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The case against a Council of Europe legal instrument on involuntary measures in psychiatry

Report[1]
Committee on Social Affairs, Health and Sustainable Development
Rapporteur: Ms Guguli MAGRADZE, Georgia, Socialist Group

Summary

Involuntary placement and treatment procedures in the context of psychiatry give rise to a large number of human rights abuses. Since 2013, the Committee on Bioethics has been drawing up an additional protocol, aimed at protecting people with mental health problems (better termed "psychosocial disabilities") from such abuses.

However, this legal instrument raises serious concerns with regard to its compatibility with the United Nations Convention on the Rights of People with Disabilities (CPRD), as it maintains a link between psychosocial disabilities and involuntary measures, a practice clearly rejected by the CPRD Committee, the monitoring body of the United Nations Convention. During the public consultation on a draft version of the additional protocol, the Council of Europe Commissioner for Human Rights and relevant United Nations bodies have thus requested that the proposal to draw up such a legal instrument be withdrawn.

An additional protocol drawn up in such circumstances would not only undermine the Council of Europe's credibility, it would also risk creating a conflict between international norms at the global and European levels. Therefore, the Committee on Bioethics should withdraw the proposal for this additional protocol and instead focus its work on promoting alternatives to involuntary measures in psychiatry in accordance with the spirit of the CRPD.

1. Reference to committee: Doc. 11316, Reference 4005 of 22 November 2013.

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A. Draft recommendation[2]

1. Involuntary placement and involuntary treatment procedures give rise to a large number of human rights violations in many member States, in particular in the context of psychiatry. Relevant provisions of the European Convention on Human Rights (ETS No. 5) and the Convention on Human Rights and Biomedicine (ETS No. 164, "Oviedo Convention"), as well as Committee of Ministers Recommendation Rec(2004)10 concerning the protection of the human rights and dignity of persons with mental disorder, authorise but strictly regulate the use of involuntary measures in psychiatry, with a view to protecting people with mental health problems (better termed "people with psychosocial disabilities") from human rights abuses.

2. Since 2013, the Committee on Bioethics of the Council of Europe (DH-BIO) has been working on drawing up an additional protocol to the Oviedo Convention, aimed at protecting the human rights and fundamental freedoms of people with mental disorders with regard to the use of involuntary placement and involuntary treatment.

3. While the Parliamentary Assembly understands the concerns that prompted the Committee on Bioethics to work on this issue, it has serious doubts about the added value of a new legal instrument in this field. Nevertheless, the Assembly's main concern about the future additional protocol relates to an even more essential question: that of its compatibility with the United Nations Convention on the Rights of Persons with Disabilities (CRPD).

4. During the public consultation on a draft version of the additional protocol conducted in 2015, a number of high-profile human rights bodies, including the Commissioner for Human Rights of the Council of Europe and the committee which is responsible for monitoring the implementation of the CRPD ("CRPD Committee"), expressed fundamental concerns about the draft additional protocol, underlining the incompatibility of its approach with that of the CRPD, and requested that the proposal to draw up a protocol be withdrawn.

5. The Assembly recalls that since its entry into force in 2008, the CRPD is the international benchmark in the field of disability, in the light of which measures taken at international and national levels are evaluated. Thus, the CRPD should be the point of departure for any work of the Council of Europe in this area.

6. The CRPD does not explicitly refer to involuntary placement or treatment of people with disabilities, including people with psychosocial disabilities. However, Article 14 on the right to liberty and security clearly states that the deprivation of liberty based on the existence of disability would be contrary to the CRPD.

7. The CRPD Committee interprets Article 14 as prohibiting the deprivation of liberty on the basis of disability even if additional criteria, such as dangerousness to one's self or others, are also used to justify it. The committee considers that mental health laws providing for such instances are incompatible with Article 14, are discriminatory in nature and amount to arbitrary deprivation of liberty, as other people who might be at risk of being a danger to themselves or others are not subjected to the same limitations of their rights. It also considers that forced treatment by psychiatric and other health and medical professionals is a violation of the right to equal recognition before the law and an infringement of the right to personal integrity, among others.

