-BIO to reconsider its priority to move forward with this version of the draft Additional Protocol. Instead, the expertise and resources of the DH-BIO could certainly fill important gaps in this field, always when aligned with the corps of international human rights law and in close consultation and cooperation with disabled persons organisations (DPOs), the UNCRPD Committee and NHRIs. For example, both the Council of Europe’s [Commissioner for Human Rights](mailto:info@ennhri.org) and [Parliamentary Assembly](mailto:info@ennhri.org) have proposed that the DH-BIO works on developing and promoting positive guidance and “good practice models” for alternatives to forced treatment, including devising measures to increase the involvement of persons with psychosocial disabilities in decisions affecting their health.

ENNHRI welcomes the example set by Portugal, Bulgaria and the former Yugoslav Republic of Macedonia, countries that have indicated their opposition to the draft Additional Protocol as it stands. We respectfully call upon Member States of the Council of Europe to ask for the withdrawal of this draft text and, if the draft is ultimately put to a vote, to oppose its adoption. Given the depth and significance of the matters concerned, thorough further consultations and dialogue with a broad range of stakeholders are vital. In this regard, Member States are encouraged to duly consider the UNCRPD Committee’s [Statement](mailto:info@ennhri.org) and the comments from the Council of Europe’s Commissioner for Human Rights on the draft Additional Protocol.
As a network of National Human Rights Institutions in Europe, gathered to work together in the promotion and protection of the rights of persons with disabilities in the region, ENNHRI welcomes the Council of Europe’s commitment to the principles of transparency, mutual respect and meaningful dialogue with different stakeholders. ENNHRI remains available to provide further information and look forward to continuing to engage in a constructive, transparent dialogue on this matter.

About the European Network of National Human Rights Institutions (ENNHRI)

ENNHRI, the European Network of National Human Rights Institutions, brings together 42 National Human Rights Institutions (NHRIs) from across wider Europe. ENNHRI’s mission is to promote and protect human rights across the European region. ENNHRI supports the development of European NHRIs by: advising on the establishment and accreditation of NHRIs; coordinating the exchange of information and good practice between members; organising capacity building and training on NHRI methodologies and human rights; building solidarity between European NHRIs; providing support for NHRIs under threat and facilitating NHRIs’ engagement with regional and international mechanisms.
Paris, le 5 décembre 2018

Avis du Défenseur des droits n° 18-29

Le Défenseur des droits,

Vu l’article 71-1 de la Constitution du 4 octobre 1958 ;

Vu la loi organique n°2011-333 du 29 mars 2011 relative au Défenseur des droits ;

Emet l’avis ci-joint sur le projet de protocole additionnel à la Convention sur la protection des droits de l’homme et la dignité des personnes atteintes de troubles mentaux en matière de placement et de traitement involontaires,

Le Défenseur des droits

Jacques TOUBON
I. Contexte


Lors de la mise en œuvre des dispositions de ce texte, le Comité de la Bioéthique (DH-BIO)¹ a constaté des lacunes juridiques dans certains États membres, notamment quant aux mesures de placement et de traitement involontaires. Face à cela, il s’est engagé en 2013 dans la préparation d’un projet de protocole additionnel à la Convention d’Oviedo, relatif à la protection des droits des personnes atteintes de troubles mentaux. Cette démarche a été soutenue par le Comité directeur pour les droits de l’homme (CDDH) et le Comité européen pour la prévention de la torture (CPT).

L’objectif de ce projet est de développer, dans un instrument juridiquement contraignant, les dispositions de l’article 7 de la Convention sur les droits de l’homme et la biomédecine², ainsi que celles de l’article 5 §1 (e) de la Convention européenne des droits de l’homme³ (CEDH), en énonçant des garanties fondamentales. De fait, le DH-BIO a constaté que plusieurs pays procédaient au placement involontaire de façon arbitraire, donnant lieu à un nombre important de violations des droits humains et la CEDH est régulièrement saisie d’affaires concernant des abus et graves violations résultant de ces mesures.

Aux fins de la préparation de ce projet, une audition d’OINGs représentant les différents secteurs concernés a été organisée en 2014. En 2015, le Comité a rendu public pour consultation un projet de protocole en tant que document de travail (DH BIO/INF (2015) 7) dans l’objectif de susciter des observations de la part de personnes et d’institutions représentant les différentes parties prenantes concernées. Durant cette consultation, un certain nombre d’organes de protection des droits de l’homme, dont le Commissaire aux droits de l’homme du Conseil de l’Europe et le Comité chargé du suivi de la mise en œuvre de la Convention internationale des droits des personnes handicapées (CRPD), ont fait part de leurs préoccupations fondamentales, en soulignant l’incompatibilité de son approche avec celle de la Convention internationale des droits des personnes handicapées (CIDPH), et ont demandé que la proposition visant à élaborer un protocole soit retirée⁴. En 2016, l’Assemblée Parlementaire du CoE (APCE) a été de même avis et a adopté une position contre

¹ Depuis 1985, le Comité ad hoc d’experts pour la bioéthique (CAHBI) devenu en 1992 le Comité directeur pour la bioéthique (CDBI), placé directement sous l’autorité du Comité des Ministres, est responsable des activités intergouvernementales du Conseil de l’Europe dans le domaine de la bioéthique. À compter de 2012, le CDBI est devenu le Comité de bioéthique (DH-BIO) et dépend du Comité directeur des droits de l’Homme (CDDH).

² « La personne qui souffre d’un trouble mental grave ne peut être soumise, sans son consentement, à une intervention ayant pour objet de traiter ce trouble que lorsque l’absence d’un tel traitement risque d’être gravement préjudiciable à sa santé et sous réserve des conditions de protection prévues par la loi comprenant des procédures de surveillance et de contrôle ainsi que des voies de recours ». 

³ « Toute personne a droit à la liberté et à la sûreté. Nul ne peut être privé de sa liberté, sauf dans les cas suivants et selon les voies légales : e) s’il s’agit de la détention régulière d’une personne susceptible de propager une maladie contagieuse, d’un aliéné, d’un alcoolique, d’un toxicomane ou d’un vagabond ». 

un instrument juridique sur les mesures involontaires en psychiatrie. Le Comité ad hoc d’experts sur les droits des personnes handicapées (CAHDPH) a aussi émis son avis sur la question.

En dépit de ces positions, le 9 novembre 2016, le Comité des Ministres a adopté une réponse favorable au projet, considérant en particulier que le Protocole additionnel « contribuerait à la prévention des abus et faciliterait la transition progressive vers une application plus uniforme par les États membres des mesures volontaires en psychiatrie, dans l’esprit de la Convention des Nations Unies relative aux droits des personnes handicapées ».

Sur cette base, en décembre 2016, le DH-BIO a repris le travail sur le projet de protocole à la lumière des commentaires reçus lors de la consultation publique de 2015. Les propositions de révision de ce projet ont été présentées et discutées le 24 mai 2018, lors de la 13ème réunion du Comité. À cette occasion, il a été décidé que ce texte fera prochainement l’objet d’une nouvelle consultation auprès des entités concernées5, pour un avis jusqu’au 5 novembre 2018.

Le nouveau projet de protocole révisé a été rendu public. Son texte s’est amélioré : certains termes dépassés ont été substitués et plus de garanties y sont prévues, comme la personne de confiance et celles concernant l’isolement et la contention. Toutefois, son approche – controversée – reste la même.

Lors de la 20e session (tenue entre le 27 août et le 21 septembre 2018), le CRPD a émis un avis défavorable au nouveau projet et demande aux États parties de la CIDPH aussi membres du Conseil de l’Europe de se positionner contrairement à ce document6. En effet, le Comité soulève que le projet de protocole est contraire aux articles 12 (droit à la personnalité juridique), 14 (droit à la liberté et sécurité), 17 (droit à l’intégrité) et 25 (droit à la santé et au consentement aux soins) de la Convention. Le Portugal, la Bulgarie et l’Ancienne République Yougoslavie de Macédoine se sont aussi positionnés contre le texte.


Le 8 novembre 2018, la Commission aux droits de l’homme du CoE a rendu public son avis contre le projet, en suivant les observations déjà présentées par son prédécesseur, Nils Muïžnieks. La Conférence des OING a aussi rendu publique la consultation faite sur ce sujet, qui montre que la majorité de ces organisations s’opposent au protocole. À ce jour, les avis des autres organes consultés n’ont pas été rendus publics.

Une réunion au sein du DH-BIO afin d’analyser les avis et de déterminer la suite des travaux a été fixée du 20 au 23 novembre 2018. Dans ce cadre, le 6 novembre dernier, le ministère des Affaires

5 À savoir le CDDH, le CPT, l’Assemblée parlementaire, la Commission aux droits de l’homme, la Conférence des OING et le Comité européen pour les problèmes criminels (CPCD) – ce dernier concernant l’applicabilité du protocole aux personnes faisant l’objet d’une mesure involontaire pour répondre à un état de santé mentale pendant qu’elles purgent une peine de prison ou qu’elles sont en détention, mais sans que la mesure ait un rapport avec une infraction pénale (celle à l’origine de l’emprisonnement ou de la détention ou une autre).

6 « The Committee strongly recommends that all States parties to the Convention on the Rights of Persons with Disabilities who are members of the Council of Europe explicitly oppose the adoption of the Additional Protocol to the Oviedo Convention » (CRPD, Statement by the Committee on the Rights of Persons with Disabilities calling States parties to oppose the draft Additional Protocol to the Oviedo Convention, 21 août – 21 septembre 2018).
étrangères français a demandé au Défenseur des droits ses observations éventuelles sur le projet avant le 19 novembre 2018.

II. Problématique

La polémique qui existe autour de ce projet concerne l’encadrement de la pratique du traitement sans consentement, comme l’administration forcée de médicaments, les mesures de mise en isolement et sous contention, l’électroconvulsivothérapie forcée et du placement forcé en institution. Le caractère préjudiciable de ces mesures pour l’amélioration de l’état de santé des personnes qui les subissent fait l’unanimité et, selon le DH-BIO, le projet de protocole n’a pas pour objectif de les promouvoir. La question se pose quant à l’opportunité de les encadrer.

D’un côté, comme l’affirment plusieurs institutions de protection des droits de l’homme, le traitement involontaire est contraire à la CIDPH et ne doit pas être encouragé : l’encadrer signifierait le rendre acceptable. De l’autre côté, comme l’affirme le Conseil des Ministres, le DH-BIO et la Direction des droits de l’homme et État de droit, encadrer cette pratique permettrait de limiter des abus, de combler un vide juridique dans certains États membres et d’offrir plus de garanties aux personnes qui subissent de tels traitements.

En outre, il est inévitables de noter que le projet de protocole en question est très similaire à la législation française sur les soins sans consentement. Le débat sur la conformité à la CIDPH peut donc être transposé en France (ce qui a d’ailleurs déjà été soulevé par la Rapporture de l’ONU, Catalina Devandas, lors de sa visite en 2017).

L’approbation de ce protocole facultatif soulèvera aussi un conflit entre deux normes de droit international, l’une au niveau universel (onusien) et l’autre au niveau régional (européen). Soutenir ce projet signifie créer une confusion au sein des États membres, d’autant plus que l’Union européenne a ratifié la CIDPH, et aura pour effet d’affaiblir la portée de cette dernière.

III. Une approche contraire à la CIDPH

Il est important de noter que la base légale de ce projet de protocole est antérieure à la CIDPH. La Convention impose un changement de paradigme en remplaçant les approches médicales et caritatives du handicap par une approche fondée sur les droits de l’homme et place la dignité des personnes au rang des principes généraux (article 3). Son article 14 §1 (b) interdit toute privation de liberté fondée uniquement sur le handicap. Dans sa directive sur cet article, le CRPD affirme que l’ajout d’autres critères, tels que la dangerosité pour soi ou pour autrui, n’est pas suffisant pour justifier une telle privation. Ainsi, selon le CRPD, toute loi sur la santé mentale prévoyant des soins sans consentement est incompatible avec la Convention.

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10 CRPD, Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities, adopted during the Committee’s 14th session, held in September 2015 (en anglais).
En tant que mécanisme national de suivi, le Défenseur des droits ne peut que constater, comme l’ont fait plusieurs organes internationaux et experts, que le projet de protocole en question est contraire à la CIDPH. Il suit le Commissaire aux droits de l’homme du CoE, qui a souligné que « le conflit avec la CIDPH ne se limite pas au principe de l’acceptabilité des placements involontaires : il concerne également le langage stigmatisant et archaïque utilisé dans le projet de protocole additionnel (comme les personnes atteintes de "troubles mentaux"), son approche discriminatoire et son indifférence aux besoins de soutien positif des personnes concernées afin de renforcer leurs droits fondamentaux ».

De même, il rejoint la Commission des questions sociales, de la santé et du développement durable qui affirme que : « comme il n’est pas conforme à la CIDPH et n’intègre pas le changement de paradigme qu’elle introduit, le protocole additionnel ne pourra pas faciliter la transition progressive vers une application plus uniforme par les États membres des mesures volontaristes en psychiatrie, dans l’esprit de la CIDPH ».

Le Défenseur des droits rejoint aussi la Commission sur l’égalité et la non-discrimination qui affirme que « le protocole additionnel risque donc de cristalliser des normes qui sont non seulement aujourd’hui en conflit avec la CIDPH mais qui s’avéreront rapidement moins exigeantes que celles de la CEDH telles qu’interprétées par la jurisprudence de la Cour ».

Ainsi, l’approbation de ce protocole additionnel au sein du CoE créeait une insécurité juridique due à un conflit de normes de droit universel (onusien) et de droit régional – pallié jusqu’à présent par la jurisprudence de la Cour européenne des droits de l’homme – et affaiblirait la portée de la CIDPH dans les États membres.

IV. Une solution qui ne s’avère pas effective en pratique

Selon l’ancien Commissaire aux droits de l’homme du CoE, « il faudrait, au contraire, commencer par se demander comment éviter la coercition et comment aider au mieux la personne concernée à faire des choix en matière de soins. Pourtant, les États se sont davantage attachés à concevoir des garanties et des contrôles juridictionnels, qui souvent ne fonctionnent pas dans la pratique ».

Dans ce sens, les réponses proposées par le projet de protocole en question se basent sur un système établi et qui s’avère déjà insuffisant dans les États qui le mettent en œuvre. Comme l’ont affirmé différents organes, l’insertion de ces garanties dans les textes de loi n’empêche pas, en soi, les abus. En effet, même dans les pays où ces garanties sont déjà prévues juridiquement, comme c’est le cas de la France, des violations aux droits des personnes persistent. De plus, l’encadrement de mesures de traitement ou de placement sans consentement a comme conséquence un surcroît des recours à celles-ci et non pas un recul.

Le système français de soins sans consentement, prévu par la loi du 27 septembre 2013, est en effet très similaire à celui prévu par le projet de protocole en question, notamment au niveau des garanties (droit à un avocat, accès au juge, personne de confiance…). En 2017, une analyse de la mise en œuvre de cette loi a été faite par la Commission des affaires sociales de l’Assemblée nationale.

11 Commissaire aux droits de l’homme, Commentaires de Dunja Mijatović au projet de Protocole additionnel à la Convention d’Oviedo, 8 novembre 2018, §8, en anglais.
12 Commission des questions sociales, de la santé et du développement durable, Commentaires sur le projet de Protocole additionnel à la Convention d’Oviedo, adoptés le 11 octobre 2018, p. 3.
française. Dans ce rapport\textsuperscript{16}, une augmentation des patients sous contrainte a été constaté depuis la mise en œuvre de cette loi. En outre, s’agissant des droits des personnes admises en soins psychiatriques sans consentement, « un important hiatus [est constaté] entre les progrès opérés par la loi de 2013 en matière de garantie des libertés individuelles et leur traduction concrète dans le quotidien des usagers, notamment en raison d’une insuffisance de moyens humains et financiers, mais aussi en raison du degré d’implication des acteurs sur le terrain » et d’une diversité de pratiques (aussi bien en matière d’information des patients sur leurs droits, d’établissement des certificats médicaux, d’isolement et de contention que de conduite de la procédure, de déroulement de l’audience et de taux de mainlevées judiciaires).

De surcroît, le Contrôleur général les lieux de privation de liberté (CGLPL), autorité française indépendante, a publié en 2016 un rapport sur les mesures d’isolement et de contention dans les établissements de santé mentale en France\textsuperscript{17}. Il constate, au cours de ses visites, que « l’hôpital, havre de soins, laisse se perpétrer et se perpétuer, au fond de ses unités, des pratiques qui s’apparentent, dans certaines conditions, à des traitements inhumains et dégradants »\textsuperscript{18}.

Ainsi, contrairement à l’idée selon laquelle cet instrument faciliterait la transition progressive vers une application plus uniforme des mesures volontaires en psychiatrie par les États membres, il contribue à sa légitimation et rend plus difficile son dépassement. En maintenant le statu quo qui est à l’origine des violations des droits, le projet de protocole propose donc une solution inadaptée.

V. Des situations exceptionnelles à ne pas ignorer

Le Défenseur des droits s’aligne sur les différents organes et experts qui affirment que la solution consiste en concevoir et promouvoir des mesures substitutives au traitement sans consentement. Pour autant, il est impératif que ces mesures prennent en compte la situation des personnes qui sont dans la totale impossibilité de consentir.

En effet, la question reste entière pour ce qui concerne les situations dans lesquelles il est établi qu’une personne est dans l’incapacité totale de donner son consentement libre et éclairé (ex : état psychotique aigu, état de démence, ...). Il convient de constater que la CIDPH reste muette sur ce point. Les observations générales du Comité, bien que très éclairantes sur le sens à donner aux stipulations de la Convention, ne peuvent pas à elles seules étendre la portée des obligations prévues par la Convention.

La portée des stipulations de la CIDPH doit s’analyser en cohérence avec les autres textes internationaux. Le principe de non-discrimination en droit international des droits de l’homme ne semble pas a priori interdire la mise en place d’un mécanisme ayant pour effet de limiter l’exercice des droits dès lors que la mesure de limitation repose sur des motifs objectifs et raisonnables\textsuperscript{19}. Le Défenseur des droits considère néanmoins que le recours à un tel mécanisme ne saurait s’entendre qu’à titre exceptionnel, c’est-à-dire dans les cas où la personne est dans l’incapacité totale d’exprimer consentement, que cette incapacité est établie de façon objective, et à défaut de pouvoir mettre en place d’autres formes de prise en charge. Il convient d’axer les réflexions sur les garanties à prévoir afin d’établir de telles situations. Lorsqu’un tel dispositif s’avère indispensable à la protection de la personne, son consentement doit être systématiquement recherché à tout moment.

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\textsuperscript{17} Depuis sa création, le CGLPL a visité plus du tiers des établissements habilités à recevoir des patients en soins sans consentement dont la totalité des unités hospitalières spécialement aménagées (UHSA) et des unités pour malades difficiles (UMD).

\textsuperscript{18} CGLPL, Isolément et contention dans les établissements de santé mentale, Éditions Dallaz, 2016, p. VIII.

VI. Conclusion

Eu égard à ce qui précède, le Défenseur des droits, en qualité de mécanisme indépendant de suivi, constate que le projet de protocole n’est pas conforme aux principes de la CIDPH. En outre, il ne peut que constater que la solution proposée par le DH-BIO, en dépit de l’objectif recherché – à savoir prévenir le recours à des mesures abusives et arbitraires de placement ou de traitement involontaires à l’égard de personnes souffrant d’un handicap psychosocial – s’avère, en pratique, inefficace et à l’origine des abus qu’il entend éviter.

Dès lors, il encourage les organes du Conseil de l’Europe à trouver une solution permettant d’assurer une application plus uniforme par les États membres des mesures volontaristes en psychiatrie, dans l’esprit de la CIDPH. À cet égard, il partage l’avis de l’APCE qui recommande de se concentrer sur la promotion d’alternatives aux mesures involontaires en psychiatrie.

Cependant, dans un souci de protection des droits des personnes le plus vulnérables, le Défenseur des droits rappelle l’existence de situations, certes exceptionnelles, des personnes dans l’incapacité totale de donner leur consentement. Ces situations ne doivent pas être négligées lors de la conception des mesures substitutives.

