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

Report[1]
Committee on Social Affairs, Health and Sustainable Development
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Summary

In Europe, there is an overall increase in the use of involuntary measures in mental health settings. This mainly results from a culture of confinement which focuses and relies on coercion, rather than practices that are respectful of the human rights of the persons concerned, including of their right to health care on the basis of free and informed consent.

Mental health systems across Europe should be reformed to conform to a human rights-based approach which is compatible with the United Nations Convention on the Rights of Persons with Disabilities. This requires mental health services that rely on coercion to be abandoned, and practices relying on consent to be placed at the centre of mental health systems.

The Parliamentary Assembly thus urges member States to start to transition to the abolition of coercive practices and proposes a number of measures to this end. Welcoming the Committee on Bioethics (DH-BIO)'s plans to engage in a study on promoting voluntary measures, the Assembly invites the Committee of Ministers to encourage the DH-BIO to carry out such a study, while also proposing to prepare guidelines on ending coercion in mental health.

1. Reference to committee: Doc. 14334, Reference 4309 of 30 June 2017.

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A. Draft resolution[2]

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 have been 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 damage to health.

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, which ultimately leads 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 health care on the basis of 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 that must be abandoned.

7. In view of the elements above, and convinced that greater awareness, cross-stakeholder co-ordination and political commitment are crucial in initiating and sustaining the much-needed change in mental health policies, the Parliamentary Assembly urges the member States to immediately start to transition to the abolition of coercive practices in mental health settings. To this end, it calls on the member States to:

7.1. develop, as a first step, a roadmap 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. 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. 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. dedicate adequate resources to prevention and early identification of mental health conditions and early, non-coercive intervention, especially in children and young people, without stigmatisation;

7.5. 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;

2. Draft resolution adopted unanimously by the committee on 13 May 2019.

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

7.8. 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[3]

1. The Parliamentary Assembly refers to its Resolution … (2019) "Ending coercion in mental health: the need for a human rights-based approach" and its Recommendation 2091 (2016) on the case against a Council of Europe legal instrument on involuntary measures in psychiatry.

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 the DH-BIO to carry out such a study, with the involvement of all relevant actors in the field and, in particular, relevant non-governmental organisations 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 from 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 Ms Reina de Bruijn-Wezeman, rapporteur

1. Introduction

"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[4]

1.1. Procedure

1. In June 2017, Ms Stella Kyriakides (Cyprus, EPP/CD), former Chairperson of the Committee on Social Affairs, Health and Sustainable Development, and 21 other Parliamentary 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.[5] 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 the 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.[6] 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.[7] 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).[8]

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[9] 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 focus and reliance on coercive measures[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.

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4. As quoted by Ms Olga Runciman, Psychologist and owner of *Psycovery*, at the hearing on 9 October 2018.
5. See the report by Ms Guguli Magradze (Georgia, SOC), former rapporteur on this issue, Doc. 14007.
6. AS/Soc (2018) 16 rev 2.
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.

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, *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 on 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.[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.[12] According to a recent report documenting the current practice in mental health systems in 36 European countries[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.[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 *Länder*.[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 United Nations consultation on human rights and mental health in May 2018,[16] the United Nations 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

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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.
11. A/HRC/RES/36/13.
12. It should be noted that Article 5.1.e of the European Convention on Human Rights (ETS No. 5) 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 Rooman v. Belgium, Application No. 18052/11, 31 January 2019, paragraph 205).
13. Mapping and understanding exclusion: institutional, coercive and community-based services and practices across Europe, prepared by Mental Health Europe, the Tizard Centre and the University of Kent, December 2017.
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, paragraph 15.
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, *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.
16. Consultation organised by the Office of the United Nations High Commissioner for Human Rights, on 14-15 May 2018, in Geneva (Switzerland).

the rule in the majority of mental health systems, particularly in developed countries.[17] 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.[18] 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.[19]

8. Likewise, France is reported to be one of the European countries that has the highest rates of involuntary placement,[20] 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.[21] In my own country, the Netherlands, the trend is similar, despite the government's intentions to reduce the number of involuntary measures.[22] 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.[23]