8. In view of the above, the Assembly concludes that any legal instrument that maintains a link between involuntary measures and disability will be discriminatory and thus violate the CRPD. It notes that the draft additional protocol maintains such a link, as having a "mental disorder" constitutes the basis of the involuntary treatment and placement, together with other criteria.

9. The Assembly notes that member States face challenges in reconciling the non-discrimination principles of the CRPD with traditional mental health-care and human rights provisions. It also notes that there is resistance from some member States to accept the above interpretation of the CRPD Committee. However, it considers that the Council of Europe's position ought to be independent from the position of some of its member States. 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 it would also risk creating an explicit conflict between international norms at the global and European levels.

10. The Assembly also notes that at their 1168th meeting, the Ministers' Deputies instructed the steering and ad hoc committees to assess the necessity or advisability of drafting additional protocols to the conventions for which they have been given responsibility. It considers that an additional protocol drawn up in such circumstances cannot fulfil the "advisability" criterion required by the Committee of Ministers.

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2. Draft recommendation adopted unanimously by the committee on 15 March 2016.

11. Consequently, the Assembly recommends that the Committee of Ministers instruct the Committee on Bioethics to:

11.1. withdraw the proposal to draw up an additional protocol concerning the protection of human rights and dignity of persons with mental disorders with regard to involuntary placement and involuntary treatment;

11.2. 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.

12. 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 required by the CRPD and Assembly Resolution 2039 (2015) on equality and inclusion for people with disabilities.

B. Explanatory memorandum by Ms Guguli Magradze, rapporteur

1. Introduction

1. In 2013, the Committee on Bioethics of the Council of Europe (DH-BIO) started drawing up an additional protocol to the Convention on Human Rights and Biomedicine (ETS No. 164, "Oviedo Convention"), aimed at protecting the human rights and fundamental freedoms of people with "mental disorders" with regard to the use of involuntary placement and involuntary treatment.[3] To this end, a drafting group was set up, which held its first meeting on 19 and 20 June 2013.

2. On 1 October 2013, with a view to ensuring the maximum impact of the Parliamentary Assembly's views on the additional protocol's drafting process and its final result, the Committee on Social Affairs, Health and Sustainable Development tabled a motion for a recommendation entitled "Involuntary placement and treatment of people with psychosocial disability: need for a new paradigm", which this report originates from. Referring to the United Nations Convention on the Rights of Persons with Disabilities (CRPD) and its rights-based approach characterised by non-discrimination, autonomy and inclusion of people with disabilities, the motion stressed that the very principle of involuntary measures for people with psychosocial disabilities (mental health problems)[4] was being challenged.

3. On 11 March 2014, jointly with the Bureau of the DH-BIO, the drafting group organised a hearing of international non-governmental organisations (INGOs) representing different stakeholders (including patients, health professionals and people with psychosocial disabilities). On 6 May 2014, the DH-BIO held a first exchange of views on a preliminary draft additional protocol prepared by the drafting group on the basis of DH-BIO delegations' comments and INGOs' remarks formulated at the aforementioned hearing. At its meeting on 13 November 2014, the DH-BIO held an exchange of views on the revised version of the draft additional protocol.[5]

4. On 24 March 2015, I presented to the Committee on Social Affairs, Health and Sustainable Development an introductory memorandum in which I raised my doubts about the compatibility of the draft additional protocol with the CRPD and the appropriateness of elaborating, at Council of Europe level, a legally binding instrument on involuntary placement and treatment of people with psychosocial disabilities. I also raised my concerns with regard to the additional protocol's drafting process, which was being conducted behind closed doors, without direct involvement of disability rights organisations, as required by the CRPD and the Assembly.[6] In order to ensure that the Assembly's views and concerns were heard at an early stage, I proposed to make the memorandum available to the DH-BIO as well as the Commissioner for Human Rights of the Council of Europe. The committee agreed to this proposal.

5. On 5 May 2015, I attended the DH-BIO meeting and presented in person the concerns raised in my introductory memorandum. The DH-BIO considered that in the preparation of the additional protocol, due account had been taken of existing legal instruments, in particular the CRPD. At the same meeting, the DH-BIO agreed to make public for consultation a draft version of the additional protocol.