Jacques TOUBON
Reference should also be made to the psychiatric care for prisoners, as well as on additional safeguards for children following the principle of the „best interests of the child“ formulated in Art. 3 of the UN Convention on the Rights of the Child (in special Articles, if appropriate).

In addition, the CPT’s own on-site observations and reports received from other sources indicate that the deliberate ill-treatment of patients in psychiatric establishments does occur from time to time. A number of questions are closely-linked to the issue of the prevention of ill-treatment (e.g. means of restraint, complaints procedures, contact with the outside world, choice of staff and staff supervision, training of the staff, external supervision).

In the Draft Explanatory Report concerning Articles 17 and 18 “Information and Communication” we would like to add that a patient shall be informed about his/her rights “regularly, properly and comprehensibly”.

Concerning para 52 of the Draft Explanatory Report we do not agree that “merely financial risk” is not sufficient to apply involuntary measures. For example, a patient in acute mania may face a risk of economic bankruptcy. This suggestion may be further discussed during the next DH-BIO meeting.

NATIONAL INSTITUTIONS

Equality and Anti-Discrimination Ombud (Norway)

The Norwegian Equality and Anti-Discrimination Ombud refer to the letter from the Committee on Bioethics dated 22 June 2015. The Ombud appreciates the opportunity to give our remarks to the draft Protocol on the Convention on Human Rights and Biomedicine concerning the protection of human rights and dignity of persons with mental disorders with regard to involuntary placement and involuntary treatment.

About the Equality and Anti-Discrimination Ombud
The Equality and Anti-Discrimination Ombud is an independent public body that operates free from the instruction of the Norwegian Government. The main task of the Ombud is to promote equality and fight discrimination based on gender, ethnicity, religion, disability, sexual orientation, gender identity, gender expression and age.

The Ombud has a legal mandate to monitor the implementation of the UN’s Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), Convention on Racial Discrimination (CERD) and Convention on Rights of Persons with Disabilities (CRPD) in Norway.

General remarks to the draft Protocol
The Ombud welcomes the intention behind the draft Protocol, namely to limit the use of involuntary treatment and involuntary placement of people with mental or psychosocial disabilities. The Ombud agrees that there is a pressing need to reduce the use of involuntary placements and involuntary treatment in this field. However, in its current form, the Ombud can not support the draft Protocol.

In line with the United Nations Convention on the Rights of Persons with Disabilities, the Ombud is of the opinion that the very essence in strengthening the rights and freedoms of people with disabilities is to ensure that international and domestic legislation is non-discriminatory. This includes a zero-tolerance for legislation where mental or psychosocial disabilities are a criterion for use of coercion. The draft Protocol, on the other hand, is as a
whole based on the idea that “mental disorder” is a legitimate criterion for use of involuntary treatment and involuntary placement.

Involuntary placement
According to CRPD article 14, the existence of disability can not, in any case, justify a deprivation of liberty. In a statement from the CRPD-committee from September 2014, the Committee elaborates its view on the interpretation of this article as an *absolute prohibition of detention on the basis of disability*. The Committee establishes that article 14 does not permit people with mental or psychosocial disabilities to be detained on the grounds of their disability. This prohibition includes legislation where the disability is one of more criterions for deprivation, for example where the other criterion is that a person is dangerous to himself/herself or to others.

In the view of the Ombud the draft Protocol, in its current form, is not compatible with article 14 as interpreted by the CRPD committee.

Involuntary treatment
CRPD article 25 states that people with disabilities have a right to health care on the basis of free and informed consent. The article must be read in conjunction with article 15 and 17 of the CRPD. Article 15 protects the freedom from torture or cruel, inhuman or degrading treatment or punishment, and article 17 protects the right to integrity of person.

Involuntary treatment is a serious interference with the right to integrity of person, and in gross cases involuntary treatment can be defined as inhumane or degrading treatment in breach with article 15 of the Convention.

In light of the CRPD committee’s clear and unequivocal interpretation of the Convention when it comes to using disabilities as a criterion for use of coercion, the Ombud finds that mental disability can not be a criterion for use of involuntary treatment.

In the view of the Ombud the draft Protocol, in its current form, is not compatible with CRPD article 25 read in conjunction with article 15 and 17 as interpreted by the CRPD committee.

Conclusion
The Ombud finds the draft Protocol is not in conformity with CRPD and the fundamental idea of non-discriminatory legislation. In worst case, the draft Protocol its current form can weaken the implementation of CRPD in the member States.

On these grounds, the Ombud can not support the further work of the Committee on Bioethics on the draft Protocol to the Convention on Human Rights and Biomedicine concerning the protection of human rights and dignity of persons with mental disorders with regard to involuntary placement and involuntary treatment.

In the view of the Ombud, this draft Protocol is not the tool that is necessary to end discriminatory practice against people with disabilities. We recommend that the draft Protocol is re-written to be in line with the United Nations Convention on the Rights of Persons with Disabilities, or that the work is discontinued.

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63 Statement on article 14 of the Convention on the Rights of Persons with Disabilities
To the attention of:

Mr Philippe Boillat  
Director General  
Directorate General Human Rights and Rule of Law  
Council of Europe  
F-67075 Strasbourg Cedex

Vienna, 8 December 2015  
Ref: 2015-outgoing-001625

Subject: Consultation on draft Additional Protocol to the Convention on Human Rights and Biomedicine.

Dear Mr Boillat,

Thank you very much for the invitation to comment on the draft Additional Protocol to the Convention on Human Rights and Biomedicine concerning the protection of human rights and dignity of persons with mental disorders with regard to involuntary placement and involuntary treatment.

In June 2014, FRA provided comments, through the EU Delegation to the Council of Europe, on an earlier preliminary draft. This followed a request for comments by members of the CDDH. FRA’s comments (attached) reflected concern about the overall approach of the draft Additional Protocol, and that adopting the draft Additional Protocol in its current form could raise issues for those EU Member States which have ratified the convention.

In particular, FRA’s comments highlighted the authoritative interpretation provided by the Committee on the Rights of Persons with Disabilities (CRPD), and freedom from torture (Art. 15 of the CRPD), and freedom from violence, exploitation and abuse (Art. 16 of the CRPD)

In addition, I would like to draw your attention to the CRPD Committee’s Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities which were adopted in September 2015. The guidelines (attached) further elaborate the Committee’s position with regard to involuntary placement and involuntary treatment. They reiterate the Committee’s call for States parties to “repeal provisions which allow for involuntary commitment of persons with disabilities in mental health institutions based on actual or perceived impairments” (§10).
FRA will inform the other members of the EU Framework to promote, protect and monitor the implementation of the CRPD, established under Article 33(2) of the convention about the on-going process.

FRA would be interested in continuing to follow the drafting process, but at the moment cannot provide further expertise due to human resource constraints. I would be grateful if you could keep me informed about its further progress.

Yours sincerely,

Constantinos Manolopoulos

cc: Jari Vilén, Head of delegation, European Union Delegation to the Council of Europe
    Laurence Lwoff, Head of Bioethics Unit, Council of Europe
    Mario Oetheimer and Markus Jaeger, FRA-Council of Europe contact points
Comments by Dunja Mijatović, Council of Europe Commissioner for Human Rights
on the draft Additional Protocol to the Convention on Human Rights and Biomedicine
concerning the Protection of Human Rights and Dignity of Persons with Mental Disorder
with regard to Involuntary Placement and Involuntary Treatment

Strasbourg, 8 November 2018

1. The Commissioner for Human Rights would like to thank the Committee on Bioethics (DH-BIO) for having invited her to provide comments on a draft Additional Protocol to the Convention on Human Rights and Biomedicine (Oviedo Convention) concerning “the Protection of Human Rights and Dignity of Persons with Mental Disorder with regard to Involuntary Placement and Involuntary Treatment” (hereinafter, “the draft Additional Protocol”).

2. The present comments are based on the extensive country and thematic work of the Commissioner’s Office on various issues relating to persons with disabilities, including legal capacity and the right to live in the community, as well as specific human rights implications of involuntary measures in psychiatric settings.

3. The Commissioner observes that this is the second time that her Office has been invited to comment on the draft Additional Protocol. She notes, in particular, that her predecessor sent detailed comments on a previous version of the draft Additional Protocol on 9 November 2015, raising numerous concerns of such a fundamental nature about the basic assumptions of the draft Additional Protocol that he called on the DH-BIO not to adopt it and to reprioritise its work concerning persons with psychosocial disabilities.¹ She fully endorses this position on the Draft Protocol and the present observations should be seen as complementing her predecessor’s comments. She further notes similar positions expressed, around that time or thereafter, by the Parliamentary Assembly which conveyed its opposition to that text, the United Nations Committee on the Rights of Persons with Disabilities,² the Office of the UN High Commissioner for Human Rights, the UN Special Rapporteurs on the rights of persons with disabilities, the UN Working Group on Arbitrary Detention, the Fundamental Rights Agency of the EU, as well as by numerous NGOs representing persons with disabilities.

4. The Commissioner would like to stress that she fully shares the concerns expressed in these earlier comments and finds that they continue to apply to the present draft. In the opinion of the Commissioner, the amendments to the previous version of the draft Additional Protocol have not resolved the fundamental problems surrounding the text. Certain changes, in particular the inclusion of its Chapter VI on specific situations, could even create further problems.

5. While noting that the DH-BIO started this work with the commendable intention of improving the protection of persons with psychosocial disabilities with regard to involuntary measures ordered in a medical context, she considers that the draft Additional Protocol, rather than satisfying that ambition, unfortunately risks provoking the opposite result. In the opinion of the Commissioner, this risk not only stems from the specific drafting choices concerning the different provisions of the text, but also from the general approach behind it. The Commissioner regrets, therefore, that she must again express opposition to this draft Additional Protocol and call on the DH-BIO not to adopt it.

² See notably the “Statement by the Committee on the Rights of Persons with Disabilities calling States parties to oppose the draft Additional Protocol to the Oviedo Convention”, adopted during the Committee’s 20th session, held from 27 August to 21 September 2018 in Geneva.
6. The following comments should therefore be seen as a brief explanation of the reasons which brought the Commissioner to this conclusion. These concerns include the conflict this draft Additional Protocol would engender with the UN Convention on the Rights of Persons with Disabilities (hereinafter, “the CRPD”), its failure to address the source of the problem, as well as the insufficient consultation in the drafting of the draft Additional Protocol of the very persons which it purports to protect, and their opposition to this text.

**Conflict with the UN Convention on the Rights of Persons with Disabilities (CRPD)**

7. The Commissioner stresses that the Council of Europe should abstain from elaborating norms which are in conflict with global human rights standards or which could weaken the protections provided in those standards. In this respect, the Commissioner notes that the CRPD adopted in 2006 is one of the most widely ratified core human rights instruments of the United Nations and that it has been ratified by 46 of the 47 member states of the Council of Europe, as well as the European Union. For the Commissioner, the CRPD is the international benchmark and legal reference point in all matters pertaining to disability. She also notes that the Committee on the Rights of Persons with Disabilities, the authoritative treaty body set up under the CRPD, as well as many other UN human rights bodies, explicitly expressed the view that the draft Additional Protocol would be incompatible with this Convention.

8. The issues of incompatibility raised are not simply limited to whether involuntary measures are admissible under the CRPD. They also concern, inter alia:

- stigmatising language used in the draft Additional Protocol to refer to persons with psychosocial disabilities, informed by an out-dated, medical model of disability;
- the fact that the scope of application of the draft Additional Protocol and the criteria set out in the text are inherently discriminatory, in that they apply only to people with “mental disorder”;
- a very narrow and inadequate approach to the crucial question of support needs of persons with psychosocial disabilities in order to be able to exercise their legal capacity and autonomy on an equal basis with others in mental health settings.

9. Given this context, the Commissioner thinks that any interpretation according to which the draft Additional Protocol is compatible with the letter or spirit of the CRPD is no longer tenable. She considers that the adoption of the draft Additional Protocol would on the contrary create a clear conflict between international standards. Such a situation could lead to confusion among relevant stakeholders and undermine the human rights protections to which persons living in Europe are entitled.

10. Under these circumstances, to continue work on this Additional Protocol would set a serious legal precedent where the Council of Europe would adopt a legally binding text which falls below UN and internationally agreed human rights standards.

**Failure to address the source of the problem**

11. The Commissioner notes that the decision to elaborate a legally binding instrument on this issue was taken in 2011 based on an examination of the implementation of the Committee of Ministers Recommendation Rec(2004)10 concerning the protection of human rights and dignity of persons with mental disorder, as this examination revealed at the time “legal gaps in certain Member States”. Considering that the great majority of the 46 Council of Europe member states who are parties to the CRPD ratified the Convention around or after that time, the relevance of this as a basis to justify the need for this draft Additional Protocol could be disputed. Nevertheless, the Commissioner would be interested in receiving detailed information from the DH-BIO on the legal gaps that it has identified in specific member states, as this would be useful in her country work to raise with the authorities of those states.

12. However, in the Commissioner’s view, the assessment that the lack of legal safeguards is a significant cause of the many abuses persons with psychosocial disabilities continue to suffer in medical settings in Europe is disputable. In the experience of her Office, the vast majority of Council of Europe member states already have similar or even more protective safeguards in place, which however fail on a regular basis to prevent needless involuntary placements and other serious abuses – a circumstance suggesting that the root causes of these abuses must be sought elsewhere. The Commissioner fully subscribes to the reasoning provided in her Office’s previous comments mentioned above which go into considerable detail as to why this is the case. One of
the main reasons is the inherently discriminatory nature of most legal systems when it comes to persons with psychosocial disabilities, such as their failure to take account of their support needs, the unpreparedness of judges to handle the human rights implications of involuntary measures, and the inbuilt inequality and biases when it comes to decisions on involuntary measures.

13. The Commissioner considers that, in the current context in Europe, what is necessary is guidance on how member states can avoid recourse to involuntary measures. In this respect, she notes that although the Additional Protocol encourages the use of involuntary measures as a last resort, it does not provide details, standards or guidance about what the alternatives to such measures should look like or at what stage they should be considered as insufficient. In the opinion of the Commissioner, the provisions of the Protocol encouraging member states to use alternative measures and to keep involuntary measures proportionate are too general and imprecise to lead to any concrete policy changes on the ground. The Protocol is therefore highly unlikely to lead to an improvement or a significant reduction of human rights violations suffered by persons with psychosocial disabilities in settings where they are already routinely and unnecessarily subjected to involuntary measures. Furthermore, by coming out with a binding legal instrument on a very narrow part of a multifaceted and complex question, the Council of Europe could be adding to the confusion and thereby delaying reforms, the necessity of which has been put in stark contrast by the CRPD.

14. In addition, the Commissioner notes that the legal terms used in the draft Additional Protocol are defined too broadly and imprecisely, leaving too much to the discretion of physicians. Rather than limiting involuntary measures to the strict minimum necessary, this situation could on the contrary lead to an increase, due to the appearance of legality an international binding instrument such as this Additional Protocol could grant to practices potentially causing human rights violations. While the Commissioner understands the difficulty of reaching a consensus in an international standard-setting context on the exceptional and precise situations and cases this draft Additional Protocol should apply to, she nonetheless considers that the danger posed by an overly broad interpretation of its provisions is very high and could lead to negative human rights implications.

Lack of support and involvement of representative organisations of the persons most affected by the draft Additional Protocol

15. The Commissioner stresses that the CRPD clearly provides, as a general obligation, the close consultation and active involvement of persons with disabilities, through their representative organisations, in any decision-making process concerning issues relating to persons with disabilities. As her Office has been advocating for a long time, the Commissioner considers that this obligation must also apply to decision-making processes within the Council of Europe, in particular to any standard-setting activity which could potentially have an impact on the implementation of the CRPD by member states.

16. The Commissioner notes that some of the most representative organisations of persons with disabilities (and in particular intellectual and psychosocial disabilities) in Europe, with whom her Office co-operates on a regular basis, sent an open letter to the Council of Europe on 14 May 2018 asking for the withdrawal of the Additional Protocol, stating that they would no longer attend the meetings of the DH-BIO as their inputs were “systematically ignored”, and claiming that their lack of inclusion in the decision-making process alone is not in line with Article 4.3 of the CRPD. The Commissioner notes that the consultation of these organisations occurred at a late stage of the drafting process and does not seem to have led to any significant change in the draft Additional Protocol, which continues to largely reflect the approach of the 2004 Recommendation of the Committee of Ministers “concerning the protection of the human rights and dignity of persons with mental disorder” predating the entry into force of the CRPD. Furthermore, the Commissioner understands that these organisations were not consulted on the crucial question of the actual need for this instrument and its general approach, which would have been appropriate before starting work of such a nature, and were only asked to submit drafting amendments on an existing text with which they had very fundamental disagreements.
Conclusion

17. The Commissioner considers that the draft Additional Protocol, by not addressing the most crucial issues which could reduce recourse to involuntary measures, as well as the vagueness and imprecision of its definitions and standards, is unlikely to improve the human rights situation of persons with psychosocial disabilities. On the contrary, by going against views expressed by the persons concerned and creating confusion at the international level about hard-fought global standards, the adoption of this Additional Protocol would, in her opinion, ultimately be counterproductive for the protection of the rights of persons with psychosocial disabilities. Therefore, she calls on the DH-BIO not to adopt the draft Additional Protocol.

18. The Commissioner wishes to clarify that her position as outlined above should not be understood as a call for the immediate abolition of involuntary measures in psychiatry. It should be read as an appeal not to disrupt, by creating more legal uncertainty, the already on-going process of the reduction of such measures in many Council of Europe member states. What is needed instead is guidance and support to the reform process of mental health systems in order to ensure that the maximum number of persons with psychosocial disabilities would voluntarily seek treatment without the fear of losing their dignity and autonomy. Such guidance and support would not only avoid the serious incompatibility problem with the CRPD, it would also be a far more direct and useful way of dealing with the numerous human rights violations which regularly occur in the context of involuntary measures in Council of Europe member states, a situation which the DH-BIO acknowledges and rightly wants to improve.
Persons with psychosocial disabilities are one of the most vulnerable groups in Europe.

The UN Convention on the Rights of Persons with Disabilities (the CRPD), ratified already by 46 of our member states, is my reference point regarding this group, as for all persons with disabilities. This convention represents a clear legal progress and a shift from a medical to a social model.

Yet, the medical model is proving particularly persistent when it comes to mental health, especially for involuntary measures. This is perhaps linked to the continuing stigmatisation faced by people with psychosocial disabilities, and the exaggeration of the danger they represent to themselves or others, including sensationalisation in mainstream media.

What is clear is that involuntary placements and treatments remain among the most common and severe interferences with human rights in Europe, and a lot can be done by all member states to drastically reduce their number. I would even say that minimising them should be considered a CRPD obligation, while offering the highest attainable standard of mental health care respecting dignity and autonomy.

This is why I think the Council of Europe is going the wrong direction with the drafting of an Additional Protocol focusing only on legal safeguards for involuntary measures and mostly ignoring the conditions that lead to them. I am in full agreement with the Parliamentary Assembly on this.

Even if it is not its intended goal, I think that this text would potentially prolong the status quo, if not worsen the situation. This is because it relies on an old, pre-CRPD approach and detracts from the urgency of changing the mental health paradigm. I also fear that the Protocol would put our organisation on a collision course with universal human rights standards.

DH-BIO’s interpretation of member states’ obligations under the CRPD contradicts the opinions of the actual treaty body and UN Special Rapporteurs, other UN bodies, the Fundamental Rights Agency, and disability rights NGOs. The conflict with the CRPD is not limited to the principle of acceptability of involuntary placements: it also concerns: outdated, stigmatising language used in the draft Additional Protocol (such as persons with “mental disorder”); its discriminatory approach; and its neglect of the positive support needs of the persons in question to enforce their human rights.

