**Overview of issues created by the Draft Additional Protocol to the Council of Europe’s Oviedo Convention in light of the CRPD**

The EU and all its Member States have ratified the UN Convention on the Rights of Persons with Disabilities (CRPD). In addition, 46 of the 47 Members of the Council of Europe ratified the CRPD.

The CRPD was adopted in 2006. It protects the rights of persons with disabilities, including persons with psychosocial disabilities, people with intellectual disabilities and people with dementia. It is based on a human rights-based approach to disability. It is the most authoritative human rights instrument on disability rights.

The draft additional protocol to the Oviedo Convention of the Council of Europe aims at regulating involuntary treatment and placement in psychiatry. It is based on a [2004 Recommendation](https://search.coe.int/cm/Pages/result_details.aspx?ObjectID=09000016805dc0c1) made before the introduction of the CRPD, and has been negotiated since 2014. The draft protocol promotes a medical model of disability which authorises placement and treatment in psychiatry without the consent of the person.

**Main contradictions between the CRPD and**

**the draft additional protocol**

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| **Convention on the Rights of Persons with Disabilities** | **Draft additional protocol (version December 2020, to be presented for a vote)** |
| **Right to health and deprivation of legal capacity** | |
| **Article 25** of the CRPD states: “persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability,” which includes requiring “health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent…”  *Informed consent includes the possibility to refuse treatment, even when there are grounds to believe that treatment would benefit their health. Persons with disabilities should be treated no differently, and thus have the equal right to accept or refuse medical treatment.*  **CRPD Article 12** states that persons with disabilities enjoy “the right to recognition everywhere as persons before the law. States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life. States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.”  *States parties have an obligation not to deprive persons with disabilities of the right to make their own decisions, nor to permit others to provide consent on their behalf. Instead, States parties must provide persons with disabilities with access to supported decision-making, including for the provision of consent for medical treatment.[[1]](#footnote-1)* | While **Article 3** of thedraft additional protocol states that “Measures in mental health care shall, as a general rule, only be carried out with the free and informed consent of the person concerned or, where, according to law, the person does not have the capacity to consent, respecting his or her wishes,” *the scope and purpose of the draft additional protocol is to create a framework under which involuntary measures in mental health are authorised.*  **Article 2** of the draft protocol explicitly states that involuntary measuresrefer to “any placement and/or treatment of a person **without that person’s free and informed consent or against the will of the person**.” It also recognises deprivation of legal capacity and a substitute decision-making mechanism through the designation of a representative (“a person provided for by law to represent the interests of, and take decisions on behalf of, a person who does not have, according to law, the capacity to consent”). |
| **Involuntary treatment and placement** | |
| **Article 14** of the CRPD states: “States Parties shall ensure that persons with disabilities, on an equal basis with others: Enjoy the right to liberty and security of person [and] Are not 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.”  *Many existing national laws, like the draft additional protocol, justify detention on the grounds of actual or perceived so-called “mental impairment” or based on “potential dangerousness” of a person. 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 disabilities and persons with intellectual disabilities. The CRPD committee has found these laws to be discriminatory and in violation of article 14.* | **Chapter IV** of the draft additional protocol, and in particular **articles 11 and 12,** establishes criteria for involuntary placement.Under article 12, a decision on involuntary measures can be taken by a court or any competent body after the examination of one physician.  **“Article 11 – Criteria for involuntary placement and for** **involuntary treatment**  Involuntary placement and/or involuntary treatment may only be used if the following criteria are met:  i. a) the person’s current mental health condition represents a significant risk of serious harm to his or her health and his or her ability to decide on the measure is severely impaired or  b) the person’s current mental health condition represents a significant risk of serious harm to others;  ii.the measure has a therapeutic purpose;  and  iii. any voluntary measure is insufficient to address the risk(s) referred to in paragraph i).”  **“Article 12 – Standard procedures for taking decisions on involuntary placement and on involuntary treatment**  1. The decision to subject a person to involuntary placement or to involuntary treatment shall be taken by a court or another competent body. The court or other competent body shall:   1. act on the basis of an appropriate medical examination by at least one physician having the requisite competence and experience, in accordance with applicable professional obligations and standards; 2. ensure that the criteria set out in Article 11are met; 3. act in accordance with procedures provided by law based on the principles that the person concerned shall be heard in person and with the support of his or her person of trust, if any; 4. take into account the opinion of the person concerned, and any relevant previously expressed wishes made by that person; and 5. consult the representative of the person, if any.   **2.** The decision to subject a person to an involuntary measureshall specifythe period of its validity and shall be documented.  **3.** The law shall specify the maximum period of validity of any decision to subject a person to an involuntary measureand the arrangements for periodic review.”  **Article 13** foresees a procedure for taking decisions in emergency situations. Under that procedure, the decision by a court or other competent body is not necessary, and involuntary measures can be taken after a medical examination.  **“Article 13 – Procedures for taking decisions in emergency situations**  1. When there is insufficient time to follow the procedures set out in Article 12 because of the imminent risk of serious harm, either to the health of the individual concerned, or to others, the decision to subject a person to involuntary placement and/or to involuntary treatment may be taken by a court or other competent body, under the following conditions:  i. involuntary placement and/or involuntary treatment shall only take place on the basis of a medical examinationappropriate to the measure concerned;  ii. the criteria set out in Article 11are met;  iii. paragraph 1iii, iv and v of Article 12 shall be complied with as far as possible;  iv. decisions to subject a person to involuntary placement and/or involuntary treatment shall be documented.  2. The law shall specify the maximum periodfor which an emergency measure may be applied.  3. The duration of the emergency measure shall be as short as possible. It shall neither extend beyond the emergency situation nor the maximum period under paragraph 2, except where a procedure under Article 12 has been initiated.” |
| **Right to physical integrity** | |
| **Article 17** of the CRPD states: “Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others.”  *The CRPD Committee recognises that involuntary placement and treatment represent a threat to the right to physical integrity. In practice, non-consensual treatment can 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, prohibited by* ***article 15*** *of the CRPD.* | **Article 17** of the draft additional protocol explicitly allows measures of seclusion and restraint.  **“Article 17 – Seclusion and restraint**  1. Parties shall ensure the development of methods and programmes preventing the use of seclusion and restraint.  2. Seclusion and restraint shall only be used, subject to the protective conditions provided for by law, to prevent seriousimminent harm to the person concerned or others. Seclusion and restraint shall always take place in an appropriate environment. In accordance with the principle of proportionality and necessity, seclusion and restraint shall only be used as a last resort and for a time limited to its strict necessity.  3. Any resort to seclusion or restraint shall be specifically and expresslyordered by a physician or immediately brought to the attention of a physicianwith a view to seeking the latter’s approval. The nature of, reasons for, and duration of, every resort to seclusion or restraint shall be recorded in the person’s medical file as well asspecifically registered.  4. Persons subject to seclusion or mechanical restraint shall be continuously monitored by an appropriately trained member of staff.  5.Any use of seclusion or restraint may be subject to the complaints procedures provided in Article 22.”  According to **article 18** of the draft protocol, treatment aiming at causing irreversible effects should not be used in the context of involuntary measures.  **“Article 18 – Treatment aiming at causing irreversible effects**  Treatment aiming at causing irreversible physical effects shall not be used in the context of involuntary measures.”  However, the explanatory report of the draft protocol indicates that measures that may, as unintended side effects, have irreversible physical effects, such as electro-convulsive therapy (ECT), **are not prohibited** by the draft protocol (see para. 103 of explanatory report).  “**Article 18 – Treatment with the aim of producing irreversible effects**  102. Article 18 addresses recourse to treatment that aims at causing irreversible physical effects. An example of such a treatment is a psychosurgical operation aimed at producing a small lesion at a specific site in the brain. Such treatments shall only be undertaken with the free and informed consent of the person concerned. The difficulty of ensuring that consent is truly voluntary when a person is subject to involuntary measures means that it is ruled out to use such treatments in the context of involuntary placement and/or involuntary treatment.  103. This Article does not cover treatments that may, as an unintended side-effect, have irreversible physical effects, as for example electroconvulsive therapy (ECT). However, in view of the particular intrusiveness of this method, the CPT recommends that, save for exceptional circumstances clearly and strictly defined by law, patients should be free to refuse or consent to ECT, after receiving information on the likely beneficial effects and risks. Similar considerations could apply to the use of deep brain stimulation in the context of treatment of persons with mental health problems.” |