6. The public consultation was launched in June 2015 and lasted until 15 November 2015. In total, 39 submissions were received, including from the Parliamentary Assembly's General Rapporteur on the rights of lesbian, gay, bisexual and transgender (LGBT) people, the Commissioner for Human Rights, the Committee of experts on the rights of people with disabilities of the Council of Europe, United Nations bodies, the European Union Agency for Fundamental Rights and non-governmental organisations (NGOs). There were mainly two types of replies: those which had fundamental concerns about the draft additional protocol, underlining the incompatibility of its approach with the CRPD, and requesting that the proposal to draw up a protocol be withdrawn; and replies with drafting proposals, implicitly or explicitly accepting the approach taken by the draft additional protocol.

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3. 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.

4. Admittedly, "people with mental health problems" is a more user-friendly term than "people with psychosocial disabilities". However, I prefer to use the latter, as this is the term favoured by the UN Committee on the Rights of Persons with Disabilities as well as the Commissioner for Human Rights of the Council of Europe.

5. The Committee Secretariat attended the hearing of INGOs as well as the said DH-BIO meetings.

6. In its Resolution 2039 (2015) "Equality and inclusion for people with disabilities", the Assembly called on the Council of Europe member States to closely consult and actively involve the organisations representing people with disabilities in the development of policies and measures for people with disabilities. This call should equally apply to Council of Europe bodies.

7. At its last meeting on 1 December 2015, the DH-BIO held an exchange of views on the comments received during the public consultation. Present during the discussions, I expressed my full trust that the concerns raised by several human rights bodies with regard to the compatibility of the draft additional protocol with the CRPD (for similar reasons to those presented in my introductory memorandum) would be heard by the DH-BIO. Considering the nature of the comments received, the DH-BIO agreed to reflect on the possible ways forward on this topic. To this end, DH-BIO delegations were invited to reply to a number of questions, including on whether the DH-BIO should continue its work on the additional protocol.

8. At its next meeting to be held from 31 May to 2 June 2016, the DH-BIO will discuss possible ways forward on the issue, based on delegations' replies. By providing an official Assembly position with regard to the draft additional protocol, this report aims to contribute to the upcoming DH-BIO discussion.

2. The United Nations Convention on the Rights of Persons with Disabilities and the paradigm shift

9. As clearly reflected above, the issue of involuntary placement and treatment of people with psychosocial disabilities cannot be addressed without due consideration of the CRPD, which is the first global treaty on the rights of people with disabilities. With 163 States Parties as of February 2016, the CRPD is one of the most widely ratified of the United Nation's human rights treaties. A total of 41 member States of the Council of Europe have ratified it, as well as the European Union.[7] It is currently the reference instrument in the field of disability, in the light of which measures taken at international and national levels are evaluated.

10. The CRPD does not create new rights or rights specific to people with disabilities but reaffirms a number of substantive rights for them. Disability is not formally defined in the CRPD, but its Article 1 states that "[p]ersons 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".

11. 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.[8] 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.[9]

12. The CRPD also 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 people 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. 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.

3. Legal framework on involuntary placement and treatment of people with psychosocial disabilities

13. Historically, as a result of the medical model, curing or managing disability revolved around identifying and understanding it, and learning to control it and alter its course. Therefore, the response to disability has been mainly one of social compensation through the development of specialist caring services (in institutions). However necessary and well-intentioned they may be, such responses have compounded the problem of exclusion and led to stigmatisation. Taken together with the risk of violence inherent to institutionalisation, they

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7. The CRPD entered into force in 2008. Council of Europe member States that have not yet ratified it are Finland, Iceland, Ireland, Liechtenstein, Monaco and the Netherlands.

8. The Commissioner for Human Rights, "Who gets to decide? Right to legal capacity for persons with intellectual and psychosocial disabilities", Issue paper, 2012.