Lack of added value is another concern: the experience of my Office shows that lacking legal safeguards are very rarely the real problem. The actual issue is that these safeguards are ineffective and even the best ones can be reduced to a formality between the physicians and judges in the daily reality of our legal systems, which remain ill-adapted to the needs of persons with psychosocial disabilities.
Therefore, the protocol is trying to solve the wrong problem. The standards we need urgently today are not more safeguards, but what the states should do as a minimum to avoid involuntary measures in the first place. The Protocol only says that the states should do their best, without defining what the minimum efforts should be. It will therefore not improve the situation on the ground.

When it comes to these efforts, the divergence in practices and recourse to involuntary measures in our member states is remarkable. While only few comparative studies exist, they all point to the fact that the rate of involuntary admissions can vary enormously from one country to another, by up to 35 times. I do not think that this is because some countries have better safeguards than others or have fewer persons with mental health problems.

Even within the regions of the same country situations can be very diverse. For instance, in France certain geographic regions had involuntary admission rates 80% higher than others. Same for coercive measures: studies in Germany, for example, show that their use increases depending on the hospital, perhaps up to ten times.

This to me clearly signals that safeguards for involuntary measures are not the issue and that our member states urgently need clearer guidance on minimum standards concerning alternatives to involuntary measures. This draft Additional Protocol does not address that need, and even overshadows it by its exclusive focus on safeguards.

I also share the concerns of the Assembly on the lack of proper consultation of the persons concerned in the drafting procedure. The history of the human rights of persons with disabilities is all about how they were treated as objects, with no say on their own destiny, and not as subjects of human rights with personal autonomy. This has started changing in recent decades due to their activism, with the motto “nothing about us without us”. This approach has triumphed with the CRPD, which also clearly states that no policy should be approved without the full involvement of persons with disabilities in its elaboration.

So why is this being neglected in the drafting of this Additional Protocol? some of the most respected and relevant NGOs working in this area protest that their concerns and opinions have been ignored in the drafting process, despite their consultation by the DH-BIO. I agree that their involvement has been clearly too limited to satisfy the CRPD criteria. I feel that this should justify a fundamental questioning of the soundness of the project as a whole. Dismissing this opposition would be equivalent to saying that persons with psychosocial disabilities do not understand what is in the Protocol or what is good for them. Many similar mistakes made in the past should serve as a warning!

I am not saying that involuntary placements must disappear overnight, but we cannot continue as if the CRPD and its paradigm shift had never happened. Any worthy contribution in this field must rethink the old criteria for involuntary measures by making them non-discriminatory vis-à-vis people with psychosocial disabilities. But it is much more important and urgent to address the general mental health policy context within which these measures occur. The draft does neither of these things.

As to what can be done regarding that general context, there are many factors that seem to have an impact on the need for involuntary measures. Only to name a few: availability and ease of access to community and out-patient treatment; implication of the person’s support network in treatment; possibility of giving advance directives when one is feeling better for future crises; specialists working on securing trust and consent … It is also likely that the amount of stigma around mental health issues and the fear of involuntary measures discourage persons with psychosocial disabilities from seeking treatment at an early stage of mental illness.

So maybe the time has come to regard the use of involuntary measures less as the core of the mental health system, but more as a symptom of its failings.

I would be fully ready to support work in the Council of Europe that would go in the direction of a better respect of the human rights of persons with psychosocial disabilities in Europe, as long as this work is carried out in consultation and co-operation with all relevant actors and in particular the persons most concerned by the need of improving access to mental health care. This could include...
for instance developing minimum standards concerning alternatives to involuntary measures in psychiatry.

Under these conditions, I find it very unfortunate that the work on this Protocol is continuing despite the clear warnings given by the Parliamentary Assembly to the Committee of Ministers, and also by my Office which on several occasions pointed out serious human rights concerns.
Committee on Social Affairs, Health and Sustainable Development

Ending coercion in mental health: the need for a human rights-based approach

Rapporteur: Ms Reina de Bruijn-Wezeman, Netherlands, ALDE

Report

A. Draft resolution

1. Across Europe, a growing number of persons with mental health conditions or psychosocial disabilities are subject to coercive measures such as involuntary placement and treatment. Even in countries where so-called restrictive laws were introduced to reduce the recourse to such measures, the trend is similar, indicating that in practice such laws do not seem to produce the intended results.

2. The overall increase in the use of involuntary measures in mental health settings mainly results from a culture of confinement, which focuses and relies on coercion to “control” and “treat” patients who are considered potentially “dangerous” to themselves or others. Indeed, the notion of risk of harm to oneself or others remains a strong focus in justifications for involuntary measures across Council of Europe member States, despite the lack of empirical evidence regarding both the association between mental health conditions and violence, and the effectiveness of coercive measures in preventing self-harm or harm to others.

3. Evidence from sociological fieldwork research on persons with mental health conditions on the other hand, points to overwhelmingly negative experiences of coercive measures, including pain, trauma and fear. Involuntary “treatments” administered against the will of patients, such as forced medication and forced electroshocks, are perceived as particularly traumatic. They also raise major ethical issues, as they can cause potentially irreversible health damage.

4. Coercion also has a deterring effect on persons with mental health conditions, who avoid or delay contact with the health-care system for fear of losing their dignity and autonomy, thus ultimately leading to negative health outcomes, including intense life-threatening distress and crisis situations, which in turn lead to more coercion. There is a need to break this vicious circle.

5. Mental health systems across Europe should be reformed to adopt a human rights-based approach, which is compatible with the United Nations Convention on the Rights of Persons with Disabilities, and respectful of medical ethics and of the human rights of the persons concerned, including of their right to free and informed consent.

6. A number of positive examples from within and outside Europe, including hospital-based strategies, community-based responses, such as peer-led crisis or respite services, and other initiatives, such as advance planning, have proven to be highly successful in preventing and reducing recourse to coercive practices. These promising practices are also highly effective in assisting persons with mental health conditions during crisis situations, and should thus be placed at the centre of mental health systems. Services which rely on coercion should be considered unacceptable alternatives, which must be abandoned.

7. In view of the elements above, and convinced that greater awareness, cross-stakeholder coordination and political commitment are crucial in initiating and sustaining the much-needed change in mental health

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1 Reference to Committee: Doc. 14334 Reference no. 4309 of 30 June 2017.
2 Draft resolution adopted unanimously by the Committee on 13 May 2019.
policies, the Parliamentary Assembly urges Council of Europe member States to immediately start to transition to the abolition of coercive practices in mental health settings. To this end, it calls on member States:

7.1. to develop, as a first step, a road map to radically reduce recourse to coercive measures, with the participation of all stakeholders, including in particular persons with mental health conditions and service providers;

7.2. to develop effective and accessible support services for persons experiencing crises and emotional distress, including safe and supportive spaces to discuss suicide and self-harm;

7.3. to develop, fund and provide resources for research on non-coercive measures, including community-based responses such as peer-led crisis or respite services, and other initiatives, such as advance planning;

7.4. to dedicate adequate resources toward prevention and early identification of mental health conditions and early, non-coercive intervention, especially in children and young people, without stigmatisation;

7.5. to fight the stereotypes against persons with mental health conditions and, in particular, the erroneous public narrative about violence and persons with mental health conditions, through effective awareness-raising activities involving all relevant stakeholders, including service providers, media, police and law enforcement officers, and the general public, as well as people with lived experience of mental health conditions;

7.6. to review the curricula of higher education institutions, in particular those of schools of medicine, law and social work, to ensure that they reflect the provisions of the United Nations Convention on the Rights of Persons with Disabilities;

7.7. to fight against the exclusion of persons with mental health conditions by ensuring that they have access to appropriate social protection, including housing and work or employment;

7.8. to provide adequate social and financial support to families of persons with mental health conditions to enable them to cope with the stress and pressure of supporting their loved ones;

B. Draft recommendation


2. The Assembly reiterates the urgent need for the Council of Europe, as the leading regional human rights organisation, to fully integrate the paradigm shift initiated by the United Nations Convention on the Rights of Persons with Disabilities (CRPD) into its work regarding the protection of human rights and dignity of persons with mental health conditions or psychosocial disabilities. It thus calls on the Committee of Ministers to prioritise support to member States to immediately start to transition to the abolition of coercive practices in mental health settings.

3. The Assembly notes with satisfaction that the Council of Europe Committee on Bioethics (DH-BIO) is planning to engage in a study on “Good practices in mental healthcare – how to promote voluntary measures”. It invites the Committee of Ministers to encourage DH-BIO to carry out such a study, with the involvement of all relevant actors in the field and, in particular, relevant NGOs representing persons with mental health conditions or psychosocial disabilities.

4. The Assembly notes the continued widespread opposition to the pursuance of work on an Additional Protocol to the Convention on Human Rights and Biomedicine (ETS No.164), concerning the protection of human rights and dignity of persons with “mental disorder”, with regard to involuntary placement and involuntary treatment. Taking into consideration the comments received during the consultations in 2015 and 2018 (including by the Assembly’s competent committees), which underline the draft Protocol’s incompatibility with the CRPD and its incapacity to protect persons with mental health conditions or psychosocial disabilities from violations of their human rights, the Assembly invites the Committee of Ministers to redirect efforts from the drafting of the Additional Protocol to the drafting of Guidelines on ending coercion in mental health.

3 Draft recommendation adopted unanimously by the Committee on 13 May 2019.
C. Explanatory memorandum by the rapporteur, Ms Reina de Bruijn-Wezeman

“Of all tyrannies, a tyranny sincerely exercised for the good of its victims may be the most oppressive […] [T]hose who torment us for our own good will torment us without end for they do so with the approval of their own conscience.”

C.S. Lewis, God in the Dock: Essays on Theology and Ethics

1. Introduction

1.1. Procedure

1. In June 2017, Ms Stella Kyriakides (Cyprus, EPP/CD), former Committee Chairperson, and 21 other Assembly members tabled a motion for a resolution on “Protecting the rights of people with psychosocial disabilities with regard to involuntary measures in psychiatry”. The motion was a follow-up to our Committee’s previous work on the same issue, which had culminated in the adoption of Recommendation 2091 (2016) on “The case against a Council of Europe legal instrument on involuntary measures in psychiatry”. In this recommendation, the Assembly had opposed the drafting of an Additional Protocol to the Convention on Human Rights and Biomedicine (ETS No.164), concerning the protection of human rights and dignity of persons with “mental disorder”, with regard to involuntary placement and involuntary treatment.

2. The historical background of the motion, including the process that led to Recommendation 2091 (2016) and its outcome (i.e. the Committee of Ministers’ decision to continue the work on the Additional Protocol despite the Assembly’s recommendations) are detailed in my revised introductory memorandum, which was declassified on 11 October 2018. The memorandum also contains an exhaustive description of the work carried out since I took over the rapporteurship, including the joint hearing with the Committee on Equality and Non-Discrimination (which is seized for opinion on this report) held on 9 October 2018. At this hearing, different stakeholders had the opportunity to present their position on the draft Additional Protocol. After the hearing, both Committees adopted their comments on the draft Additional Protocol following the request of the Council of Europe Committee on Bioethics (DH-BIO) and, consistent with the Assembly’s position in 2016, they called for work on this legal instrument to cease and the focus to be put on alternatives to involuntary measures (for the comments of the Committee on Social Affairs, Health and Sustainable Development, see Appendix).

1.2. Aim and scope of the report

3. The motion at the origin of this report was tabled to ensure continued involvement in the Additional Protocol’s drafting process, with a view to minimising negative effects this text may have on the rights of persons with psychosocial disabilities and contributing to ensuring the adequate involvement of disability-rights organisations in the drafting process. After the Committee adopted its comments on the draft Additional Protocol and took a clear position on these issues in October 2018, I proposed to reorient the report’s focus on an aspect which is at the very heart of the controversy around this legal instrument: that is the continuing

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4 As quoted by Ms Olga Runciman, Psychologist and owner of Psycovery, at the hearing of 9 October 2018.
5 See the report by Ms Guguli Magradze (Georgia, SOC), former Rapporteur on this issue, Doc. 14007.
7 The minutes of the hearing have been declassified and are available on both Committees’ websites.
8 The Council of Europe Commissioner for Human Rights, who was also asked to submit comments, took the same position as the Assembly in 2016 and its Committees in 2018. See https://rm.coe.int/comments-by-dunja-mijatovic-council-of-europe-commissioner-for-human-r/16808f1111.
9 “Psychosocial disability” is an internationally recognised term to describe the experience of people who have mental impairments which, in interaction with various societal barriers, may hinder the full realisation of their rights. It reflects one of the key principles of the social model of disability (as opposed to the medical model of disability) that underpins the United Nations Convention on the Rights of Persons with Disabilities, which is that a medical diagnosis (of having a mental health condition) becomes a disability because of the barriers people with such diagnosis encounter, not as a consequence of their mental health condition. Not everyone with a mental health condition will have a level of impairment that will result in a psychosocial disability. The Convention on the Rights of Persons with Disabilities has been ratified by all Council of Europe member States except Liechtenstein.
focus and reliance on coercive measures\textsuperscript{10} and the lack of a human rights-based approach in mental health in general. At its meeting on 19 March 2019, the Committee agreed to this proposal and the ensuing title change.

4. Indeed, in a Resolution on “Mental health and human rights” adopted on 28 September 2017, the United Nations Human Rights Council expressed deep concern that persons with mental health conditions or psychosocial disabilities may be subject to, \textit{inter alia}, widespread discrimination, stigma, prejudice, violence, abuse, social exclusion and segregation, unlawful or arbitrary institutionalisation, overmedicalisation and treatment practices that fail to respect their autonomy, will and preferences. Affirming the importance of adopting a human rights approach in the context of mental health, the Human Rights Council called upon States to abandon all practices that fail to respect the rights, will and preferences of all persons, on an equal basis, and that lead to power imbalance, stigma and discrimination in mental health settings. It also requested the High Commissioner for Human Rights to identify strategies to promote human rights in mental health and to eliminate discrimination, stigma, violence, coercion and abuse in this regard.\textsuperscript{11}

2. Coercion in mental health in Europe: current state of play

5. Across Europe, there are no mental health systems that have already switched to fully consensual practices. All Council of Europe member States provide for involuntary placement and treatment, mostly through specific mental health laws.\textsuperscript{12} According to a recent report documenting the current practice in mental health systems in 36 European countries\textsuperscript{13} (including 35 Council of Europe member States and Israel), in addition to the threshold criterion of being diagnosed with a “mental illness” or “mental disorder”, presenting a significant risk of serious harm to oneself or others is a common criterion for involuntary placement. In most countries involuntary placement is understood as an authorisation for involuntary treatment. All 36 countries reported having procedural requirements and safeguards set out in legislation for those undergoing involuntary placement and treatment, mainly consisting of an independent review or authorisation by a court or tribunal.\textsuperscript{14}

6. At the joint hearing held in October 2018, the Council of Europe Commissioner for Human Rights, Ms Dunja Mijatović, stressed that there was a remarkable divergence in practices and recourse to involuntary measures in Council of Europe member States: the few comparative studies on this issue show that the rate of involuntary admissions can vary enormously from one country to another, by up to 35 times, and even within the regions of the same country. For instance, in France, certain geographic regions have involuntary admission rates up to 80% higher than others. Similarly, data from Germany show that the use of detention in hospitals and the use of mechanical restraint (being strapped to a bed frame), physical restraint (being held down by staff), and seclusion (being locked in a small room) vary considerably from hospital to hospital (between 2% and 10% of patients), and between German States.\textsuperscript{15}

7. Notwithstanding these disparities, there is an overall increase in the use of involuntary measures in mental health settings, including in countries where so-called restrictive laws were introduced with the aim of reducing recourse to such measures. At the UN consultation on human rights and mental health in

\textsuperscript{10} Coercive measures/coercion in this report refer to involuntary, forced or non-consensual measures carried out in mental health services against people with mental health conditions. They include in particular involuntary placement, involuntary treatment, different types of restraint and seclusion.

\textsuperscript{11} A/HRC/RES/36/13.

\textsuperscript{12} It should be noted that Article 5§1 (e) of the European Convention on Human Rights allows the lawful detention of “persons of unsound mind”. The European Court of Human Rights considers that Article 5 does not contain a prohibition on detention on the basis of impairment, in contrast to the United Nations Committee on the Rights of Persons with Disabilities (see the Grand Chamber judgment in the case of \textit{Rooman v. Belgium, application no. 18052/11, 31 January 2019}, par. 205).

\textsuperscript{13} Mapping and understanding exclusion: institutional, coercive and community-based services and practices across Europe, prepared by Mental Health Europe, the Tizard Centre and University of Kent, December 2017.

\textsuperscript{14} These findings are consistent with the situation worldwide. See the latest report of the UN Special Rapporteur on the Rights of Persons with Disabilities focusing on disability-specific forms of detention, A/HRC/40/54, 11 January 2019, par. 15.

\textsuperscript{15} These variations may suggest that the use of coercion reflects the institutional culture, rather than a variation in patient behaviour. “Germany without Coercive Treatment in Psychiatry – A 15 Month Real World Experience”, M. Zinkler, \textit{Laws} 2016, 5 (1), 15. To support this argument, the writer refers to the case of one institution in Germany, which was always characterised by a low degree of the use of coercive medication, and where the use of coercive anti-psychotic medication is obsolete since 2011. The institution has, from its beginnings in 1995, operated an open-doors policy. There are no locked wards; voluntary and detained patients are treated in open wards; all members of staff are trained in de-escalation techniques. The institution does not use seclusion rooms to contain disruptive behaviour.
May 2018, the UN Special Rapporteur on the Rights of Persons with Disabilities, Ms Catalina Devandas Aguilar (hereafter “the UN Special Rapporteur”) agreed that coercion and exclusion have become the rule in the majority of mental health systems, particularly in developed countries. At the same consultation, Professor Sashidharan, from the University of Glasgow, explained that since the deinstitutionalisation of psychiatry in the 1970s and 80s in most western European countries, the balance is shifting today in favour of coercive measures. In England, the rate of involuntary psychiatric hospital admission has increased by more than a third in the past six years. More than half of admissions to psychiatric hospitals in England are now involuntary, the highest rate recorded since the 1983 Mental Health Act.

8. Likewise, France is reported to be one of the European countries that has the highest rates of involuntary placement, with a 15% increase in psychiatric coercion since the 2011 law reform, the objective of which was to strengthen the rights of forcibly hospitalised patients. In my own country, the Netherlands, the trend is similar, despite the government’s intentions to reduce the number of involuntary measures. Amongst the 36 countries surveyed in the above-mentioned report, the only countries that report a decrease in the use of coercive measures are Finland and Germany, following legislative changes and targeted programmes to reduce the use of coercion in psychiatry.

9. These are serious signals from which we must conclude that the mental health-care system as we know it is failing, and that restrictive laws regarding involuntary measures do not necessarily reduce coercion in practice. In fact, during the October hearing, the UN Special Rapporteur stressed that involuntary measures have always been allowed on the basis that they should be exceptional and surrounded by safeguards; yet it is precisely in those States where such legislation is in place that the rate of recourse to involuntary measures is the highest.

10. This worrying trend should mainly be attributed to a culture of confinement which focuses and relies on coercion and fails to ensure adequate access to community-based and out-patient services, inevitably leading to crisis situations, which in turn lead to more coercion. There is a need to break this vicious circle. As rightly stressed by the Council of Europe Commissioner for Human Rights at the October hearing, “maybe the time has come to regard the use of involuntary measures less as the core of the mental health system, but more as a symptom of its failings.”

3. From stigma to coercion: negative perceptions attached to mental health conditions and their impact on the use of coercive measures

“It’s hard to think well of yourself in a word that sees you as a threat”.

A. Solomon, psychiatric patient and professor of clinical psychology

11. The stigma attached to mental health conditions is closely linked to the use of coercion in the mental health context. Indeed, persons with psychosocial disabilities have been marginalised, shunned and demonised throughout history. We often see psychosocial disability associated with criminality, deviance and detention.26 These stigmas lead to widespread perceptions that persons with psychosocial disabilities are prone to violence and dangerous, both to themselves and to others.27 The stereotype of dangerousness negatively impacts how service providers and the general public react in situations involving persons with psychosocial disabilities or mental health conditions, in particular in crisis situations, leading to social distance and discriminatory behaviour and recourse to coercive practices. As revealed in the previous chapter, the notion of risk of harm to oneself or others remains a strong focus in justifications for involuntary placement and treatment.