10. This worrying trend should mainly be attributed to a culture of confinement[24] 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 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".[25]

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, *Mental Illness Is Not a Horror Show, New York Times, 26 October 2016*

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

17. A/HRC/39/36, 24 July 2018, paragraph 13.
18. Ill-conceived and under-resourced deinstitutionalisation processes have greatly increased homelessness and incarceration among people with severe mental health problems. For example, in France, nearly 45 000 people with psychosocial disabilities are living in the streets, and 25 000 are in prison (A/HRC/39/36, 24 July 2018, paragraph 20). In my country, the Netherlands, since the reduction of the number of beds in institutions, the number of incidents involving people with confused behaviour has doubled to more than 90 000 reports per year.
19. Because of concerns about this drastic increase, an independent review of the Mental Health Act was commissioned.
20. «Psychiatrie: Il est possible de soigner mieux en enfermant moins», Adeline Hazan, Contrôleure générale des lieux de privation de liberté, *Le Monde*, 17 September 2018.
21. A/HRC/39/36, 24 July 2018, paragraph 20.
22. See also in A/HRC/40/54, 11 January 2019, paragraph 16.
23. This confirms the remark of our committee's former rapporteur on this issue, Ms Magradze: "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." See Doc. 14007, footnote 27.
24. "Lieux de privation de liberté: un rapport dénonce la culture de l'enfermement", *Le Monde*, 27 March 2019.
25. CommDH-Speech(2018)10.
26. Paul Deany, Disability Rights Fund, intervention at the 9th session of the Conference of States Parties to the Convention on the Rights of Persons with Disabilities, 15 June 2016.

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, 8 003 people diagnosed with schizophrenia in the United States 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 decreases after involuntary treatment. Additionally, there is compelling evidence that suicide is very difficult, if not impossible, to predict.[36] [37]

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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, paragraph 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, *New York Times*, 26 October 2016.
29. A/HRC/40/54, 11 January 2019, paragraph 27.
30. Op. cit., footnote 24.
31. "Violence and mental illness: what is the true story?", Varshney M., et al, *Journal of Epidemiology and Community Health*, March 2016, Vol. 70, No. 3.
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, 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.
35. Op. cit., footnote 32.
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, paragraph 35.
37. "No, psychiatry could not have prevented the Germanwings disaster", Gary Greenberg, *The New Yorker*, 2 April 2015.

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 crises.

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 the 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 practices can be highly successful and are worthy of more attention from States.[41] A few examples from these publications and other literature are presented below.

20. High & Intensive Care Units (Netherlands): HIC Units are acute admission wards focussing on restoring and maintaining contact and on 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,

38. Involuntary placement and involuntary treatment of persons with mental health problems, Fundamental Rights Agency, 2012.
39. Op. cit., footnote 13.
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*.
41. Alternatives to Coercion in Mental Health Settings: A Literature Review, Goodings P. et al. (2018), Melbourne Society Equity Institute.

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 access to 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 people 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 is a 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 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 6 000 to 7 000 people 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.[42]

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.

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

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.

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 choose (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.

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.[46] 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 practise the skills needed to identify, treat and provide care for persons with mental health conditions.[47]

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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.
44. The Lancet Commission on global mental health and sustainable development, *The Lancet*, Vol. 392, No. 10157.
45. A/HRC/39/36, 24 July 2018, paragraph 16.
46. A/HRC/40/54, 11 January 2019, paragraph 82.
47. Op. cit., footnote 44.