9. Ibid. Indeed, if disability is not an attribute located within an individual but results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others, then with support of varying degrees, these significant barriers can be counteracted. "Mental health law and the UN Convention on the rights of persons with disabilities", G. Szmukler, R. Daw, F. Callard, *International Journal of Law and Psychiatry*, 37 (2014), pp. 245-252.

are no longer considered as appropriate responses to disability. States have therefore been called upon to give up the culture of institutionalisation of people with disabilities and move towards community-based services.[10]

14. Nevertheless, all over Europe, hundreds of thousands of people with disabilities continue to live in institutions, sometimes against their will. This is the case in particular for people with psychosocial disabilities. In fact, mental health laws in many countries authorise their involuntary placement and treatment based on their alleged danger to themselves or to others.

3.1. The CRPD and the CPRD Committee's stand

15. The CRPD does not explicitly refer to involuntary placement or treatment of persons with disabilities. Its Article 14.1 reiterates the formulation of the right to liberty and security and clearly states that the deprivation of liberty based on the existence of disability would be contrary to the CRPD.

16. In September 2015, the CRPD Committee adopted guidelines with a view to providing further clarification on Article 14. It noted that the legislation of several States Parties, including mental health laws, still provided instances in which persons may be detained on the grounds of their actual or perceived impairment, provided there were also other reasons for their detention, including that they were deemed dangerous to themselves or others. According to the CRPD Committee, this practice is incompatible with Article 14, discriminatory in nature and amounts to arbitrary deprivation of liberty.

17. In the aforementioned guidelines, referring to the negotiations leading up to the adoption of the CRPD, the Committee noted that Article 14 prohibited the deprivation of liberty on the basis of actual or perceived impairment even if additional factors or criteria were also used to justify the deprivation of liberty.[11] It stressed that involuntary commitment to mental health facilities carried with it the denial of the person's legal capacity to decide about care, treatment and admission to a hospital or institution, and therefore violated Article 12 (Equal recognition before the law) in conjunction with Article 14.[12]

18. Already in 2014, in its General Comment No. 1 concerning Article 12, the CRPD Committee had clarified that States Parties should refrain from the practice of denying the legal capacity of persons with disabilities and detaining them in institutions against their will, either without the free and informed consent of the persons concerned or with the consent of a substitute decision-maker[13], and considered this practice to be an arbitrary deprivation of liberty violating Articles 12 and 14 of the Convention.[14]

19. In the same General Comment, the CRPD Committee stated the following concerning involuntary treatment: "The right to enjoyment of the highest attainable standard of health (art. 25) includes the right to health care on the basis of free and informed consent. States parties have an obligation to require all health and medical professionals (including psychiatric professionals) to obtain the free and informed consent of persons with disabilities prior to any treatment … forced treatment by psychiatric and other health and medical professionals is a violation of the right to equal recognition before the law and an infringement of the rights to personal integrity (art. 17); freedom from torture (art. 15); and freedom from violence, exploitation and abuse (art. 16). This practice denies the legal capacity of a person to choose medical treatment and is therefore a violation of article 12 of the Convention. … Forced treatment is a particular problem for persons with psychosocial, intellectual and other cognitive disabilities."

20. On this basis, the CRPD Committee recommended that "States parties abolish policies and legislative provisions that allow or perpetrate forced treatment, as it is an ongoing violation found in mental health laws across the globe, despite empirical evidence indicating its lack of effectiveness and the views of people using mental health systems who have experienced deep pain and trauma as a result of forced treatment".[15]

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10. See Assembly Resolution 2039 (2015) on the equality and inclusion for people with disabilities and Resolution 1642 (2009) on access to rights for people with disabilities and their full and active participation in society, as well as the recommendations of the Commissioner for Human Rights in "The right of people with disabilities to live independently and be included in the community", Issue paper, 2012.
11. The CRPD Committee reports that following extensive discussions, the need to include a qualifier, such as "solely" or "exclusively", in the prohibition of deprivation of liberty due to the existence of an actual or perceived impairment in the draft text of article 14.1 had been ruled out. Indeed, States opposed it, arguing that it could lead to misinterpretation and allow deprivation of liberty on the basis of actual or perceived impairment in conjunction with other conditions, like danger to self or others.
12. See paragraphs 6, 7 and 10 of the Guidelines on Article 14 of the CRPD.
13. A legal representative, guardian or tutor with court-authorised power to take decisions on behalf of the individual.
14. Document CRPD/C/GC/1, paragraph 40.
15. Ibid., paragraphs 41-42.