12. The mainstream media’s tendency to sensationalise fatal cases involving persons with mental health conditions (in particular extreme violent crimes, such as mass shootings) exacerbates the stigmatisation, usually spurring more restrictions on those diagnosed with a mental health condition.28 The UN Special Rapporteur reports that the stereotype of dangerousness has significantly increased over the last decades, fuelled by negative media coverage that emphasises the psychiatric history of a perpetrator or, failing that, speculates about an “untreated” diagnosis.29 Similarly, in a recently published report, the head of the Controller General of Places of Deprivation of Liberty in France, Ms Adeline Hazan, observes that in mental health settings, “the potential dangerousness of the patient, very often imaginary, has taken an increasing place” in practice.30

13. Yet, the association between mental conditions and violence is not borne out by the research available on the subject.31 Violence against/risk of harm to others are typically associated with those diagnosed with schizophrenia. However, there is limited evidence to justify this claim. In what is perhaps the largest study to date on the correlation between schizophrenia and rates of violent crime, 8003 people diagnosed with schizophrenia in the USA were compared with general population controls in terms of criminal convictions for violent crimes. For the vast majority of those with the diagnosis who had committed a violent crime, the acts were attributed to drug abuse. Where other factors were controlled for, those diagnosed with schizophrenia who had not abused drugs were only 1.2 times more likely to have committed at least one violent crime than the control group.32 Other data also confirm that mental health conditions and violence are related primarily through the accumulation of risk factors of various kinds, for example, historical (past violence, juvenile detention, physical abuse), clinical (substance abuse),33 dispositional (sex, age, etc.) and contextual (recent divorce, unemployment, victimisation amongst those suffering from a mental health condition).34

14. It also remains an open question in the literature on psychiatric coercion and violence, whether the range of involuntary placement and treatment measures are effective in reducing the risk of violence.35 As far as the risk of self-harm is concerned, medical literature does not provide strong evidence on whether the risk for suicide

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27 “Persons with psychosocial disabilities continue to be falsely viewed as dangerous, despite clear evidence that they are commonly victims rather than perpetrators of violence”. Report of the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/HRC/35/21, 28 March 2017, par. 25.
28 “The misperception that mentally ill people are inherently dangerous is one of the most treacherous ideas in circulation about us. It surfaces widely every time a mass shooter is on the loose, and results in the subjugation of people who are not menacing in any way”, Andrew Solomon, The New York Times, 26 October 2016.
29 A/HRC/40/54, 11 January 2019, par. 27.
32 Comments submitted by the Hallmark Disability Research Initiative at the University of Melbourne, during the public consultation on the draft additional protocol carried out in 2015, DH-BIO/INF (2015) 20 available on https://www.coe.int/en/web/bioethics/psychiatry.
33 In fact, for those with mental illness without substance abuse, the relationship with violence is modest at best.
34 Op. cit. footnote 31. It is interesting to note that other groups, such as young men drinking alcohol or known domestic abuse perpetrators, whose propensity to violence as compared to others is empirically established, do not face restrictions on their right to liberty similar to those faced by persons with psychosocial disabilities.
decreases after involuntary treatment. Additionally, there is compelling evidence that suicide is very difficult, if not impossible, to predict.36,37

4. The impact of coercion on users and providers of mental health services

15. While there is a lack of robust empirical evidence regarding the effectiveness of coercive measures in preventing self-harm or harm to others, there is a compelling body of evidence on their detrimental effects. Indeed, evidence from sociological fieldwork research on persons with mental health conditions points to overwhelmingly negative experiences of involuntary placement or treatment.38 These include trauma and fear, pain, humiliation, shame, stigmatisation and self-stigmatisation. In particular, perceptions of involuntary treatment - which regularly accompanies involuntary placement -, such as forced medication and forced electroshocks, or restraint are overwhelmingly traumatic and can be grouped in four categories: negative psychological impact, re-traumatisation, perceptions of unethical practices, and broken spirit.39

16. In this context, it should be noted that anti-psychotic medication has potentially serious adverse effects and can potentially cause irreversible health damage such as motor co-ordination problems (tardive dyskinesia - a disorder characterised by involuntary movements most often affecting the mouth, lips and tongue, and sometimes the trunk or other parts of the body, such as the arms and the legs), hormonal changes, or changes in brain tissue. Similarly, there is evidence suggesting that ‘electroshock therapy’ has irreversible damaging effects such as memory loss. Thus, in addition to their traumatic effects, such “treatments” administrated against the will of persons with mental health conditions raise major medical and ethical issues.

17. Moreover, patients who are coerced into accepting hospitalisation and/or medication are less likely to adhere to the treatment following their discharge and thus less likely to seek treatment in the future. As stated by the representative of the European Network of (Ex-) Users and Survivors of Psychiatry (ENUSP) during the October hearing, coercive measures have a deterring effect, as they destroy the trust of the person subjected to them in the capacity of psychiatry to support them, and lead to their avoidance of all contact with the health-care system, which in itself increases the risk of new or additional crisis.

18. Involuntary measures also have a negative impact on the service providers, i.e. mental health professionals dealing with patients with mental health conditions. At the last meeting of DH-BIO held in November 2018, the representative of the European Association of Service Providers for Persons with Disabilities (EASPD) pointed out that service providers used coercion every day, thus knowing they were harming fundamental rights. Every one of their members wanted to stop using coercion, but they did not have or did not know about alternatives. Service Providers were failing in their objectives to help persons with disabilities. They could not make the change to the use of alternative measures alone; they needed a proper framework which corresponds to the Convention on the Rights of Persons with Disabilities (CRPD) and is not coercive.40

5. How to prevent, reduce and eliminate coercion in mental health settings?

5.1. Successful and promising practices

19. Mental Health Europe recently published a report on successful and promising programmes and practices which help to prevent, reduce and eliminate coercion in mental health care. The report contains a number of positive examples from within and outside Europe, including hospital-based strategies, community-based responses (including peer-led services), and other initiatives, such as crisis or respite services and advance planning. Similarly, a literature review commissioned by the United Nations Office in Geneva to inform the report of the UN Special Rapporteur, shows that policies aimed at preventing or reducing coercive

36 “Prevention of suicide demands comprehensive multisectoral strategies, including safe and supportive spaces to discuss suicide and self-harm, free from any potential coercive intervention”. A/HRC/40/54, 11 January 2019, par. 35.
37 “No, psychiatry could not have prevented the Germanwings disaster”, Gary Greenberg, The New Yorker, 2 April 2015.
40 “(…), coercion must stop being the norm (…). This institutional violence (…) primarily affects patients, but also the service providers”. Pour un renouveau des soins psychiques, manifeste pour un printemps de la psychiatrie, 22 January 2019, l’Humanité.
practices can be highly successful and are worthy of more attention from States. A few examples from these publications and other literature are presented below.

20. **High & Intensive Care Units (Netherlands):** HIC Units are acute admission wards focusing on restoring and maintaining contact and crisis prevention. They were developed in 2013 by a multidisciplinary group of experts, including users and family representatives. The Units require a multidisciplinary team (psychiatrists, nurses, psychologists, users), who must be specifically trained in crisis management, handling aggression and suicidal behaviour. A specific architectural environment is cultivated including one-person bedrooms, large and light living rooms and the availability of outdoor spaces. The approach includes methods such as a careful assessment of the risk of escalation and setting up an individual crisis plan, in consultation with the person concerned and their relatives. This plan describes how escalation can be prevented. The Units show promising results, in terms of the use of seclusion in inpatient wards. The decrease of seclusion rates is not associated with an increase of forced medication. If coercion is used, it must be documented, and this data is regularly discussed among staff members, in order to further assess how to reduce coercion, with the aim of eliminating this practice.

21. **Mental Health Mobile Units (Greece):** These Units have contributed to the reduction of involuntary hospital admissions. The main objective is to keep the user within the community. The local community and other health services, as well as key individuals (local authorities, police department, prosecutors) actively participate in the work of the Mobile Units. By allowing persons to stay in their communities and offering services as close to the user’s home as possible, the Mobile Units ensure stability and continuity of care.

22. **The Open Dialogue Approach to Acute Psychosis:** This practice originally developed in Finland in which care decisions are made with the personal input of the individual concerned, together with wider networks of their choice. Open Dialogue is based on support in people’s homes and communities. Service providers aim to facilitate regular ‘network meetings’ between the person and his/her choice of an immediate network of friends, carers or family, and several consistently-attending members of the health-care team. There has not yet been a major evaluation on the direct impact of Open Dialogue on the use of coercion but, in Lapland, the Model has entirely replaced emergency, medicalised treatment. Overall benefits of a two-year follow-up were less hospitalisation, more family meetings, less medication, fewer relapses and better employment status.

23. **The personal ombudsmen support model in Sweden:** This was developed based on the recognition that existing legal capacity systems did not meet the needs of many persons with psychosocial disabilities who were pushed around between authorities and unable to access their rights. It started as a pilot project, but showed such good results – it was appreciated by the clients, it reduced the number of in-patient hospitalisations and resulted in cost-savings – that today it has become a country-wide permanent arrangement of about 300 ombudsmen supporting 6000-7000 persons with psychosocial disabilities. The ombudsman is a professional who works 100% on the commission of the individual, and for the individual only. This type of support has also been successful in helping those who are the hardest to reach and who have previously often been left without support. This includes persons diagnosed with schizophrenia, persons experiencing delusions and psychosis, and those who are homeless or live in very isolated conditions, avoiding all contact with the authorities.

24. **Peer-run respite houses:** The term ‘respite house’ typically refers to community-based, small, residential settings where people can go for short periods of time when they are experiencing a mental health crisis. Peer-run respite houses were founded in the United States, but have also been established in Switzerland, Germany, Sweden, Hungary, Denmark, the Netherlands and France. Respite houses are characterised by non-medical staff, peer support, empowerment of residents and ‘being with’ residents in times of crisis, social networking, and mutual responsibility. They tend to involve minimal use of anti-psychotic medication based on personal choices of each resident and mental health services are usually dispensed outside of the respite house. Respite houses aim to increase meaningful choices for recovery and decrease the health system’s reliance on costly, coercive and less person-centred modes of mental health services. Currently, respite houses in several European countries rely on financing from budgets devoted to homeless shelters only, and are not always open to any users who feel unwell and need a break from their home environment which could prevent involuntary hospitalisation.

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41 Alternatives to Coercion in Mental Health Settings: A Literature Review, Goodings P. et al. (2018), Melbourne Society Equity Institute.

42 Who gets to decide, Right to legal capacity for persons with intellectual and psychosocial disabilities, Issue paper, Council of Europe Commissioner for Human Rights, April 2012.
25. QualityRights initiative (World Health Organization): This is a global initiative to improve the quality of care provided by mental health services and to promote the human rights of persons with psychosocial, intellectual and cognitive disabilities. Through QualityRights, WHO supports countries in putting into place policies, strategies, laws and services that are in line with international human rights standards, including the CRPD. One of the objectives is to create community-based and recovery-oriented services that respect and promote human rights. As part of the initiative, people with lived experience of mental health conditions take on peer support roles guiding, supporting and empowering others. Peer support volunteers help those using mental health services to understand their own triggers, goals and responsibilities, how to make a wellness plan, and give hope of moving forward in life. The initiative also involves family support groups where relatives of persons with mental health conditions come together to discuss and find ways to overcome their difficulties.

26. Advance directives: An advance directive is a legal document in which patients make decisions designed to bind themselves or to direct others, particularly during times of crisis. Many persons with mental health conditions have sufficient experience to know what will help in their recovery. Advance planning through advance directives ensures that people are treated in the manner that they chose (knowing that they may also include refusal of certain treatments), and which they have found helpful in the past. “Increasingly, patients, advocates and doctors believe that such directives could help transform mental health systems by allowing patients to shape their care, even when they lose touch with reality.”43 Such directives could be a very important tool to minimise involuntary measures, as they help in respecting the will and preferences of a person during a crisis. It is also acknowledged that simply writing a directive increases some patients’ engagement in treatment (the patient feels more in control and empowered).

5.2. Capacity-building, awareness raising and prevention

27. Any strategy to reduce and eliminate coercion in mental health should include action aimed at changing negative attitudes and stereotypes against persons with mental health conditions (and, in particular, the public narrative about violence and persons with mental health conditions), through effective training and awareness-raising activities involving all relevant stakeholders, including public officials (police officers, law enforcement, prison staff), service providers, media, families and the general public. In the Netherlands, for example, intensive efforts are made to improve the acceptance and care of individuals with psychosocial disabilities and their families in society. The local authorities, health-care professionals, experts and police work intensively together, exchanging their experiences and best practices, including through a dedicated website “Verward en dan?” (Confused and then?). On this website, which is accessible to the public, information is given about why people can be confused, how to deal with such people as members of society, where help is available, etc. There are also links to YouTube-movies showing how to react in specific circumstances, based on real-life experience. A good example is a movie showing how the audience should respond to a confused woman with a doll under her arm and looking for her child (Hoe reageert Leeuwarden op Emma? - How does Leeuwarden react to Emma?). In the German state of Baden-Württemberg, volunteers who work with refugees and asylum-seekers, for example, are being offered training in mental “first aid”, in order to be able to recognise and support persons in mental distress.

28. Social contact between people with and without experience of mental health conditions is the central active ingredient to reduce stigma and discrimination. Therefore, training and awareness-raising activities should engage people with lived experience. This engagement is likely to enhance both self-help and demand for services when needed. More people with lived experience of mental health conditions should be encouraged to be leaders, advocates, and peers to address barriers to accessing mental health care, social inclusion, and full citizenship.44

29. Considering that mental health conditions are often a direct consequence of violence, emotional neglect and ill treatment experienced during childhood,45 prevention, early detection and non-coercive intervention, especially for children and young people, are also vital. It is crucial to avoid stigmatisation in these contexts.

43 In these documents, patients specify treatments they want or do not want, like or despise; whether their crises involve suicidal feelings or hallucinations, even what the doctors should say to penetrate their psychoses. “Now mental health patients can specify their care before hallucinations and voices overwhelm them”, Pam Belluck, New York Times, 3 December 2018.
30. Higher education institutions should review their curricula, in particular within the schools of medicine, law and social work; to ensure that their curricula adequately reflect the provisions of the CRPD. Primary care and community-based health-care staff (non-specialist care providers), and providers in other relevant platforms, such as schools and the criminal justice system should acquire and practice the skills needed to identify, treat, and provide care for persons with mental health conditions.

6. Recent developments concerning the draft Additional Protocol

31. At its last meeting held on 20-22 November 2018, DH-BIO took note of the opinions on the draft Additional Protocol submitted by the European Committee for the Prevention of Torture, the Commissioner for Human Rights, the Parliamentary Assembly’s two committees and the Conference of INGOs. With the exception of the representative of the Conference of INGOs, who referred to divided views amongst those INGOs having taken part in their internal consultation, the other speakers urged DH-BIO to discontinue the project, emphasising the following concerns: conflict of the new instrument with existing international standards, in particular the CRPD; the use of stigmatising language, and the lack of meaningful involvement of civil society in the drafting process.

32. With few exceptions, delegations agreed that the objective of the work remained relevant and should be further explained. They considered that the draft must be carefully reviewed, with a particular focus on strengthening the aspect of alternative and preventive measures. It was also noted that particular attention should be given to further developing the collaboration with all relevant stakeholders. In view of these considerations, DH-BIO decided to invite the INGOs represented during the session to submit drafting proposals on alternative and preventive measures. It also decided to invite the European Psychiatric Association and other professional organisations to comment on specific aspects of the draft text.

33. On 20 November 2018, the European Network of National Human Rights Institutions (ENNHRI) released a statement calling upon Council of Europe member States to ask for the withdrawal of the present version of the draft text (and, if this draft is ultimately put to a vote), to oppose its adoption, in view of the persisting concerns with this text, including those raised by the CRPD Committee, the Council of Europe Commissioner for Human Rights and the Parliamentary Assembly. In a press release published on 21 November 2018, Human Rights Watch joined its voice to that of several other NGOs campaigning against the draft Additional Protocol and called on Council of Europe member States to oppose the text, stressing that Bulgaria, North Macedonia and Portugal had already publicly done so.

34. At its meeting held on 27–30 November 2018, the Steering Committee for Human Rights (CDDH) adopted its comments on the draft Additional Protocol. CDDH appreciated the explanatory work of the DH-BIO regarding the purposes of the exercise and deemed it important to continue and deepen such work. It supported the renewed efforts of the DH-BIO aiming at recalling the exceptional nature of involuntary measures as a last resort and to encourage the use of alternative and support measures. CDDH encouraged DH-BIO to determine, taking into consideration the comments received during the public consultation, when, and under which conditions, to resume the work on the Additional Protocol. At its meeting held on 27-29 November 2018, the European Committee on Crime Problems (CDPC) decided not to provide any opinion on the draft Additional Protocol.

35. In an opinion dated 5 December 2018, the French Ombudsman (défenseur des droits) concluded that the draft Additional Protocol was incompatible with the principles enshrined in the CRPD, stressing that the solution proposed by DH-BIO – despite its intended purpose of preventing abusive and arbitrary involuntary placement and treatment – had proven to be ineffective in practice and was at the origin of the abuses which it intended to

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46 A/HRC/40/54, 11 January 2019, par. 82.
48 ENNHRI brings together 42 National Human Rights Institutions from across wider Europe. ENNHRI’s mission is to promote and protect human rights across the European region.
49 “Council of Europe: A threat to Rights of People with Disabilities”, HRW, 21 November 2018.
50 At its 20th session held from 27 August to 21 September 2018 in Geneva, the Committee on the Rights of Persons with disabilities adopted a public statement calling States parties to the CRPD to oppose the draft Additional Protocol. The statement refers to previous opposition made by other UN actors, i.e. the Working Group on Arbitrary Detention, the Special Rapporteur on the rights of persons with disabilities, and the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
51 See Appendix XIV to the meeting report of CDDH available on https://rm.coe.int/steering-committee-for-human-rights-cddh-report-90th-meeting-strasbourg/16809036ca
prevent. The Ombudsman agreed with the Assembly that work should rather concentrate on promoting alternatives to involuntary measures in psychiatry. He also stressed that there were situations – albeit exceptional – where persons would not have the capacity to give consent: these situations should not be neglected.

36. Finally, in her 4th quarterly activity report 2018, the Council of Europe Commissioner for Human Rights, referring to her participation in the October hearing and her written comments submitted to DH-BIO, recalled her opposition to the draft Additional Protocol explaining the reasons therefore (incompatibility of the draft text’s approach with the CRPD; doubts about the added value of this instrument; and insufficient consultation of disability rights NGOs), as well as her call on DH-BIO not to adopt the draft Additional Protocol, and her recommendation to focus instead on alternatives to involuntary measures.52

37. At its meeting in Strasbourg on 4-7 June 2019, in the light of the comments received from its delegations and professional organisations, DH-BIO is expected to decide on the organisation of the work on the draft Additional Protocol. It will also examine a concept note on a draft study on “Good practices in mental healthcare – how to promote voluntary measures”, and, possibly agree on the modalities of its further development. DH-BIO should be encouraged to carry out such a study, with the involvement of all relevant actors in the field, and in particular relevant NGOs representing persons with mental health problems or psychosocial disabilities.

7. Conclusion

38. Use of coercion in mental health leads to human rights violations and breeds hopelessness for service users and for service providers who are “forced to use force”. Coercive measures impede healthy and respectful relationships between service providers and users, which ultimately has a negative impact on mental health outcomes. Thus, States need guidance and support in reforming their mental health systems to ensure that a maximum number of persons with psychosocial disabilities will voluntarily seek treatment without fear of losing their dignity and autonomy.53

39. The solution lies in the good practices and tools from within and outside the health system that offer solutions and support in crisis or emergency situations, and which are respectful of medical ethics and of the human rights of the individual concerned, including of their right to free and informed consent.54 These promising practices should be placed at the centre of mental health systems. Coercive services and institutional care should be considered unacceptable alternatives which must be abandoned.55 Yet, abandoning coercion does not mean abandoning patients and should not be used as an excuse to reduce the overall mental health budget. There should, instead, be more funding and resources for research on alternative responses.