In practice, there is evidence that laws on involuntary treatment and placement in psychiatry do not prevent coercion. The Council of Europe’s Parliamentary Assembly’s May 2019 [report on ending coercion in mental healthcare](https://pace.coe.int/en/files/27701/html) states: “there is an overall increase in the use of involuntary measures in mental health settings, including in countries where …. *laws were introduced with the aim of reducing recourse to such measures*” (such as France and the Netherlands).

**Criticism and Calls for the Withdrawal of the draft Additional Protocol from the UN and the Council of Europe**

Since 2017, the **UN Committee on the Rights of Persons with Disabilities and UN Special Rapporteurs** have published several statements and open letters highlighting the violations created by the draft additional protocol in light of the CRPD:

* [Open letter on Draft Additional Protocol to the Oviedo Convention (June 2021)](https://www.ohchr.org/en/hrbodies/crpd/pages/crpdindex.aspx#:~:text=Open%20letter%20on%20Draft%20Additional%20Protocol%20to%20the%20Oviedo%20Convention)
* [Press release by OHCHR: “UN Rights experts call on Council of Europe to stop legislation for coercive mental health measures” (May 2021)](https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=27126&LangID=E)
* [Statement by the UN Committee on the Rights of Persons with Disabilities (2018)](https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=9&ved=2ahUKEwip5Z7zqbHiAhVExcQBHdIuBrcQFjAIegQIAxAC&url=https%3A%2F%2Fwww.ohchr.org%2FDocuments%2FHRBodies%2FCRPD%2FStatements%2FStatementOviedo_CRPD20th.docx&usg=AOvVaw303kjLb-LXrXm9Uaa5cxhF)
* [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)](https://rm.coe.int/letter-un-bodies-to-sg/16808e5e28)

Relevant statements by the Council of Europe Commissioner for Human Rights and PACE:

* [Comments by Dunja Mijatović, Council of Europe Commissioner for Human Rights during the PACE Hearing on deinstitutionalisation of persons with disabilities (2021)](https://rm.coe.int/hearing-on-deinstitutionalisation-of-persons-with-disabilities-organis/1680a1c779)
* [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)](https://rm.coe.int/comments-by-dunja-mijatovic-council-of-europe-commissioner-for-human-r/16808f1111)
* [Speech at PACE’s joint hearing on protecting the rights of people with psychosocialdisabilities with regard to involuntary measures in psychiatry (2018)](https://rm.coe.int/16808ee5fb)

**Parliamentary Assembly (PACE)**

* [Resolution 2291 (2019) Ending coercion in mental health: the need for a human rights-based approach](http://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-en.asp?fileid=28038&lang=en)
* 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

1. See Committee’s General Comment No 1 of 2014 (CRPD/C/CG/1) [↑](#footnote-ref-1)