3.2. Council of Europe instruments

3.2.1. European Convention on Human Rights

21. Article 5.1.*e* of the European Convention on Human Rights (ETS No. 5, "the Convention") explicitly allows for the detention of persons of "unsound mind". The European Court of Human Rights ("the Court") has established when the deprivation of liberty on grounds of "unsound mind" could be justified: either the person concerned constitutes a serious threat because of his or her violent behaviour, or the detention is required for therapeutic reasons. The Court also established criteria concerning the medical assessment, which should be based on the person's actual state of mental health and not solely on past events, as well as on the thresholds which must be met for the deprivation of liberty to comply with Article 5.1.*e*).[16] Moreover, the Court set some procedural safeguards, such as the requirement for a speedy determination of the lawfulness of the detention in situations where people are detained in psychiatric institutions.

22. The Convention does not contain any specific provision on involuntary treatment. However, relevant cases brought before the Court have been examined under Articles 3 (prohibition of torture) and 8 (right to respect for private life). In the landmark case of *Herczegfalvy v. Austria* concerning an applicant who had been placed under guardianship, forcibly administered food and neuroleptics, isolated and handcuffed to a security bed (with consent to treatment from his guardian), the Court considered that it was for the medical authorities to decide on therapeutic methods to be used for patients entirely incapable of deciding for themselves. As a general rule, a measure which was a therapeutic necessity, could not be regarded as inhuman or degrading, but the medical necessity of a measure had to be convincingly shown.

3.2.2. Oviedo Convention

23. Article 7 of the Oviedo Convention explicitly authorises the involuntary treatment of persons who have a "mental disorder" of a serious nature, but only in cases where without such treatment, there is likely to be serious harm to the health of the person concerned. Moreover, the treatment must aim to alleviate the mental health problem. This provision constitutes an exception to the general rule of consent enshrined in Article 5.[17] Moreover, Article 6, concerning the protection of persons not able to consent, specifies in its paragraph 3 that "where, according to law, an adult does not have the capacity to consent to an intervention because of a mental disability, a disease or for similar reasons, the intervention may only be carried out with the authorisation of his or her representative or an authority or a person or body provided for by law".

3.2.3. Committee of Ministers Recommendation Rec(2004)10

24. In 2004, following a process of reflection conducted within the Council of Europe on the protection of persons with "mental disorders", during which a public consultation was carried out on the basis of a White Paper, the Committee of Ministers adopted Recommendation Rec(2004)10 concerning the protection of the human rights and dignity of persons with mental disorder. Concerning involuntary placement, this recommendation follows the interpretation of Article 5 of the European Convention on Human Rights and confirms the Court's approach. It brings together the safeguards elaborated by the Court and lays out thresholds that should be met before a decision can be taken on placement. In terms of involuntary treatment, the recommendation goes beyond the European Convention on Human Rights and the Oviedo Convention and requires, for instance, that involuntary treatment form part of a written treatment plan, a safeguard that ensures improved monitoring of whether the medical decisions were based on sound evidence and whether the treatment was the least restrictive possible.[18]

3.3. Commissioner for Human Rights

25. In recent years, the Commissioner has issued three papers concerning the rights of people with disabilities, which are clearly inspired by the CRPD rather than Council of Europe instruments. In this context, the Commissioner has been somewhat critical towards the involuntary placement and treatment of people with disabilities. Indeed, pointing out that people with disabilities were sometimes forcibly confined to

16. The mental disorder must be of a kind or degree warranting compulsory confinement and the validity of confinement would depend upon the persistence of such a disorder.
17. According to Article 5, an intervention in the health field may only be carried out after the person concerned has given free and informed consent to it.
18. For further information on Council of Europe standards, see the European Union Agency for Fundamental Rights report on "Involuntary placement and involuntary treatment of persons with mental health problems", 2012.