40. In addition to ensuring health-related rights, States should also ensure that persons with psychosocial disabilities or mental health conditions can effectively exercise their rights connected to social protection, including housing and work or employment. Families of persons with mental health conditions need to be given adequate social and financial support to be able to cope with the stress and pressure of providing the necessary support to their loved ones.

41. This report comes at a crucial moment of transition, as many States have started to commit to the CRPD and implement it. As the leading regional human rights organisation, the Council of Europe should accompany and encourage this transition.

42. The transition of all mental health services and legislation towards totally consensual practices entails major challenges for all Council of Europe member States. In her written comments on the draft Additional Protocol, the Commissioner clarified that her position (opposing the draft Additional Protocol) “should not be understood as a call for the immediate abolition of involuntary measures in psychiatry”, since such a fundamental change cannot happen overnight. Similarly, while opposing the draft Additional Protocol, this report acknowledges that under international law, States have a duty to protect life and that current practice relies on involuntary measures when it comes to responding to intense life-threatening distress and crisis situations (often referred to as “acute and emergency situations”). It thus calls for a redirection of Council of Europe’s efforts from the drafting of the Additional Protocol to the drafting of Guidelines on ending coercion in mental health.

53 Comments of the Council of Europe Commissioner for Human Rights on the draft Additional Protocol, par. 18.
43. Only by pursuing the ambitious target on ending coercion in mental health can States achieve systemic change leading to a human rights-based mental health system. To this end, and as a first step, the report encourages member States to make bold commitments to radically reduce coercive medical practices, including in “acute and emergency situations”, with a view to their progressive elimination, bearing in mind that this is a challenging process that will take time. It is high time to start changing the way that society and States deal with mental illness. “There is a need for psychiatry to transform and embrace a human rights-based approach.”

56 A/HRC/40/54, 11 January 2019, par. 32.
Comments on the draft Additional Protocol to the Oviedo Convention, concerning the protection of human rights and dignity of persons with mental disorder with regard to involuntary placement and involuntary treatment

Comments adopted by the Committee on 11 October 2018

1. Introduction

1. The Committee on Social Affairs, Health and Sustainable Development welcomes the opportunity to comment on the draft Additional Protocol (and its draft explanatory memorandum), and particularly appreciates the declassification of the draft, which will allow other stakeholders (including relevant UN mechanisms, NGOs, and associations of persons with psychosocial disabilities) to see the changes made to the draft since 2015. However, the changes made have been few, and few have gone in a direction which receives the support of the Committee.57 The comments made by the Committee in 2017 – and the detailed appendix of comments by the then-Chairperson, Ms Stella Kyriakides (Cyprus, EPP/CD) – thus remain fully valid to this day.58

2. In 2017, the Committee justified the submission of the comments to the draft Protocol as follows: “Despite the Assembly’s fundamental opposition to the drafting of this Protocol, it is important that the Assembly closely follow the work thereon, both regarding content (how to minimise the negative effect this Additional Protocol may have on the rights of persons with psychosocial disabilities, as well as on the credibility of the Council of Europe as a regional human rights organisation?) and procedure (how to ensure the adequate involvement of disability rights organisations in the drafting procedure?).”59 The Committee’s 2017 comments did not lead to a substantial change in the draft Additional Protocol.

3. The Committee therefore does not wish to make additional comments on the provisions of the draft Additional Protocol but has decided to concentrate on the underlying approach of the Protocol and on the need for meaningful consultation.

2. Meaningful consultation is vital

4. It is important to note the paradigm shift introduced by the adoption, in 2006, of the UN Convention on the Rights of Persons with Disabilities (CRPD) and the fact that it has since been ratified by 46 of 47 Council of Europe member States, as well as by the European Union (EU).

5. The former Rapporteur, Ms Guguli Magradze (Georgia, SOC), explained the paradigm shift as follows in her 2016 report: “The CRPD does not create new rights or rights specific to people with disabilities but reaffirms a number of substantive rights for them. […] Thus, the CRPD recognises that it is the various barriers encountered by people with impairments which create the situation of disability. This way of understanding disability is fundamentally different from viewing disability as a consequence of the individuals’ impairment. It means that it is society’s failure to create an inclusive environment that disables individuals rather than any mental or intellectual conditions attached to the person. Hence, the CRPD totally shifts the traditional approach where the disability is perceived through the so-called medical model, which basically sees the disabled person as the problem, and tries to adapt him/her to fit into the world as it is. With the CRPD, persons with disabilities become holders of rights (subjects) rather than being mere recipients of charity or medical attention (objects). This also signifies a move from paternalism to empowerment.”60

6. This paradigm shift also extends to questions of procedure, as the CRPD translates into legal terms the disability rights movement’s slogan, “Nothing about us without us”, by obliging the States Parties to engage in close and active consultation with the organisations representing persons with disabilities when they develop and implement legislation and policies in order to apply the convention. Moreover, it sets up a committee (CRPD

57 For example, the addition of an article on the use of “seclusion and restraint” and on “treatment with the aim of producing irreversible effects” (Chapter VI - Specific situations) does not receive the support of the Committee.
58 Comments transmitted to DH-BIO on 27 April 2017.
59 Ibid, par. 7.
60 Doc. 14007 (2016), explanatory memorandum, par.s 10-11.
Committee) comprising 18 independent experts, which is responsible for monitoring the implementation of the convention.\(^{61}\)

7. The meaningful consultation of disability-rights organisations in the drafting process in DH-BIO is therefore vital. After resuming the work on the Additional Protocol end of 2016, DH-BIO invited the following organisations to its meetings, at their own cost: the European Association of Service Providers for Persons with Disabilities (EASPD), the European Disability Forum (EDF) and Rehabilitation International (RI). In two meetings (in June and in November 2017), the EDF delegation included representatives from Mental Health Europe and European Network of (ex-) Users and Survivors of Psychiatry (ENUSP).\(^{62}\) This is the only time where persons directly concerned by the Additional Protocol had any kind of representation in the drafting process.\(^{63}\)

8. On 14 May 2018, the European Disability Forum (together with its members ENUSP, Autism Europe, Inclusion Europe, Mental Health Europe, and with the International Disability Alliance) sent an open letter to the Secretary General of the Council of Europe in which they conveyed their “deepest concerns and opposition” to the adoption of the draft Additional Protocol to the Oviedo Convention, and announced that they would not attend the upcoming meeting of DH-BIO on 24 May 2018: “Despite our previous active engagement in these meetings, our inputs have been systematically ignored and the process has not been fully transparent, as we, civil society, never endorsed any aspects of this draft Additional Protocol. It is very concerning that organizations of persons with disabilities are not consulted in a meaningful way in this process, in line with article 4.3 of the UN CRPD regarding “decision-making processes concerning issues relating to persons with disabilities.”\(^{64}\) The “closed” nature of the work of DH-BIO has also been criticised by the main UN mechanisms concerned.\(^{65}\)

9. At the joint hearing on this issue, held by the Committee on Social Affairs, Health and Sustainable Development and the Committee on Equality and Non-Discrimination on 9 October 2018, referring to the protestations above from the most respected and relevant NGOs working in this area, the Council of Europe Commissioner for Human Rights agreed that their involvement has been “clearly too limited to satisfy the CRPD criteria” and that “[their protestations] should justify a fundamental questioning of the soundness of the project as a whole”. She also pointed out that “dismissing opposition from them would be equivalent to saying that persons with psychosocial disabilities do not understand what is in the Protocol or what is good for them” and that “many similar mistakes made in the past should serve as a warning”.

10. The Committee thus agrees with the NGOs mentioned above that the good faith, transparency, mutual respect, meaningful dialogue and sincere desire to reach consensus which are the foundation stone of the CPRD process mandated in article 4.3 have, so far, not been met by DH-BIO. The Committee urges DH-BIO to carry out a meaningful consultation, to take place as a matter of priority.

3. **Underlying approach**

11. As the Special Rapporteur on the Rights of Persons with Disabilities, Catalina Devandas Aguilar, pointed out at the May 2018 UN consultation on human rights and mental health\(^{66}\), coercion and exclusion have become the rule in the majority of mental health systems, particularly in developed countries, and even involuntary interventions, such as electroconvulsive therapies, psychosurgery, forced sterilisation and other invasive, painful.

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\(^{61}\) Where the States which have ratified the Optional Protocol to the CRPD are concerned, the CRPD Committee may also receive and examine individual and collective petitions.

\(^{62}\) For the joint-statement of ENUSP and Mental Health Europe, see appendix IV of the report of the 11th meeting of DH-BIO. For the written comments of these organisations on the draft Additional Protocol, see documents DH-BIO (2017) 18, DH-BIO (2017) 31 and DH-BIO (2018) 7 rev.

\(^{63}\) Early in the drafting process, in March 2014, the drafting group organised a hearing of international non-governmental organisations representing different stakeholders (including patients, health professionals and person with psychosocial disabilities).


\(^{65}\) Letter addressed to the Secretary General of the Council of Europe, 29 September 2017 by the Special Rapporteur on the Rights of Persons with Disabilities, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, the Chair of the Committee on the Rights of Persons with Disabilities, and the Vice-Chair of the Working Group on Arbitrary Detention, https://spccommreports.ohchr.org/TMResultsBase/DownloadPublicCommunicationFile?gld=23360

and irreversible treatments, continue to be permitted, contrary to the CRPD. She considered that the draft Additional Protocol would serve to legitimise those coercive practices, and called upon member States of the Council of Europe to stand against it, as it represented an unacceptable backward step in rights protection. At the hearing of 9 October 2018, she also stressed that the draft Protocol’s approach was problematic as it was using “an out-dated normative framework” which is incompatible with the CRPD.

12. The Assembly’s main concern addressed in its 2016 Recommendation, that is, the incompatibility of the future legal instrument with the CRPD, remains valid. The same concern is shared by a number of high-profile human rights bodies and experts, including not only the UN Special Rapporteur on the Rights of Persons with Disabilities (see above), but also the CRPD Committee and the Commissioner for Human Rights of the Council of Europe who pointed out that “the conflict with the CRPD is not limited to the principle of acceptability of involuntary placements: it also concerns: outdated, stigmatising language used in the draft Additional Protocol (such as persons with “mental disorder”); its discriminatory approach; and its neglect of the positive support needs of the persons in question to enforce their human rights”. As the draft Additional Protocol is not in conformity with the CRPD and does not integrate the paradigm shift of the CRPD, it will not be able to “encourage the progressive transition to a more uniform application of voluntary measures in psychiatry by the member States, in accordance with the spirit of the CRPD”, as the Committee of Ministers had considered in its reply to the Assembly’s 2016 Recommendation.

13. In her concluding remarks at the hearing of 9 October 2018, the Chairperson of DH-BIO, Ms Ioan recalled that the draft Additional Protocol aimed at strengthening the rights of persons concerned by involuntary measures by introducing legal safeguards. However, as pointed out by the Commissioner on Human Rights: “the standards we need urgently today are not more safeguards, but what the states should do as a minimum to avoid involuntary measures in the first place”.

14. The draft Additional Protocol, as it stands today, is not fit for purpose. It will not protect persons with psychosocial disabilities from violations of their human rights, because it maintains the status quo, which is at the origin of human rights violations and abuses. It risks multiplying recourse to involuntary measures imposed on persons with psychosocial disabilities, by regulating what should be the exception – which then far easily become the norm –, thus multiplying also the attendant human rights violations and abuses. In addition, the draft Additional Protocol risks undermining the global human rights standards enshrined in the CRPD, and thus to weaken the application of these (higher) standards in Europe. It also risks undermining the credibility of the Council of Europe as a regional human rights organisation.

15. According to the summary of the UN consultation on human rights and mental health, at which the Committee Rapporteur Ms Reina de Brujin-Wezeman (Netherlands, ALDE) represented the Assembly, participants “discussed the topic of mental health as a human rights issue and agreed that the situation could be improved through system-wide strategies and human rights-based services to combat discrimination, stigma, violence, coercion and abuse”. Indeed, several participants spoke against the draft Additional Protocol at this consultation (and no-one spoke in its favour), for reasons both of procedure and content.

16. Thus, in the opening session, several speakers expressed alarm about the ongoing process within the Council of Europe of drafting the Protocol “to legitimise involuntary treatment of persons with psychosocial disabilities, in violation of the Convention on the Rights of Persons with Disabilities, in a deliberate move away from the advances made to ensure human rights in mental health, such as the QualityRights initiative of the World Health Organization (WHO)”.

The United Nations High Commissioner for Human Rights, Zeid Ra’ad Al Hussein, “called for the elimination of practices such as forced treatment, including forced medication, forced electroconvulsive treatment, forced institutionalization and segregation. Instead, he called on States to ensure access to a range of support services within the community, including peer support, and reminded participants that the Convention on the Rights of Persons with Disabilities offered the legal framework to uphold the rights of persons with psychosocial disabilities — including the exercise of legal capacity, free and informed consent, the right to live and be included in the community and the right to liberty and security, without discrimination.”

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68 The Council of Europe Commissioner for Human Rights, hearing of 9 October 2018.
69 The Council of Europe Commissioner for Human Rights, hearing of 9 October 2018.
71 The Chair of the Indonesian Mental Health Association, Yeni Rosa Damayanti, ibid, par. 4.
72 Ibid, par. 5.
17. It is also worth quoting the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Dr Dainius Pūras, who expressed "the pervasive stigmatization, overmedicalization and use of force that resulted in violations of the human rights of users of those services and persons with psychosocial disabilities worldwide. He referred to the deep power asymmetries, the predominance of the biomedical model and the biased use of knowledge, within psychiatry and mental health, as obstacles to the realization of rights. He asserted that the status quo was maintained by the concepts of dangerousness and of medical necessity to "fix a disorder", which was not supported by modern evidence and continued to justify the use of non-consensual measures as 'exceptions'."

4. **Final remarks**

18. The comments received from several high-level human rights bodies during the 2015 public consultation highlighted serious problems with the definitions and terms used (dangerously imprecise and stigmatising language), the criteria for involuntary placement and treatment (which breach the fundamental principle of non-discrimination, and legitimise the use of force and arbitrary detention), the decision-making process as regards involuntary treatment of persons with psychosocial disabilities already subjected to involuntary placement if it is allowed at all (indeed, there is a growing body of evidence concerning the damaging impact and ineffectiveness of forced psychiatric treatment), and underlined the need to make preferred use of alternative measures. These concerns have not been adequately addressed in the draft of the Additional Protocol; on the contrary, the addition of a chapter dealing with “specific situations” (on seclusion and restraint, and on treatment with the aim of producing irreversible effects) is worrying.

19. Indeed, in its Article 18, the draft prohibits treatment with the aim of producing irreversible effects in the context of involuntary measures. However, since it only covers treatment with the aim of producing irreversible physical effects, in practice, only surgical operations such as lobotomy are effectively prohibited. Any treatment with irreversible effects which are not physical (but, for example, mental), such as electro-shock “therapy”, is accepted, as well as any treatment which has irreversible side-effects (since the irreversible effects are not the aim of the treatment). This article would only be acceptable if it would clearly prohibit any treatment which has irreversible side-effects without full, free and informed consent by the person treated.

20. Moreover, the perilously imprecise language defining the scope of “mental disorder” in the draft Protocol could be interpreted to include a whole range of “mental disorders” for which even DH-BIO recognises that involuntary measures would never be appropriate, such as “gender identity disorders, sleep disorders and sexual dysfunctions” (but which DH-BIO has so far not integrated into the text of the draft Protocol itself). The imprecise language of the protocol leads to the theoretical explanation that it would be perfectly legal for a transgender person or a person with a sleep disorder (whose mental health “condition” is judged to represent a significant risk of serious harm to his or her health or to others)\(^\text{24}\) to be involuntarily detained, involuntarily treated – including with electro-shock therapy and other treatments with irreversible side-effects. This is certainly not what DH-BIO really intends.

21. One last comment on the content of the draft Additional Protocol – as Ms Kyriakides stated in 2017: “Definitions, and terms used, matter” – as the last example has shown. It is therefore important that DH-BIO uses terms and definitions that are in line with all relevant human-rights standards and mechanisms. The Committee therefore urges avoiding the use of terms such as “mental disorder”, and recommends using “psychosocial disabilities”. The Committee also recommends not defining a measure as “involuntary” only when the person with “mental disorder” “objects” to the measure. As in other human rights instruments, the involuntary character of the measure should be defined by the absence of “full, free and informed consent” of the person concerned.

5. **Conclusions and recommendations**

22. To conclude: On the basis of the current version of the draft Additional Protocol submitted for comments, the Committee believes that the Assembly’s assessment in 2016 remains valid: the draft Additional Protocol is incompatible with the CRPD.

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\(^{21}\) Ibid, par. 12.

\(^{24}\) In fact, a sleep-deprived person could easily represent a significant risk of serious harm to his or her health or to others if he/she takes the wheel and causes an accident. In some countries, trans-gender persons are also considered to pose such risks - wrongly so, of course.
23. The draft Additional Protocol is also not fit for purpose: It will not protect persons with psychosocial disabilities from violations of their human rights because it maintains the status quo, which is at the origin of these human rights violations. It is unlikely to reduce the number of involuntary measures imposed on them and risks increasing recourse to such measures, by regulating what should be the exception – which then far easily become the norm –, and thus multiplying the attendant human rights violations and abuses.

24. In addition, the draft Additional Protocol risks undermining the global human rights standards enshrined in the CRPD, and thus risks weakening the application of these (higher) standards in Europe. As a consequence, it also risks undermining the credibility of the Council of Europe as a regional human rights organisation and provoking a conflict of laws.

25. In view of this assessment, the Committee urgently calls for work on the draft Additional Protocol to cease and the focus to be put on alternatives to involuntary measures, as well as on preventive measures.

26. The Committee believes that the solution lies in the good practices and tools from within and outside the health system that offer solutions and support in crisis or emergency situations, which are respectful of medical ethics and of the human rights of the individual concerned, including of their right to free and informed consent. These include programmes for personal assistance, psychosocial support and housing, which reduced the risk of institutionalisation and of being subjected to physical and sexual violence. These alternative measures should be what the Council of Europe should focus on.

27. The Committee also urges DH-BIO to respect article 4.3 of the CRPD as regards the necessary close and active consultation with the organisations representing persons with disabilities.

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75 Ibid, par. 13.
Committee on Equality and Non-Discrimination

Comments¹ on the draft Additional Protocol to the Oviedo Convention, concerning the protection of human rights and dignity of persons with mental disorder with regard to involuntary placement and involuntary treatment

1. Introduction

1. On 18 June 2018, the Council of Europe Committee on Bioethics (DH-BIO) sent the draft Additional Protocol to the Convention on Human Rights and Biomedicine (Oviedo Convention), concerning the protection of human rights and dignity of persons with mental disorder with regard to involuntary placement and involuntary treatment, to the Parliamentary Assembly for comments. Within the Assembly, under their respective terms of reference, two committees are competent to deal with this matter: the Committee on Social Affairs, Health and Sustainable Development and the Committee on Equality and Non-Discrimination. These committees held a joint hearing on 9 October 2018 on “Protecting the rights of persons with psychosocial disabilities with regard to involuntary measures in psychiatry”, with the participation of Ms Beatrice Ioan, Chairperson of the Council of Europe Committee on Bioethics; Ms Catalina Devandas-Aguilar, United Nations Special Rapporteur on the rights of persons with disabilities; Ms Dunja Mijatović, Council of Europe Commissioner for Human Rights; Mr Christos Giakoumopoulos, Director General of Human Rights and the Rule of Law of the Council of Europe; Ms Olga Runciman, Psychologist and owner of Psycovery. The elements put forward by the speakers have been taken into account in the present comments.