6. Recent developments concerning the draft additional protocol

31. At its last meeting held on 20 and 22 November 2018, the DH-BIO took note of the opinions on the draft additional protocol submitted by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), the Commissioner for Human Rights, the Parliamentary Assembly's two committees and the Conference of International Non-governmental Organisations (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 the 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, the 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)[48] released a statement calling on 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.[49] [50]

34. At its meeting held from 27 to 30 November 2018, the Steering Committee for Human Rights (CDDH) adopted its comments on the draft additional protocol. The 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. The CDDH encouraged the 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.[51] At its meeting held from 27 to 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 the 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 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 people 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 the DH-BIO, recalled her opposition to the draft additional protocol explaining the reasons therefore (incompatibility of the

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", Human Rights Watch, 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 from 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 the CDDH: https://rm.coe.int/steering-committee-for-human-rights-cddh-report-90th-meeting-strasbour/16809036ca.

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 the 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 from 4 to 7 June 2019, in the light of the comments received from its delegations and professional organisations, the 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. The 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.

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

52. CommDH(2019)2, published on 30 January 2019.
53. Comments of the Council of Europe Commissioner for Human Rights on the draft Additional Protocol, paragraph 18.
54. A/HRC/39/36, 24 July 2018, paragraph 13.
55. Op. cit., footnote 13.

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]

56. A/HRC/40/54, 11 January 2019, paragraph 32.

Appendix – 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[57]

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.[58] 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.[59]

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?)."[60] 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.

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 the 47 Council of Europe member States, as well as by the European Union.

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."[61]

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.[62]

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57. Comments approved by the committee on 11 October 2018.
58. 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.
59. Comments transmitted to the DH-BIO on 27 April 2017.
60. Ibid., paragraph 7.
61. Doc. 14007 (2016), explanatory memorandum, paragraphs 10-11.
62. 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.

7. The meaningful consultation of disability-rights organisations in the drafting process in the DH-BIO is therefore vital. After resuming the work on the additional protocol at the end of 2016, the 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 the European Network of (ex-)Users and Survivors of Psychiatry (ENUSP).[63] This is the only time when people directly concerned by the additional protocol had any kind of representation in the drafting process.[64]

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 the 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.'"[65] The "closed" nature of the work of the DH-BIO has also been criticised by the main UN mechanisms concerned.[66]

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 the DH-BIO. The committee urges the DH-BIO to carry out a meaningful consultation, to take place as a matter of priority.

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,[67] 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.[68] She considered that the draft additional protocol would serve to legitimise those coercive practices, and called on member States of the Council of Europe to stand against it, as it represented an unacceptable backward step in rights protection. At the hearing on 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.

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63. For the joint-statement of ENUSP and Mental Health Europe, see appendix IV of the report of the 11th meeting of the 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.

64. 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 persons with psychosocial disabilities).

65. www.edf-feph.org/newsroom/news/disability-organisations-urge-council-europe-withdraw-addition-protocol-oviedo.

66. Letter addressed to the Secretary General of the Council of Europe, on 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.

67. Consultation organised by the Office of the United Nations High Commissioner for Human Rights, on 14-15 May 2018, in Geneva, in accordance with UN Human Rights Council Resolution 36/13.

68. A/HRC/39/36, advance edited version, 24 July 2018, paragraph 13.

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 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".[69] 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 the 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 for 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".[70]

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 weakening 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 rapporteur 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".[71] 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)".[72] 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".[73]

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 stigmatization, overmedicalisation 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'".[74]

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69. Council of Europe Commissioner for Human Rights, hearing on 9 October 2018.
70. Ibid.
71. A/HRC/39/36, op. cit.
72. The Chair of the Indonesian Mental Health Association, Yeni Rosa Damayanti, ibid., paragraph 4.
73. Ibid., paragraph 5.
74. Ibid., paragraph 12.

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 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 clearly prohibited 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 the DH-BIO recognises that involuntary measures would never be appropriate, such as "gender identity disorders, sleep disorders and sexual dysfunctions" (but which the 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)[75] to be involuntarily detained, involuntarily treated – including with electro-shock therapy and other treatments with irreversible side-effects. This is certainly not what the 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 the 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.

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.

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.

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75. 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, transgender persons are also considered to pose such risks – wrongly so, of course.

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.[76] These alternative measures should be what the Council of Europe should focus on.

27. The committee also urges the 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.

76. Ibid., paragraph 13.