institutions by court order, or by laws which allow placement and forcible treatment of people who are assessed as having a mental illness of a nature or degree to "warrant" confinement, the Commissioner said that Article 14 of the CRPD countered that and prohibited deprivation of liberty on the basis of disability.[19]

26. More specifically, in his report on Norway, for example, the Commissioner urged the authorities to "reform legislation on involuntary placements in a way that it applies objective and non-discriminatory criteria which are not specifically aimed at people with psychosocial disabilities, while ensuring adequate safeguards against abuse for the individuals concerned".[20] The Commissioner also stated that medical treatment should be based on free and fully informed consent with the exception of life-threatening emergencies when there is no disagreement about the absence of decision-making capacity.

4. Should the Council of Europe draw up the additional protocol?

4.1. Compatibility of the draft additional protocol with the CRPD

27. In June 2011, when the then Steering Committee on Bioethics of the Council of Europe (CDBI)[21] agreed to include the elaboration of the additional protocol in its work programme, this was the outcome of three years of reflection about the relevance and the added value of a new legally binding instrument in this field. To that end, the CDBI had evaluated the impact of Recommendation Rec(2004)10[22] and also asked the Steering Committee on Human Rights (CDDH) and the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) for their opinion on the desirability of an additional protocol. Both the CDDH and the CPT backed the drafting of a binding instrument in this field.

28. The additional protocol is intended to develop, on the basis of the provisions of Recommendation Rec(2004)10 and for the first time in a legally binding instrument, the provisions of Article 5 of the European Convention on Human Rights and Article 7 of the Oviedo Convention. By doing so, it aims to give a higher legal rank to a number of fundamental principles for the protection of people with "mental disorders" with regard to involuntary placement and treatment, which then would serve as a reference in particular for the elaboration or the revision of the relevant national legislations.

29. However, the Council of Europe instruments the draft additional protocol aims to build upon fall below the CRPD standards, as they authorise the involuntary placement and treatment of people on the basis of their "mental disorder", a practice clearly rejected by the CRPD Committee because of its discriminatory nature. This may sound severe, especially considering that the rationale behind these instruments and the draft additional protocol is the protection of people with psychosocial disabilities from human rights abuses. However, one should not forget that these instruments date back to the pre-CRPD era, and thus reflect the medical model of disability prevalent at the time of their adoption.

30. Consequently, the draft additional protocol, which is based on an identical approach to that of other Council of Europe instruments, is anything but compatible with the CRPD. Major human rights bodies' comments received during the public consultation reinforce this conclusion.

4.2. Criticism received during the public consultation on the draft additional protocol

31. In fact, in their comments, both the Commissioner and the Committee of experts on the rights of people with disabilities of the Council of Europe consider that the CRPD, as the international benchmark in the field of disability, should be the point of departure for any work of the Council of Europe in this area. The Commissioner, while fully sharing the concerns expressed in my introductory memorandum,[23] not only disagrees with the draft additional protocol's approach (which he considers to be incompatible with the CRPD

19. Op. cit., footnote 10.
20. Commissioner's report following his visit to Norway, CommDH(2015)9, published on 18 May 2015, paragraph 41.
21. On 1 January 2012, following the reorganisation of intergovernmental bodies at the Council of Europe, the DH-BIO took over the responsibilities of the CDBI.
22. "Examination of the implementation of Recommendation Rec(2004)10 revealed legal gaps in certain member States, in particular concerning legal provisions governing measures for involuntary placement and treatment of persons with mental disorders." Extract from the cover letter for the public consultation on the draft additional protocol.
23. "The Commissioner fully shares the views of the rapporteur, both in terms of her initial negative assessment as to whether the Council of Europe should be drawing up an additional protocol which will give legal sanction to involuntary measures imposed on people with 'mental disorders', as well as her concerns regarding its elaboration process with no involvement of the disability rights organisations beyond one consultation meeting. Both of these conclusions were, in the Commissioner's opinion, based on a sound understanding of the CRPD and the paradigm shift it embodies."

and his own approach), but also clearly challenges the added value of a legally binding instrument offering safeguards for the use of involuntary measures. He eloquently points out that the lack of adequate safeguards for the use of involuntary measures and resulting violations is part of a far larger phenomenon: such safeguards often prove inadequate in practice, owing to the shortcomings of legal systems and their inherently discriminatory nature.[24] The Commissioner also stresses the potential risks in case of the adoption of the draft additional protocol, including in particular a conflict between international norms at the global and European levels. In a constructive approach, the Commissioner suggests that instead of an additional protocol on involuntary measures, the DH-BIO provides guidance with a view to reducing the need for coercion in psychiatry in the first place (including by promoting alternatives to involuntary measures) and fighting against discrimination of persons with psychosocial disabilities.