2. The Committee on Equality and Non-Discrimination thanks DH-BIO for this opportunity to provide comments to the draft Protocol in the context of an informal consultation. It recalls that the position of the Assembly has previously been spelt out in Recommendation 2091 (2016) on The case against a Council of Europe legal instrument on involuntary measures in psychiatry, in which it “recommend[ed] that the Committee of Ministers instruct the Committee on Bioethics to: withdraw the proposal to draw up an additional protocol concerning the protection of human rights and dignity of persons with mental disorder with regard to involuntary placement and involuntary treatment; instead focus its work on promoting alternatives to involuntary measures in psychiatry, including by devising measures to increase the involvement of persons with psychosocial disabilities in decisions affecting their health” and indicated that “Should a decision to go ahead with the additional protocol nevertheless be taken, the Assembly recommends that the Committee of Ministers encourage the Committee on Bioethics to directly involve the disability rights organisations in the drafting process, as recommended by the CRPD and Assembly Resolution 2039 (2015) on equality and inclusion for people with disabilities”.²

3. The main thrust of the contribution of the Committee in its present comments is on equality and non-discrimination aspects. Its reference is the landmark international instrument worldwide for the protection of the rights of persons with disabilities, the United Nations Convention on the Rights of Persons with Disabilities (CRPD). This Convention, which puts persons with disabilities at its heart and promotes the vision “nothing about us without us”, has been ratified by 46 of the 47 Council of Europe member States.³ The Committee emphasises that it would be a matter of serious concern, and dangerous for the rights of all persons with disabilities, if, by adopting new international standards lower than those recognised under the CRPD, the Council of Europe – the leading European human rights organisation – undermined international human rights work in this field. Indeed, the 46 member States that are parties to the CRPD have not only

¹ Comments adopted unanimously by the Committee on 10 October 2018.
² Recommendation 2091 (2016) on The case against a Council of Europe legal instrument on involuntary measures in psychiatry, paragraphs 11 and 12.
³ That is, all Council of Europe member States except Liechtenstein.
committed themselves to respecting the letter of the latter's provisions, but have also made a political commitment to achieving the paradigm shift that this convention represents.

4. The principles of inclusion and protection of the rights of persons with disabilities upheld in the CRPD are of primary importance in the disability-related work of the Committee on Equality and Non-Discrimination and of its Sub-Committee on Disability, Multiple and Intersectional Discrimination. In its resolution 2039 (2015) on Equality and inclusion of persons with disabilities, based on a draft resolution unanimously adopted by the Committee on Equality and Non-Discrimination, the Assembly called on member States to “give up the culture of institutionalisation, … and to give consideration to alternatives to care in institutions, taking account of the choices of people with disabilities”.

2. General considerations

“Of all tyrannies, a tyranny sincerely exercised for the good of its victims may be the most oppressive. … [T]hose who torment us for our own good will torment us without end for they do so with the approval of their own conscience.” C.S. Lewis, God in the Dock; Essays on Theology (Making of Modern Theology), as quoted by Ms Runciman at the hearing of 9 October 2018.

5. As was pointed out at the hearing of 9 October 2018, there is agreement that persons subjected to involuntary measures in psychiatry face grave violations of their human rights, and that States must act to stop this. The judgments of the European Court of Human Rights and the reports of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) all too clearly show this reality. Yet many Council of Europe member States have legislation that provides for involuntary measures, and continue to apply it today.

6. There is also consensus that saving lives and supporting persons with psychosocial disabilities, including in situations of extreme crisis or severe distress, is a common goal, and that member States need guidance in order to design and implement effective alternative measures that respect the dignity and rights of persons with psychosocial disabilities.

7. Different approaches exist, however, as to the best means of achieving this goal. As explained by its Chair at the hearing of 9 October 2018, DH-BIO takes the view that for as long as laws providing for involuntary measures exist and are applied, clear safeguards must be in place to ensure that they are used only as a last resort, as well as to enable persons with psychosocial disabilities to exercise their rights. However, the UN Special Rapporteur emphasised that involuntary measures have always been constructed on the basis that they should be exceptional and surrounded by safeguards – yet it is precisely in those States where such legislation is in place that the rate of recourse to involuntary measures is the highest. Thus, in essence, safeguards in this field may introduce more hurdles, but they cannot achieve what is most urgently needed: that is, to overturn the status quo. She and other speakers moreover emphasised that there is no evidence that coercive measures reduce self-harm. To the contrary, as both Ms Runciman and a speaker on behalf of the European Network of (ex)users and survivors of psychiatry (ENUSP) emphasised, coercive measures destroy the trust of the person subjected to them in the capacity of psychiatry to support them, and lead to their avoidance of all contact with the health care system. This is another reason why, as one speaker stressed, “coercion is not care”.

8. Alternatives to coercion already exist. Examples include home intervention strategies, crisis or respite services, peer-run initiatives and advance planning. While little academic writing yet exists in this field, a literature review published this week shows that such alternatives can be highly successful, and are worthy of considerable more attention from States. ⁴

9. It is important to emphasise that persons with psychosocial disabilities are frequently disempowered, and that coercive measures are the epitome of this disempowerment. The failure to recognise the capacity of persons with psychosocial disabilities to decide for themselves is one of the most fundamental forms of discrimination that they face, as discussed further below. The stereotypes and stigmas that surround persons with psychosocial disabilities in society moreover lead to widespread perceptions that all persons with psychosocial disabilities are dangerous, both to themselves and to others. This in turn leads all too rapidly to their exclusion from society. All of these factors heighten the discrimination faced by persons with psychosocial disabilities. As Ms Runciman made clear, it is crucial to listen to the stories of persons with psychosocial disabilities.

psychosocial disabilities to understand their lived history, and to understand why they are insistent that what is needed is not more of the same, but a paradigm shift.

10. One element of this paradigm shift is to cease to use the term “persons with mental disorder”, as they are referred to in the title and text of the draft Protocol, and to take on board and use the terminology of the CRPD Committee, i.e. “persons with psychosocial disabilities”. Indeed, the choice of the term is not neutral. It reflects a different approach to the matter, or an emphasis on different aspects and concerns. While “persons with mental disorder” reflects the approach long used in psychiatry, “persons with psychosocial disabilities” is the accepted human rights terminology.

3. Specific issues concerning equality and non-discrimination

11. States Parties to the CRPD have undertaken to “refrain from engaging in any act or practice that is inconsistent with the ... Convention and to ensure that public authorities and institutions act in conformity with the ... Convention” (Article 4(d) of the CRPD), and to “take all appropriate measures to eliminate discrimination on the basis of disability by any person, organization or private enterprise” (Article 4(e) of the CRPD). “States Parties shall prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds” (Article 5.2 of the CRPD). It is the potential conflict of the draft Additional Protocol with these commitments, in particular as regards respect for the right to equality, that is at the heart of the Committee’s comments below.

12. **Equal recognition before the law (Article 12 of the CRPD):** The rights of all persons with disabilities, including those with psychosocial disabilities, to recognition everywhere as persons before the law, and to enjoy legal capacity on an equal basis with others in all aspects of life, are enshrined in Article 12 of the CRPD. The CRPD Committee has drawn attention to the importance of distinguishing between a person’s legal capacity (legal standing and legal agency) and their mental capacity (decision-making skills). Where a person’s mental capacity is impaired, special measures may be needed in order to guarantee their right to enjoy their legal capacity on an equal basis with others, in accordance with Article 12 of the CRPD. Depriving them of their legal capacity is however not compatible with their right to equal recognition before the law under the CRPD.

13. **The right to liberty and equal recognition before the law (Articles 14 and 12 of the CRPD):** The CRPD provides that “the existence of a disability shall in no case justify a deprivation of liberty” (Article 14(b)). The CRPD Committee has moreover made clear that “denial of the legal capacity of persons with disabilities and their detention in institutions against their will, either without their consent or with the consent of a substitute decision-maker, constitutes arbitrary deprivation of liberty and violates articles 12 and 14 of the [CRPD]”. Involuntary placement, constitutes arbitrary deprivation of liberty and violates articles 12 and 14 of the CRPD.\(^5\) Where a person’s mental capacity is impaired, special measures may be needed in order to guarantee their right to enjoy their legal capacity on an equal basis with others, in accordance with Article 12 of the CRPD. Depriving them of their legal capacity is however not compatible with their right to equal recognition before the law under the CRPD.

14. **Autonomy, free and informed consent and equal recognition before the law (Articles 25 and 12 of the CRPD):** As part of States’ recognition that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability, Article 25(d) of the CRPD requires that health care be provided to persons with psychosocial disabilities on the basis of their free and informed consent. As the United Nations has recognised, free and informed consent to treatment is meaningless unless the person concerned also has the right to refuse it.\(^6\) There is no justification for treating persons with psychosocial disabilities differently from others in this respect: again, ignoring their legal capacity is not compatible with their right to equal recognition before the law, and special measures should instead be implemented wherever necessary to guarantee access to supported decision-making processes.

15. **Exposure to additional human rights violations once subjected to involuntary placement and/or treatment (Articles 15 and 17 of the CRPD and Articles 3 and 13 of the ECHR):** Broad agreement exists that there is an “unacceptably high prevalence of human rights violations in mental health settings” and that

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\(^5\) CRPD/C/GC/1, paragraph 13.

\(^6\) CRPD/C/GC/1, paragraph 40.

\(^7\) Mandates of the Working Group on Arbitrary Detention; the Chair of the Committee on the Rights of Persons with Disabilities; the Special Rapporteur on the rights of persons with disabilities and the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, letter to the Secretary General of the Council of Europe, 29 September 2017, Annex: Reference to international human rights law, and UN document A/HRC/35/21, paragraph 29.

\(^8\) Ibid., and UN document E/CN.4/2006/120, paragraph 82.
immediate measures to bring about change in this field are needed.\(^9\) In addition to the violations of the right to equal recognition before the law outlined above, persons with psychosocial disabilities are exposed to further human rights violations when they are placed involuntarily in mental health settings. In particular, they may disproportionately experience violations of their right to physical integrity, notably due to the use of force, restraints (whether physical or chemical, including sedation), isolation or seclusion, in breach of Article 17 of the CRPD and (in particular where the use of such measures is prolonged) in breach of the prohibition on torture and inhuman or degrading treatment under Article 15 of the CRPD and Article 3 of the ECHR.\(^10\) The World Health Organisation itself recognises that “psychiatric institutions … are associated with gross human rights violations including inhuman and degrading treatment and living conditions”, and that these violations “often occur behind closed doors and go unreported”\(^11\) – meaning that no investigation into such violations is carried out, and no redress can be granted. Persons with psychosocial disabilities thus face specific and serious violations of their rights under both the substantive and procedural arms of Article 3 and under Article 13 of the ECHR, as well as under Articles 15 and 17 of the CRPD. In short, the involuntary placement and/or treatment of persons with psychosocial disabilities based solely on their disability is also discriminatory because it exposes them to a series of grave human rights violations to which other persons are not subjected.

16. DH-BIO has argued that the safeguards included in the draft Additional Protocol are designed to assist States in aligning their legislation with the case-law of the Court in the field of involuntary measures. However, it was equally argued at the hearing of 9 October 2018 that the Court’s case-law is evolving and coming closer and closer to the standards of the CRPD. The risk is thus that the Additional Protocol may crystallise standards that are not only today in conflict with the CRPD, but will soon be lower than those set under the European Convention on Human Rights, as interpreted in the case-law of the Court. Member States, of course, remain under the obligation to give prompt and full execution to the judgements of the European Court of Human Rights.

4. Conclusions

17. For all of the above reasons, the Committee on Equality and Non-Discrimination considers that involuntary placement and treatment violate the right of persons with psychosocial disabilities to equality and to be free of discrimination, and reiterates the view already expressed by the Assembly that the Council of Europe should cease its work on the draft Additional Protocol to the Oviedo Convention. Indeed, this work can only serve to refine mechanisms that by their very nature perpetuate discrimination and other human rights violations. Not even the most careful wording, nor the strongest emphasis on the need to prioritise the autonomy of persons with psychosocial disabilities, can eliminate this flaw, which is inherent in the very conception of the draft Additional Protocol.

18. To guarantee the right of persons with psychosocial disabilities to equality and non-discrimination, all sectors of the Council of Europe need to work together to ensure that these persons are not subjected to involuntary placement or treatment and that the human rights standards designed today are forward-looking and protect human rights to the highest degree. States should invest in promoting a paradigm shift from coercive to alternative measures, ensuring that alternative treatments are available and accessible. The Council of Europe should focus its efforts and resources on supporting its member States in this process.

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\(^10\) Mandates of the Working Group on Arbitrary Detention; the Chair of the Committee on the Rights of Persons with Disabilities; the Special Rapporteur on the rights of persons with disabilities and the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, letter to the Secretary General of the Council of Europe, 29 September 2017, Annex: Reference to international human rights law, and UN document A/63/175, paragraphs 55-56 (referring to equivalent UN standards as regards torture).

Committee on Social Affairs, Health and Sustainable Development

Comments on the draft Additional Protocol to the Oviedo Convention, concerning the protection of human rights and dignity of persons with mental disorder with regard to involuntary placement and involuntary treatment

Comments adopted by the Committee on 11 October 2018

1. Introduction

1. The Committee on Social Affairs, Health and Sustainable Development welcomes the opportunity to comment on the draft Additional Protocol (and its draft explanatory memorandum), and particularly appreciates the declassification of the draft, which will allow other stakeholders (including relevant UN mechanisms, NGOs, and associations of persons with psychosocial disabilities) to see the changes made to the draft since 2015. However, the changes made have been few, and few have gone in a direction which receives the support of the Committee. The comments made by the Committee in 2017 – and the detailed appendix of comments by the then-Chairperson, Ms Stella Kyriakides (Cyprus, EPP/CD) – thus remain fully valid to this day.

2. In 2017, the Committee justified the submission of the comments to the draft Protocol as follows: “Despite the Assembly's fundamental opposition to the drafting of this Protocol, it is important that the Assembly closely follow the work thereon, both regarding content (how to minimise the negative effect this Additional Protocol may have on the rights of persons with psychosocial disabilities, as well as on the credibility of the Council of Europe as a regional human rights organisation?) and procedure (how to ensure the adequate involvement of disability rights organisations in the drafting procedure?).”

3. The Committee's 2017 comments did not lead to a substantial change in the draft Additional Protocol.

3. The Committee therefore does not wish to make additional comments on the provisions of the draft Additional Protocol, but has decided to concentrate on the underlying approach of the Protocol and on the need for meaningful consultation.

2. Meaningful consultation is vital

4. It is important to note the paradigm shift introduced by the adoption, in 2006, of the UN Convention on the Rights of Persons with Disabilities (CRPD) and the fact that it has since been ratified by 46 of 47 Council of Europe member States, as well as by the European Union (EU).

5. The former Rapporteur, Ms Guguli Magradze (Georgia, SOC), explained the paradigm shift as follows in her 2016 report: “The CRPD does not create new rights or rights specific to people with disabilities but reaffirms a number of substantive rights for them. […] Thus, the CRPD recognises that it is the various barriers encountered by people with impairments which create the situation of disability. This way of understanding disability is fundamentally different from viewing disability as a consequence of the individuals' impairment. It means that it is society's failure to create an inclusive environment that disables individuals rather than any mental or intellectual conditions attached to the person. Hence, the CRPD totally shifts the traditional approach where the disability is perceived through the so-called medical model, which basically sees the disabled person as the problem, and tries to adapt him/her to fit into the world as it is. With the

1 For example, the addition of an article on the use of “seclusion and restraint” and on “treatment with the aim of producing irreversible effects” (Chapter VI - Specific situations) does not receive the support of the Committee.
2 Comments transmitted to DH-BIO on 27 April 2017.
3 Ibid, paragraph 7.
CRPD, persons with disabilities become holders of rights (subjects) rather than being mere recipients of charity or medical attention (objects). This also signifies a move from paternalism to empowerment.\(^4\)

6. This paradigm shift also extends to questions of procedure, as the CRPD translates into legal terms the disability rights movement’s slogan, “Nothing about us without us”, by obliging the States Parties to engage in close and active consultation with the organisations representing persons with disabilities when they develop and implement legislation and policies in order to apply the convention. Moreover, it sets up a committee (CRPD Committee) comprising 18 independent experts, which is responsible for monitoring the implementation of the convention.\(^5\)

7. The meaningful consultation of disability-rights organisations in the drafting process in DH-BIO is therefore vital. After resuming the work on the Additional Protocol end of 2016, DH-BIO invited the following organisations to its meetings, at their own cost: the European Association of Service Providers for Persons with Disabilities (EASPD), the European Disability Forum (EDF) and Rehabilitation International (RI). In two meetings (in June and in November 2017), the EDF delegation included representatives from Mental Health Europe and European Network of (ex-) Users and Survivors of Psychiatry (ENUSP).\(^6\) This is the only time where persons directly concerned by the Additional Protocol had any kind of representation in the drafting process.

8. On 14 May 2018, the European Disability Forum (together with its members ENUSP, Autism Europe, Inclusion Europe, Mental Health Europe, and with the International Disability Alliance) sent an open letter to the Secretary General of the Council of Europe in which they conveyed their “deepest concerns and opposition” to the adoption of the draft Additional Protocol to the Oviedo Convention, and announced that they would not attend the upcoming meeting of DH-BIO on 24 May 2018: “Despite our previous active engagement in these meetings, our inputs have been systematically ignored and the process has not been fully transparent, as we, civil society, never endorsed any aspects of this draft Additional Protocol. It is very concerning that organizations of persons with disabilities are not consulted in a meaningful way in this process, in line with article 4.3 of the UN CRPD regarding “decision-making processes concerning issues relating to persons with disabilities.”\(^7\) The “closed” nature of the work of DH-BIO has also been criticised by the main UN mechanisms concerned.\(^9\)

9. At the joint hearing on this issue, held by the Committee on Social Affairs, Health and Sustainable Development and the Committee on Equality and Non-Discrimination on 9 October 2018, referring to the protestations above from the most respected and relevant NGOs working in this area, the Council of Europe Commissioner for Human Rights agreed that their involvement has been “clearly too limited to satisfy the CRPD criteria” and that “this should justify a fundamental questioning of the soundness of the project as a whole”. She also pointed out that “dismissing opposition from them would be equivalent to saying that persons with psychosocial disabilities do not understand what is in the Protocol or what is good for them” and that “many similar mistakes made in the past should serve as a warning”.

10. The Committee thus agrees with the NGOs mentioned above that the good faith, transparency, mutual respect, meaningful dialogue and sincere desire to reach consensus which are the foundation stone of the CPRD process mandated in article 4.3 have, so far, not been met by DH-BIO. The Committee urges DH-BIO to carry out a meaningful consultation, to take place as a matter of priority.

\(^4\) Doc. 14007 (2016), explanatory memorandum, paragraphs 10-11.
\(^5\) Where the States which have ratified the Optional Protocol to the CRPD are concerned, the CRPD Committee may also receive and examine individual and collective petitions.
\(^6\) For the joint-statement of ENUSP and Mental Health Europe, see appendix IV of the report of the 11th meeting of DH-BIO. For the written comments of these organisations on the draft Additional Protocol, see documents DH-BIO (2017) 18, DH-BIO (2017) 31 and DH-BIO (2018) 7 rev.
\(^7\) Early in the drafting process, in March 2014, the drafting group organised a hearing of international non-governmental organisations representing different stakeholders (including patients, health professionals and person with psychosocial disabilities).
\(^9\) Letter addressed to the Secretary General of the Council of Europe, 29 September 2017 by the Special Rapporteur on the rights of persons with disabilities, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, the Chair of the Committee on the Rights of Persons with Disabilities, and the Vice-Chair of the Working Group on Arbitrary Detention, https://spcommreports.ohchr.org/TMResultsBase/DownloadPublicCommunicationFile?gId=23360.
3. Underlying approach

11. As the Special Rapporteur on the rights of persons with disabilities, Catalina Devandas Aguilar, pointed out at the May 2018 UN consultation on human rights and mental health, coercion and exclusion have become the rule in the majority of mental health systems, particularly in developed countries, and even involuntary interventions, such as electroconvulsive therapies, psychosurgery, forced sterilisation and other invasive, painful and irreversible treatments, continue to be permitted, contrary to the CRPD. She considered that the draft Additional Protocol would serve to legitimise those coercive practices, and called upon member States of the Council of Europe to stand against it, as it represented an unacceptable backward step in rights protection. At the hearing of 9 October 2018, she also stressed that the draft Protocol's approach was problematic as it was using “an out-dated normative framework” which is incompatible with the CRPD.

12. The Assembly’s main concern addressed in its 2016 Recommendation, that is, the incompatibility of the future legal instrument with the CRPD, remains valid. The same concern is shared by a number of high-profile human rights bodies and experts, including not only the UN Special Rapporteur on the Rights of Persons with Disabilities (see above), but also the CRPD Committee and the Commissioner for Human Rights of the Council of Europe who pointed out that “the conflict with the CRPD is not limited to the principle of acceptability of involuntary placements: it also concerns: outdated, stigmatising language used in the draft Additional Protocol (such as persons with “mental disorder”); its discriminatory approach; and its neglect of the positive support needs of the persons in question to enforce their human rights”.

13. In her concluding remarks at the hearing of 9 October 2018, the Chairperson of DH-BIO, Ms Ioan De Wezeman recalled that the draft Additional Protocol aimed at strengthening the rights of persons concerned by involuntary measures by introducing legal safeguards. However, as pointed out by the Commissioner on Human Rights: “the standards we need urgently today are not more safeguards, but what the states should do as a minimum to avoid involuntary measures in the first place”.

14. The draft Additional Protocol, as it stands today, is not fit for purpose. It will not protect persons with psychosocial disabilities from violations of their human rights, because it maintains the status quo, which is at the origin of human rights violations and abuses. It risks multiplying recourse to involuntary measures imposed on persons with psychosocial disabilities, by regulating what should be the exception – which then far easily become the norm –, thus multiplying also the attendant human rights violations and abuses. In addition, the draft Additional Protocol risks undermining the global human rights standards enshrined in the CRPD, and thus to weaken the application of these (higher) standards in Europe. It also risks undermining the credibility of the Council of Europe as a regional human rights organisation.

15. According to the summary of the UN consultation on human rights and mental health, at which the Committee Rapporteur Ms Reina de Bruijn-Wezeman (Netherlands, ALDE) represented the Assembly, participants “discussed the topic of mental health as a human rights issue and agreed that the situation could be improved through system-wide strategies and human rights-based services to combat discrimination, stigma, violence, coercion and abuse.” Indeed, several participants spoke against the draft Additional Protocol at this consultation (and no-one spoke in its favour), for reasons both of procedure and content.

16. Thus, in the opening session, several speakers expressed alarm about the ongoing process within the Council of Europe of drafting the Protocol “to legitimize involuntary treatment of persons with psychosocial disabilities, in violation of the Convention on the Rights of Persons with Disabilities, in a deliberate move away from the advances made to ensure human rights in mental health, such as the QualityRights initiative of the World Health Organization (WHO)”.

The United Nations High Commissioner for Human Rights, Zeid Ra’ad Al Hussein, “called for the elimination of practices such as forced treatment, including forced medication, forced electroconvulsive treatment, forced institutionalization and segregation. Instead, he called

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15 The Chair of the Indonesian Mental Health Association, Yeni Rosa Damayanti, ibid, paragraph 4.
on States to ensure access to a range of support services within the community, including peer support, and reminded participants that the Convention on the Rights of Persons with Disabilities offered the legal framework to uphold the rights of persons with psychosocial disabilities — including the exercise of legal capacity, free and informed consent, the right to live and be included in the community and the right to liberty and security, without discrimination.”

17. It is also worth quoting the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Dr Dainius Pūras, who exposed “the pervasive stigmatisation, overmedicalization and use of force that resulted in violations of the human rights of users of those services and persons with psychosocial disabilities worldwide. He referred to the deep power asymmetries, the predominance of the biomedical model and the biased use of knowledge, within psychiatry and mental health, as obstacles to the realization of rights. He asserted that the status quo was maintained by the concepts of dangerousness and of medical necessity to “fix a disorder”, which was not supported by modern evidence and continued to justify the use of non-consensual measures as ‘exceptions’.”

4. Final remarks

18. The comments received from several high-level human rights bodies during the 2015 public consultation highlighted serious problems with the definitions and terms used (dangerously imprecise and stigmatising language), the criteria for involuntary placement and treatment (which breach the fundamental principle of non-discrimination, and legitimise the use of force and arbitrary detention), the decision-making process as regards involuntary treatment of already placed persons with psychosocial disabilities if it is allowed at all (indeed, there is a growing body of evidence concerning the damaging impact and ineffectiveness of forced psychiatric treatment), and underlined the need to make preferred use of alternative measures. These concerns have not been adequately addressed in the draft of the Additional Protocol; on the contrary, the addition of a chapter dealing with “specific situations” (on seclusion and restraint, and on treatment with the aim of producing irreversible effects) is worrying.

19. Indeed, in its Article 18, the draft prohibits treatment with the aim of producing irreversible effects in the context of involuntary measures. However, since it only covers treatment with the aim of producing irreversible physical effects, in practice, only surgical operations such as lobotomy are effectively prohibited. Any treatment with irreversible effects which are not physical (but, for example, mental), such as electro-shock “therapy”, is fine, as well as any treatment which has irreversible side-effects (since the irreversible effects are not the aim of the treatment). This article would only be acceptable if it would clearly prohibit any treatment which has irreversible side-effects without full, free and informed consent by the person treated.

20. Moreover, the perilously imprecise language defining the scope of “mental disorder” in the draft Protocol could be interpreted to include a whole range of “mental disorders” for whom even DH-BIO recognises that involuntary measures would never be appropriate, such as “gender identity disorders, sleep disorders and sexual dysfunctions” (but which DH-BIO has so far not integrated into the text of the draft Protocol itself). The imprecise language of the protocol leads to the theoretical explanation that it would be perfectly legal for a trans-gender person or a person with a sleep disorder (whose mental health “condition” is judged to represent a significant risk of serious harm to his or her health or to others) to be involuntarily detained, involuntarily treated — including with electro-shock therapy and other treatments with irreversible side-effects. This is certainly not what DH-BIO really intends.

21. One last comment on the content of the draft Additional Protocol — as Ms Kyriakides stated in 2017: “Definitions, and terms used, matter” — as the last example has shown. It is therefore important that DH-BIO uses terms and definitions that are in line with all relevant human-rights standards and mechanisms. The Committee therefore urges avoiding the use of terms such as “mental disorder”, and recommends using “psychosocial disabilities”. The Committee also recommends not defining a measure as “involuntary” only when the person with “mental disorder” “objects” to the measure. As in other human rights instruments, the involuntary character of the measure should be defined by the absence of “full, free and informed consent” of the person concerned.

16 Ibid, paragraph 5.
17 Ibid, paragraph 12.
18 In fact, a sleep-deprived person could easily represent a significant risk of serious harm to his or her health or to others if he/she takes the wheel and causes an accident. In some countries, trans-gender persons are also considered to pose such risks - wrongly so, of course.
5. Conclusions and recommendations

22. To conclude: On the basis of the current version of the draft Additional Protocol submitted for comments, the Committee believes that the Assembly’s assessment in 2016 remains valid: the draft Additional Protocol is incompatible with the CPRD.

23. The draft Additional Protocol is also not fit for purpose: It will not protect persons with psychosocial disabilities from violations of their human rights because it maintains the status quo, which is at the origin of these human rights violations. It is unlikely to reduce the number of involuntary measures imposed on them and risks increasing recourse to such measures, by regulating what should be the exception – which then far easily become the norm —, and thus multiplying the attendant human rights violations and abuses.

24. In addition, the draft Additional Protocol risks undermining the global human rights standards enshrined in the CRPD, and thus risks weakening the application of these (higher) standards in Europe. As a consequence, it also risks undermining the credibility of the Council of Europe as a regional human rights organisation and provoking a conflict of laws.

25. In view of this assessment, the Committee urgently calls for work on the draft Additional Protocol to cease and the focus to be put on alternatives to involuntary measures, as well as on preventive measures.

26. The Committee believes that the solution lies in the good practices and tools from within and outside the health system that offer solutions and support in crisis or emergency situations, which are respectful of medical ethics and of the human rights of the individual concerned, including of their right to free and informed consent. These include programmes for personal assistance, psychosocial support and housing, which reduced the risk of institutionalisation and of being subjected to physical and sexual violence.\(^\text{19}\) These alternative measures should be what the Council of Europe should focus on.

27. The Committee also urges DH-BIO to respect article 4.3 of the CRPD as regards the necessary close and active consultation with the organisations representing persons with disabilities.

\(^{19}\) Ibid, paragraph 13.
Statement by the Committee on the Rights of Persons with Disabilities calling States parties to oppose the draft Additional Protocol to the Oviedo Convention

Adopted during the Committee’s 20th session, held, from 27 August 21 September 2018 in Geneva


The draft Additional Protocol, which purportedly aims at protecting the rights of all persons with “mental disorders” with regard to the use of involuntary placement and involuntary treatment blatantly conflicts with the human rights of persons with disabilities recognised by the Convention on the Rights of Persons with Disabilities. It violates particularly article 5 on equality and non-discrimination in conjunction with articles 12 on the right of equal recognition before the law, article 14 on the right to liberty and security, article 17 on the right to physical and mental integrity, and article 25 on the right to health.

Article 12 of the Convention on the Rights of Persons with Disabilities states that all persons with disabilities, including those with psychosocial disabilities, have the right to equal recognition before the law and should enjoy legal capacity on an equal basis with others. It sets forth two positive aspects of personal autonomy: the respect for one’s own choices shaped by individual will and preferences, and the promotion of personal autonomy through supported decision-making. In this regard, States parties have an obligation not to deprive persons with disabilities of the right to make and pursue their own decisions, nor to permit substitute decision-makers to provide consent on their behalf. Instead, States parties must provide persons with disabilities with access to different forms of support arrangements for the exercise of their legal capacity, including the provision of consent1.

Article 14 of the Convention on the Rights of Persons with Disabilities prohibits all unlawful or arbitrary deprivation of liberty of persons with disabilities, clarifying that the existence of impairment cannot justify a deprivation of liberty. Prevalent mental health laws nowadays justify detention on the grounds of actual or perceived mental impairment, or based on potential dangerousness to themselves or others. While the criteria purport to be objective and reasonable, in practice they have the effect of targeting

1 See Committee’s General Comment No 1 of 2014 (CRPD/C/CG/1)
Committee on the Rights of Persons with Disabilities (CRPD)
Statement

persons with disabilities, in particular persons with psychosocial and persons with intellectual disabilities who are commonly considered as being dangerous and in need of treatment or care. Hence, such measures are discriminatory and in contradiction of the prohibition of deprivation of liberty on the grounds of impairment, and the right to liberty on an equal basis with others prescribed by article 14. States have an obligation to replace the use of coercive psychiatry with support in decision making on health related matters and alternative service models that are respectful of the will and preferences of the person.

Persons with intellectual or psychosocial impairments are frequently considered dangerous to themselves and others when they do not consent to and/or resist medical or therapeutic treatment. All persons, including those with disabilities, have a duty to do no harm. Legal systems based on the rule of law have criminal and other laws in place to deal with the breach of this obligation. Persons with disabilities are frequently denied equal protection under these laws by being diverted to a separate track of law, including through mental health laws. This situation would be perpetuated by the Additional Protocol to the Oviedo Convention. These laws and procedures commonly have a lower standard when it comes to human rights protection, particularly the right to due process and fair trial, and are incompatible with article 13 in conjunction with article 14 of the Convention.

Article 25 of the Convention on the Rights of Persons with Disabilities expressly requires States to provide health care to persons with disabilities on the basis of free and informed consent. Health professionals are therefore obliged to ensure that consent is always provided before any medical intervention can be performed. On the basis of respect for a person’s consent, people are also entitled to refuse treatment, even when there is ground to believe that treatment would benefit their health. Persons with psychosocial disabilities should be treated no differently, and as a result, they enjoy the same right to accept or refuse medical treatment.

Furthermore, involuntary placement and treatment represent also a threat to the right to physical integrity, as recognised by article 17 of the Convention on the Rights of Persons with Disabilities. In practice, these non-consensual interventions entail the use of force, chemical or physical restraints, isolation, seclusion, or sedation. Such practices exceed the scope of the right to health and may amount to torture or cruel, inhuman or degrading treatment.

The Committee recalls that despite these concerns being expressed to the Secretary-General of the Council of Europe in a joint letter dated 29 September 2017 by the Working Group on Arbitrary Detention, the Chair of the Committee on the Rights of 2 See the Committee’s Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities, paragraph 6. See also A/HRC/34/32, para. 29 to 32.
3 See A/HRC/34/58, paragraph 85 and A/HRC/35/21, paragraph 29.
4 See the Committee’s Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities, (para. 14) – see also A/HRC/34/32, paragraphs 29 to 32
5 See E/CN.4/2006/120, paragraph. 82
6 See A/63/175, paragraphs 55 and 56
Committee on the Rights of Persons with Disabilities (CRPD)
Statement

Persons with Disabilities, the Special Rapporteur on the rights of persons with disabilities, and the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, and to the Committee on Bioethics of the Council of Europe in submissions from other stakeholders, alternatives to the Additional Protocol that would comply with the human rights of persons with disabilities have not been discussed.

The Committee strongly recommends that all States parties to the Convention on the Rights of Persons with Disabilities who are members of the Council of Europe explicitly oppose the adoption of the Additional Protocol to the Oviedo Convention. The Committee also welcomes the opposition already expressed by the States of Portugal, Bulgaria and the Former Yugoslav Republic of Macedonia, and encourages them to raise their views before the Committee on Bioethics of the Council of Europe.

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Mr Stefan Schennach, Chairperson of the Committee on Social Affairs, Health and Sustainable Development  
Ms Elvira Kovács, Chairperson of the Committee on Equality and Non-Discrimination  
Ms Beatrice Ioan, Chairperson of the Council of Europe Committee on Bioethics,  
Ms Dunja Mijatović, Council of Europe Commissioner for Human Rights,  
Mr Christos Giakoumopoulos, Director General of Human Rights and Rule of Law of the Council of Europe  
Ms Olga Runciman, Psychologist and owner of Psycovery  

Ladies and gentlemen,  

I would like to begin by thanking the two Committees of the Parliamentary Assembly for this invitation. The topic that we are discussion today deserves the full attention of the Council as it is gaining momentum in the human rights conversations.

As an independent human rights expert I am mandated by the UN Human Rights Council to monitor and advice on the human rights situation of persons with disabilities. To that end I regularly engage with States, international and regional organizations and other relevant stakeholders to identify priority areas of concern in advancing the disability rights agenda. This engagement also allows me to learn, exchange and promote good practices related to the realization of rights and to provide technical assistance to national efforts that respect and protect persons with disabilities rights’.  

The situation of persons with psychosocial and intellectual disabilities and, particularly, their right to be free from non-consensual medical treatment, has been a priority of my mandate, and the reason why I am here today to elaborate on why the draft “Additional Protocol to the Oviedo Convention concerning
involuntary placement and involuntary treatment of persons with mental disorders” is against existing human rights standards and, therefore, should not be adopted by the Council of Europe.

To start with, I want to emphasize that we all share common goals; the goals of saving lives and supporting those that are going through difficult times; including situations of acute crisis and extreme distress. The key question is how we do it? How do we respond to these situations in a way that is respectful of the person’s dignity, physical and mental integrity and will and preferences? How do we provide responses that are human rights based?

In my view, the biggest challenge we have with the Draft Protocol is its approach. It is responding to our common concern using an out-dated normative framework; a approach that as several human rights bodies and experts have said, is contrary to the UN Convention on the Rights of Persons with Disabilities.

This Convention, in force for more than ten years, brought about a transcendental change in the way we approach the rights of persons with disabilities.

For too long, fundamental rights such as the right to legal capacity, the right to liberty and security, the right to integrity, and the right to be free from non-consensual medical treatment, were all systematically denied to persons with psychosocial disabilities.

People with psychosocial disabilities were seen as patients -"persons with mental disorders" as the draft protocol continues to calls them- who needed to be "cured" or "controlled".

The CRPD moves away from these out-dated, paternalistic, medical approaches to disability. Recalling the universality, indivisibility, interdependence and interrelatedness of human rights, the Convention stresses that all persons with disabilities should enjoy all human rights on an equal basis with others.

Exceptions to the enjoyment of rights on the basis of a mental health condition or diagnosis -as those contained in the draft protocol- are contrary to the spirit and letter of the Convention, and more specifically, to the right to equality and non-discrimination.

Here, I am sure, many of you are already asking, yes but, how does this full recognition of rights is going to help us to address our common concern of saving lives or helping those in situations of distress? Well, departing from the medical
model, the Convention emphasises the role of support in the actual implementation of rights. The notion of support embedded in the Convention is transformative and represents a unique opportunity for the development of innovative practices in the mental health context. The support paradigm of the Convention offers a rights-based approach to deal with situations of emotional crisis and severe distress.

Indeed, there is increasing evidence of the effectiveness of non-coercive interventions, inside and outside the health sector. I am referring to hospital-based strategies for reducing coercion, home intervention strategies, crisis or respite services, peer-run initiatives, advance planning, among many others.

Furthermore, there is evidence that the biomedical model and coercive practices are failing to improve mental health outcomes, reduce the risk of self-harm and facilitate access to treatment. Studies show an alarming growth of stigma and discrimination, inequality and torture and ill-treatment.

The history of psychiatry demonstrates that the good intentions of service providers can turn into violations of the human rights of service users. In the name of saving lives, we restrain, seclude and forcibly treat people, cutting off the potential for successful, supportive interventions.

When we look at the practice in Europe, there are significant differences in both legislation and clinical practices regarding involuntary treatment. Countries with mental health legislation reflecting the standards of this draft protocol experience significantly higher rates of involuntary treatment - up to 30%; whereas in areas with a long-standing tradition of community mental health and alternative practices, such as Trieste in Italy or Western Lapland in Finland, involuntary commitment is very low.

We need to continue researching and developing these practices, as well as urgently address the structural factors that normalize coercion in mental health services, including discriminatory legislation, the absence of psychosocial support, limited human resources, lack of flexibility within services, stigma and prejudices, and regulations governing liability of health professionals. So, we need to change the focus of the conversation. Instead of regulating forced interventions we need to immediately discuss about how to scale up and support the creation and sustainability of human rights based responses.
Regretfully, the draft protocol regulates what does not work - the past - instead of focusing on what we can do to improve mental health responses and to increase the participation of persons with psychosocial and intellectual disabilities.

Ladies and gentlemen,

Let me remind you that, to date, there are 177 States Parties to the UN Convention of the Rights of Persons with Disabilities, including 46 of the 47 members of the Council of Europe. And for the first time the European Union is a party to a human rights treaty.

All of them made an international commitment to respect, protect and fulfil all the rights of all persons with disabilities, including persons with psychosocial and intellectual disabilities.

The Convention stands as the most authoritative instrument to guide the formulation of legislation and policies related to the rights of persons with disabilities, and fully covers the scope of the draft additional protocol to the Oviedo Convention concerning involuntary placement and involuntary treatment.

So let me be clear: adopting this draft additional protocol will be a terrible and regretful mistake for the Council of Europe.

This is not just my opinion but the position of many human rights bodies and experts, including:

- the UN Committee on the Rights of Persons with Disabilities;
- the Working Group on Arbitrary Detention;
- the Special Rapporteur on health;
- the Commissioner for Human Rights of the Council of Europe;
- the European Union Agency for Fundamental Rights;
- the European Network of National Human Rights Institutions;
- and, most significantly, the voices of the concerned right-holders themselves: The European Disability Forum, the European Network of Users and Survivors of Psychiatry, Inclusion Europe, the International Disability Alliance, among others.

Ladies and gentlemen,

History is on the side of human rights.
The African region recently adopted an Additional Protocol to the African Charter on Human and People’s Rights on the rights of persons with disabilities, which upholds the principles of the UN Convention on the Rights of Persons with Disabilities.