32. As could be expected, the four United Nations bodies which submitted comments on the draft additional protocol[25] consider that the latter falls short of, or are expressly in conflict with the human rights standards of persons with disabilities enshrined within the CRPD and developed by the CRPD Committee. Noting that the text is based on the out-dated medical model of disability, they consider it problematic for the Council of Europe to draft standards which do not take the CRPD's paradigm shift into account. They also recall States Parties' obligation to refrain from engaging in any act or practice inconsistent with the CRPD, including by engaging in the negotiation of regional standards that are not in line with the human rights approach to disability enshrined in the CRPD. They fear that the adoption of the additional protocol risks not only lowering the level of protection of persons with disabilities, but also undermining the progressive shift in national laws and policies in the field of disability law that is currently under way. In a nutshell, they implicitly or explicitly encourage the DH-BIO to withdraw from drawing up the additional protocol and pursue other initiatives that would enhance the protection of rights of persons with disabilities and help bring national legislation into line with the CRPD.

33. The European Union Agency for Fundamental Rights, the Norwegian ombudsperson on equality and non-discrimination, some patients associations and NGOs raise similar concerns with regard to the draft additional protocol. Other replies (mainly from ministries and health professionals) support the general approach and/or make drafting proposals to the text.[26]

34. As for the Parliamentary Assembly General Rapporteur on the rights of LGBT people, his concerns focus on the term "mental disorder" which, in the draft Protocol, is defined "in accordance with internationally accepted medical standards". The draft explanatory memorandum specifies that the World Health Organization's international statistical classification of diseases and related health problems which concerns mental and behavioural disorders (ICD-10) is an example of an internationally accepted medical standard. However, as the General Rapporteur rightly points out, ICD-10 covers a large variety of "mental disorders" including "gender identity disorders", implying that transgender persons could be included in the scope of application of the draft additional protocol. Based on the real example of a national legislation requiring transgender persons seeking to change their legal gender to undergo confinement in a psychiatric institution to be diagnosed with "transsexualism", the General Rapporteur fears that the Protocol could be used to justify both the qualification of "mental disorder" for transgender persons and their placement in psychiatric institutions. I fully share his fears.

4.3. The right way forward

35. Some commentators and advocates have argued that the CRPD means that no forced detention for mental health reasons or any other disability will be permitted in any circumstances. I do not think this is an accurate interpretation. I believe there may be cases where involuntary measures are unavoidable. However, such cases should be the exception,[27] and most of all they should be neutrally defined so as to apply to all persons, and not just to people with disabilities.

36. What I understand from the CRPD and the CRPD Committee's interpretation, as well as the critical comments received during the public consultation, is that any legal instrument that keeps a link between involuntary measures and disability will be discriminatory in nature and thus violate the CRPD. The draft

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24. "The Commissioner considers that human rights of persons with psychosocial disabilities are routinely violated while respecting the letter of existing legal safeguards, including some that are very similar to those proposed in the draft Additional Protocol."

25. Namely the CRPD Committee, the Special Rapporteur on the rights of persons with disabilities, the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, the Office of the High Commissioner for Human Rights – Regional Office for Europe.