The Inter-American system also adopted a significant general comment aligning itself to the standards of the UN Disability Convention. Moreover, the Organisation of American States adopted a new Inter-American Convention on the rights of older persons, whose standards in relation to legal capacity, liberty and informed consent replicate the UN Disability Convention.

This draft additional protocol is discriminatory, contradicts international human rights law, and may lead to torture, ill-treatment and other forms of abuse. Furthermore, it does not improve mental health systems nor protect the rights of persons with psychosocial and intellectual disabilities.

Since 1949, the Council of Europe has been promoting human rights, democracy and the rule of law in Europe - a region with a strong tradition of republican and democratic values.

This bedrock was formed to address past wrongs- human rights atrocities and injustices, to ensure their non-repetition- never again. May this same bedrock of values, applicable at all times and for all people, serve as your guidance for the full inclusion of persons with disabilities in all areas of life.
Mandates of the Working Group on Arbitrary Detention; the Chair of the Committee on the Rights of Person with Disabilities; the Special Rapporteur on the rights of persons with disabilities and the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

REFERENCE:
OL OTH 23/2017

29 September 2017

Dear Mr. Jagland,

We have the honour to address you in our capacities as Working Group on Arbitrary Detention; Special Rapporteur on the rights of persons with disabilities; Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, pursuant to Human Rights Council resolutions 33/30, 35/6, and 33/9; and Chair of the Committee on the Rights of Person with Disabilities.

In this connection, we would like to bring to your attention information we have received concerning the draft Additional Protocol to the Convention on Human Rights and Biomedicine (hereinafter referred to as the Additional Protocol), elaborated by the Committee on Bioethics of the Council of Europe (DH-BIO). The draft Additional Protocol is purportedly aimed at protecting the rights of all persons with “mental disorders” with regard to the use of involuntary placement and involuntary treatment.

In June 2015, a draft version was put for open consultations and, according to the compilation of the comments, the Secretariat of the Committee has received some 40 submissions from different stakeholders (see DH-BIO/INF (2015) 20), including contributions from the United Nations Committee on the Rights of Persons with Disabilities, and the Special Rapporteur of the United Nations Human Rights Council on the Rights of Persons with Disabilities. Most of those submissions were converging around the issues of: stigmatizing language used in reference to persons with psychosocial disabilities; breach of the fundamental principle of non-discrimination; and legitimization of the use of force and arbitrary deprivation of liberty. Furthermore, the Commissioner for Human Rights and the Parliamentary Assembly of the Council of Europe called for the withdrawal of the draft Additional Protocol as it was blatantly conflicting with the human rights standards set by the United Nations Convention on the Rights of Person with Disabilities.

After the consultations, the Drafting Group continued their work in closed sessions. According to the Abridged Report on the 11th meeting of the Committee on Bioethics, which took place from 6 to 8 June 2017, a revised text has been put forward. However, there is no publicly available information regarding the new content of the draft Additional Protocol, the further organisation of the working process, and the tentative deadlines for finalization.

Ahead of the upcoming plenary session of the Committee on Bioethics, we would like to reiterate our concerns that the draft Additional Protocol openly contradicts the human rights standards set by the United Nations Convention on the Rights of Person...
with Disabilities. Furthermore, we would like to draw your Excellency’s attention that the adoption of such an instrument, which falls below the binding international human rights standards, would reflect in a negative way on the role of the Council of Europe as a prominent guardian of human rights.\(^1\) It is important to recall that 44 out of the 47 member States of the Council of Europe are also States Parties to the United Nations Convention on the Rights of Person with Disabilities, and that all 29 States Parties to the Oviedo Convention are also States Parties to the Convention on the Rights of Person with Disabilities.

In the exercise of our mandated responsibilities, we stand ready to provide further advice and technical assistance in support of the efforts of the Committee on Bioethics to ensure that the current law reform process respects the standards put forward by the Convention on the Rights of Persons with Disabilities.

Please accept, Excellency, the assurances of our highest consideration.

Elina Steinerte  
Vice-Chair of the Working Group on Arbitrary Detention

Theresa Degener  
Chair of the Committee on the Rights of Person with Disabilities

Catalina Devandas-Aguilar  
Special Rapporteur on the rights of persons with disabilities

Dainius Pūras  
Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

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\(^1\) A previous letter on the potentially harmful outcomes of the Additional Protocol was addressed to the Secretariat of the Committee on 15 November 2015. The Chair of the CRPD Committee Theresa Degener (then Vice Chair) also addressed the issue during her meeting with the Steering Committee for Human Rights at its 84th session from 7-11 December 2015, See Report CDDH(2015) R84 pg. 46 et seq.
Annex

Reference to international human rights law

In connection with above concerns, we would like to make reference to the applicable international human rights norms and standards relevant to the full enjoyment and realisation of human rights by persons with disabilities.

We would like to emphasize that the issues addressed by the draft Additional Protocol fall within the scope of the Convention on the Rights of Persons with Disabilities, which is the most authoritative instrument to guide the formulation of any standards, laws or guidelines related to the rights of persons with disabilities. Therefore, as UN experts mandated to assist States in understanding what are their obligations under the Convention and to engage in constructive dialogue with the authorities on how to accelerate its domestic implementation, we are highly concerned that the proposed text does, prima facie, fall below the human rights standards set by the Convention.

Article 12 of the Convention on the Rights of Persons with Disabilities states that all persons with disabilities, including those with psychosocial disabilities, have the right to equal recognition before the law and should enjoy legal capacity on an equal basis with others. It sets forth two positive aspects of personal autonomy: the respect for one's own choices shaped by individual will and preferences, and the promotion of personal autonomy through supported decision-making. In this regard, States parties have an obligation not to deprive persons with disabilities of the right to make and pursue their own decisions, nor to permit substitute decision-makers to provide consent on their behalf. Instead, States parties must provide persons with disabilities with access to different forms of support arrangements for the exercise of their legal capacity, including the provision of consent (see General comment No 1 (2014) CRPD/C/CG/1).

Article 14 of the Convention on the Rights of Persons with Disabilities prohibits all unlawful or arbitrary deprivation of liberty of persons with disabilities, clarifying that the existence of a disability cannot justify a deprivation of liberty. Prevalent mental health laws nowadays justify detention on the grounds of actual or perceived mental impairment, or based on potential dangerousness to themselves or others. While the criteria purport to be objective and reasonable, in practice they have the effect of targeting persons with disabilities, in particular persons with psychosocial and persons with intellectual disabilities who are commonly considered as being dangerous and in need of treatment or care. Hence, such measures are discriminatory and in contradiction of the prohibition of deprivation of liberty on the grounds of disability, and the right to liberty on an equal basis with others prescribed by Article 14 (see Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities, para. 6; A/HRC/34/32, para. 29-32). States have an obligation to replace the use of coercive psychiatry with support in decision making on health related matters and alternative service models that are respectful of the will and preferences of the person (see A/HRC/34/58, para. 85; A/HRC/35/21, para. 29).
Article 25 of the Convention on the Rights of Persons with Disabilities expressly requires states to provide health care to persons with disabilities on the basis of free and informed consent. Health professionals are therefore obliged to ensure that consent is always provided before any medical intervention can be performed. On the basis of respect for a person’s consent, people are also entitled to refuse treatment, even when there is ground to believe that treatment would benefit their health (see E/CN.4/2006/120, para. 82). Persons with psychosocial disabilities should be treated no differently and as a result they enjoy the same right to accept or refuse medical treatment.

Furthermore, involuntary placement and treatment represent also a threat to the right to physical integrity, as secured by Article 17 of the Convention on the Rights of Persons with Disabilities. In practice these non-consensual interventions entail the use of force, chemical or physical restraints, isolation, seclusion, or sedation. Such practices exceed the scope of the right to health and may amount to torture or cruel, inhuman or degrading treatment (see A/63/175, paras. 55-56).

Scientific and experiential research, which is available today, shows that persons with psychosocial disabilities can live independently when empowered through appropriate legal protection and support (see A/HRC/35/21, para. 25). Furthermore, it must be mentioned that the reductionist biomedical model of psychiatry, heavily reliant on coercion and medicalization in everyday practice, is under increased scientific critique that is backed up by sturdy research (see A/HRC/35/21). In this context, it is worth noting that the Resource Book on Mental Health, Human Rights and Legislation, developed by the World Health Organization to guide States on the procedures and safeguards related to involuntary treatment, has been withdrawn. This document, drafted prior to the coming into force of the Convention on the Rights of Persons with Disabilities, was deemed incompatible with the latest human rights standards. The World Health Organization resolved to abide by the Convention on the Rights of Persons with Disabilities and ground their future work on the formulation of rights-based guidance (see http://www.who.int/mental_health/policy/legislation/en/).

We would like, therefore, to encourage the Council of Europe to take into consideration all these recent developments within the international human rights law framework and the compelling body of evidence on the detrimental social and individual effects of coercion during the debate of the proposals for an Additional Protocol. Non-discrimination as a principle and a right must be a central feature of any human rights instrument. The Additional Protocol risks to fragment the corps of international human rights law of which its own legitimacy rests upon its coherence. By creating divergent and contradictory standards, it is less likely that States will be drawn to implement provisions, thus leaving a gap in rights protection and impeding current reform initiatives giving effect to the Convention on the Rights of Persons with Disabilities.

Finally, we would like to remind you the obligation set forth by the Convention on the Rights of Person with Disabilities to closely consult with and actively involve persons with disabilities, in particular persons with psychosocial disabilities, through their representative organizations, in the development and implementation of any mental
health legislation or policy (Article 4(3)). Good faith should be a foundation stone of this process, and consultations must embrace transparency, mutual respect, meaningful dialogue and a sincere desire to reach consensus.

The full texts of the human rights instruments and standards outlined above are available at www.ohchr.org and can be provided upon request.
Office of the United Nations High Commissioner for Human Rights – Regional Office for Europe (OHCHR-ROE)

The Office of the United Nations High Commissioner for Human Rights – Regional Office for Europe (OHCHR-ROE) – welcomes the opportunity to provide comments on the draft Additional Protocol to the Oviedo Convention concerning the protection of human rights and dignity of persons with mental disorders with regard to involuntary placement and involuntary treatment. We also welcome the fact that the draft Additional Protocol has been opened for public consultation.

In preparing these comments, we have consulted with a variety of civil society stakeholders, including disabled persons’ organizations, human rights experts, and others. The comments below set out OHCHR-ROE’s concerns with the current draft, in particular as regards alignment with the UN Convention on the Rights of Persons with Disabilities.

Departure from international standards
The United Nations Convention on the Rights of Persons with Disabilities (CRPD) represents a paradigm shift away from the charitable and medical approach to disability. The CRPD brings a human rights-based approach to disability: it challenges paternalistic views by emphasizing the person as a rights-holder and an active subject of rights, rather than a passive object of care.

The CRPD applies to situations that the draft Additional Protocol seeks to regulate. Nevertheless, while the draft Additional Protocol refers to the CRPD in its preamble, it does not appear to take its spirit nor its provisions into account in a meaningful way, let alone to use it as a basis of the standard-setting effort. OHCHR-ROE is concerned that the draft Additional Protocol remains apparently based on the medical model of disability, i.e., as if reflecting the situation prior to adoption of the CRPD.

In our view, it is problematic for the Council of Europe to draft standards, one decade after the CRPD adoption, which do not take the aforementioned paradigm shift fully into account. Indeed, as a general rule, regional bodies such as the Council of Europe should take full account of those international standards which most of its Member States are bound by. Currently, 41 out 47 Member States of the Council of Europe have ratified the CRPD and are thus legally bound by its provisions. Further, all States parties to the Oviedo Convention have either signed or ratified the CRPD. We are convinced that in no case should regional initiatives set standards lower than international ones when it comes to human rights protection. On the contrary, such bodies should, in their work, aim to contribute to the full implementation of those international standards.

The aim of the CRPD is the full and equal enjoyment of all human rights by persons with disabilities. According to the CRPD, persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others. This definition includes persons with psychosocial disabilities. However, use of the term “mental disorder” in the draft considers persons with disabilities as patients rather than rights-holders, reflecting the medical model. According to the draft Explanatory Report the term “mental disorder” is defined broadly in accordance with internationally accepted medical standards – but that reinforces the medical perspective, rather than taking the notion of disability as enshrined in the CRPD as a starting point.
Capacity to consent and liberty and security of the person
The draft Additional Protocol as a whole concerns non-consensual treatment or placement and applies to persons who have not expressed consent to being placed or treated. Article 2 of the draft Protocol defines involuntary as: "a placement or a treatment measure applied to a person with mental disorder who objects to the measure1".

The entire approach of the draft Additional Protocol thus appears to be starting from very different premises than Article 14 of the CRPD, according to which State parties shall ensure that persons with disabilities "shall not be deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law and that the existence of a disability shall in no case justify a deprivation of liberty". If persons with disabilities are deprived of their liberty "through any process, they are entitled to guarantees in accordance with international human rights law". Article 14 of the Convention is, in essence, a non-discrimination provision, prohibiting all discrimination based on disability in its exercise.

Working document concerning the protection of human rights and dignity of persons with mental disorder with regard to involuntary placement and involuntary treatment, DH-BIO/INF (2015) 7, article 2(4).

In addition, the notion of “representative” applies in the draft Additional Protocol to cases in which a person does not have, according to law, the capacity to consent. This again contrary to Article 12(2) CRPD, which provides that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life. The CRPD Committee has insisted that a person’s status as a person with disability or the existence of an impairment must never be grounds for denying legal capacity.2 While some national laws currently deny legal capacity to persons with disabilities in particular cases, the CRPD Committee has specifically called on such States parties to reform these laws. In this regard, setting standards for substitute decision-making (Articles 2, 10, 11 and 12 of the draft Additional Protocol read together) instead of supported decision-making (Article 12 UN CRPD) also runs contrary to the principles of non-discrimination, of individual autonomy, which includes the freedom to make one’s own decisions, and the right to inclusion in society.

Consent and Prohibition of torture
Article 15(1) of the CRPD provides that no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his or her free consent to medical or scientific experimentation.

Further, the CRPD Committee has called on States parties to protect the security and personal integrity of persons with disabilities who are deprived of their liberty, including by eliminating the use of forced treatment, seclusion and various methods of restraint in medical facilities, including physical, chemical and mechanic restraints. The Committee has found that these practices are not consistent with the prohibition of torture and other cruel, inhumane or degrading treatment or punishment against persons with disabilities pursuant to article 15 of the Convention. In relation to Article 7 of the International Covenant on Civil and Political Rights (prohibition of torture), the United Nations Special Rapporteur on torture has remarked on the issue of treatment without consent: "Whereas a fully justified medical treatment may lead to severe pain or suffering, medical treatments of an intrusive and irreversible nature, when they lack a therapeutic purpose, or aim at correcting or alleviating a disability, may constitute torture and ill-treatment if enforced or administered without the free and informed consent of the person concerned."
Conclusion
We would like to recall that, pursuant to article 4.1.d) of the CRPD, Member States of the Council of Europe that are parties to the CRPD should refrain from engaging in any act or practice that is inconsistent with the CRPD. This includes engaging in the negotiation of regional standards that are not in line with the human rights approach to disability enshrined in the Convention.

We are of the view that the draft Additional Protocol risks not only lowering the level of protection of persons with disabilities (in particular persons with psychosocial disabilities), but also undermining the progressive shift in national laws and policies in the field of disability law that is currently under way as States seek to modernize their approach in the light of the obligations stemming from the CRPD. Due to the aforementioned paradigm shift, this process is often challenging for States parties to the CRPD, including Council of Europe Member States; but it is nonetheless going on, as shown (for instance) by the recent reforms in the area of legal capacity in several Council of Europe Member States. Therefore, we are concerned that the adoption of the proposed regional standard would merely reinforce conservative tendencies and slow down the process of CRPD-induced change of legislation and policy in Council of Europe Member States.

Therefore, OHCHR-ROE would like to encourage you to withdraw this proposal while pursuing – in cooperation with a wide range of stakeholders including disabled persons’ organizations – other initiatives that would enhance the protection of rights of persons with disabilities and help to bring national legislation in line with the UN CRPD.

A letter from relevant stakeholders under the OHCHR-ROE

The undersigned organizations thank you for the opportunity to provide comments to the draft Additional Protocol concerning the protection of human rights and dignity of persons with mental disorder with regard to involuntary placement and involuntary treatment.

We have each prepared our respective comments, in line with the mandates of our organizations, which set out concerns regarding the compatibility of the draft Additional Protocol with the United Nations Convention on the Rights of Persons with Disabilities (UN CRPD). In addition, we have prepared this joint letter as we have some common, overall issues to raise regarding the draft. Our main concerns arise in relation to non-discrimination, equal recognition before the law, liberty and security of a person, right to health and prohibition of torture and ill-treatment. Furthermore, we are concerned about the lack of meaningful involvement and consultation of disabled persons’ organizations in the elaboration and drafting of this document, contrary to article 4(3) of the UN CRPD.

It is important to recall at the outset that 41 out of 47 Member States of the Council of Europe (CoE) have ratified the UN CRPD. In addition, 5 CoE Member States have signed but not yet ratified the UN CRPD, and are therefore bound, in the period between signing and ratification or consent to be bound, to refrain from acts that would defeat the object and purpose of the treaty.

The UN CRPD is based on the recognition of persons with disabilities, including those with psychosocial disabilities, as rights holders, not objects of care. However, both the overall approach of, and the language used in the draft Additional Protocol reflect the old, medical model of disability which constitutes a step back from the developments that led to the adoption of the UN CRPD. The stated aim of the draft Additional Protocol is to clarify the “standards of protection applicable to the use of involuntary placement and of involuntary treatment”. It is our view that the raison d’être and the provisions contained in the
document (as detailed further in our comments) demonstrate that the guiding principles of the UN CRPD, namely non-discrimination and equality, autonomy, participation and inclusion in society, are not incorporated in a meaningful way in the draft.

We also have concerns with the draft viewing involuntary treatment and placement as a form of “therapy” or “care”. There is a growing and convincing body of evidence of involuntary interventions violating human rights and in some cases, even amounting to torture. The CRPD Committee has stated in several concluding observations, as well as in their General Comment No. 1 and in their Guidelines on CRPD Art. 14, that forced treatment by psychiatric or other health and medical professionals is a violation of the right to equal recognition before the law and not consistent with the prohibition of torture and other cruel, inhuman or degrading treatment or punishment pursuant to article 15 of the CRPD.

Finally, we take this opportunity to recall that regional human rights standards should not aim lower than nor undermine international human rights standards. The standards in this draft Additional Protocol appear to reflect provisions contained in national laws currently in force in some CoE Member States, for instance related to legal capacity and to involuntary placement and treatment. However, in its reviews of State Party reports to date, the UN Committee on the Rights of Persons with Disabilities has identified some such national laws as requiring reform in order to be in line with the UN CRPD. While it is understood that some legislative reforms may take time, the State Parties’ obligation to abolish discriminatory regimes of detention and practices amounting to torture or other ill-treatment is of immediate application.

States Parties to the UN CRPD have undertaken to put in place systems that respect persons with disabilities as rights holders, and not objects of care. However, the document in question does not promote nor encourage the principles underlying the UN CRPD. Rather, it sets out standards that step away from those contained in the UN CRPD.

Given the nature of our concerns, we have come to the conclusion that they cannot meaningfully be addressed by partial changes to some of its provisions. Therefore, we would like to encourage you to withdraw this proposal while pursuing – in cooperation with a wide range of stakeholders including disabled persons’ organizations (DPOs) – other initiatives that would enhance the protection of rights of persons with disabilities and help to bring national legislation in line with the UN CRPD.

MINISTRIES

Ministry of Health (Denmark)

The Danish Ministry of Health would like to put forward the following comments:

**Article 1, line 46**

According to article 1.1: “Parties to this Protocol shall protect the dignity and identity of all persons with mental disorder and guarantee, without discrimination, respect for their integrity and other rights and fundamental freedoms with regard to involuntary placement and involuntary treatment”.

The definition “mental disorder” has not been clarified in the explanatory report and there seems to be some uncertainty about what the term implies. In Denmark involuntary treatment and involuntary placement can take place on the ground of “insanity/psychosis” and not on the grounds on mental disorder.