26. For the compilation of comments received during the public consultation, see document DH-BIO/INF(2015)20 on the DH-BIO's website: www.coe.int/en/web/bioethics/home.

additional protocol discriminates against people with psychosocial disabilities (and is therefore incompatible with the CRPD) because it maintains the medical diagnosis (of having a "mental disorder") as the basis of the involuntary treatment and placement, and does not subject other people who might be at risk of being a danger to themselves or others to the same limitations of their rights (for example, in the context of domestic violence, so-called "honour crimes" or threatened murder-suicides in the family). This does not mean that persons with disabilities, including those with psychosocial disabilities, cannot be lawfully subject to detention for care and treatment; it only means that "the legal grounds upon which restriction of liberty is determined must be de-linked from the disability and neutrally defined so as to apply to all persons on an equal basis".[28]

37. I am aware of the challenges that the member States face in reconciling the non-discrimination principles of the CRPD with traditional mental health-care and human rights provisions. I am also aware that there is much resistance from some member States to accepting the CRPD Committee's interpretation.[29] However, I believe that the question we should be asking ourselves is a question of principle that is entirely independent from the position of some member States: that is whether the Council of Europe can ignore the CRPD's interpretation by its monitoring body established under international law and go ahead with drawing up an additional protocol which is incompatible with the paradigm shift introduced by the CRPD, without undermining its own credibility and taking the risk of creating an explicit conflict between international norms at the global and European levels? Can such an additional protocol fulfil the "advisability" criterion required by the Committee of Ministers for drawing up new legal instruments?[30] I truly don't think so. I believe that the Council of Europe should acknowledge the position of the CRPD Committee and act accordingly. While we cannot change already existing Council of Europe legal instruments adopted before the CRPD, we can refrain from elaborating a new instrument in this field, and especially a legally binding one.

38. Echoing the comments of the Commissioner for Human Rights, we should also ask ourselves whether an additional protocol would really have an added value and whether instead we should not be focusing our energy on developing measures to increase the involvement of persons with psychosocial disabilities in decisions affecting their health, including by replacing their substitute decision-making mechanisms by supported decision-making mechanisms (for example by establishing support networks or a system of persons of trust), abolish the plenary guardianship system whereby the legal capacity of people with psychosocial disabilities can be removed, give up the culture of institutionalisation and give consideration to alternatives to care in institutions (for example community care), taking account of the choices of people with disabilities.[31]

39. In view of these elements, I come to the conclusion that the DH-BIO should withdraw the draft additional protocol.

5. Conclusion

40. I trust that the Committee of Ministers and the DH-BIO will hear the call made in this report, as well as by several human rights bodies during the public consultation. However, should this not be the case and the Council of Europe goes ahead with the drafting of the additional protocol, disability rights organisations should be fully involved in the drafting process. The hearing of INGOs held in March 2014 was a welcome initiative, as was the public consultation which took place in 2015. However, these are by no means an appropriate or sufficient way of involving the disability rights organisations. The latter should be involved in the entire drafting process.

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27. When it comes to measures with a particular history of abuse, such as involuntary measures imposed on people with psychosocial disabilities, these should be truly exceptional. In a similar case concerning the removal of children from their families by social services, our Committee's stance has been that one should not regulate the exception (but rather leave this to the Courts) otherwise it can far too easily become the norm, and thus lead exactly to the kind of abuse which should be avoided.

28. Annual report of the High Commissioner for Human Rights to the General Assembly, A/HRC/10/48, paragraphs 48-49.

29. Whether or not they agree with it, States Parties have at minimum, an obligation to engage with and attach great weight to the CRPD Committee's interpretation.

30. Document CM/Del/Dec(2013)1168/10.2.

31. For similar suggestions, see the Assembly resolutions mentioned in footnote 10, and the recently published evaluation report on the Council of Europe 2006-2015 Action Plan to promote the rights and full participation of people with disabilities in society: "Implementation of the Council of Europe Action Plan to promote the rights and full participation of people with disabilities in society: Improving the quality of life of people with disabilities in Europe 2006-2015".

41. Finally, it goes without saying that the Assembly may initiate another motion on the draft additional protocol with a view to being involved in the drafting process should it continue despite the many misgivings expressed by the Assembly, the CPRD Committee, the Commissioner for Human Rights, and key United Nations organisations. Should the Assembly choose not to do so, it will have the opportunity to formulate its comments when the Committee of Ministers requests its statutory opinion on the final version of the draft additional protocol.