

Doc. 14910
18 June 2019

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

Committee Opinion¹

Committee on Equality and Non-Discrimination

Rapporteur: Ms Sahiba GAFAROVA, Azerbaijan, European Conservatives Group

A. Conclusions of the committee

1. The Committee on Equality and Non-Discrimination congratulates Ms Reina de Bruijn-Wezeman (Netherlands, ALDE), rapporteur of the Committee on Social Affairs, Health and Sustainable Development, on her report on “Ending coercion in mental health: the need for a human rights-based approach”. It is a comprehensive and balanced report that makes clear why ending coercion is essential in order to respect the human rights of persons who face mental health issues. In addition, it sets out evidence-based proposals for alternative ways forward.
2. The committee fully supports the report of Ms de Bruijn-Wezeman. It welcomes her recognition that the United Nations Convention on the Rights of Persons with Disabilities (CRPD) – which has to date been ratified by all Council of Europe member States except Liechtenstein – today sets the benchmark for human rights standards in this field. Her report highlights the harmful effects of the use of coercive measures such as involuntary placement and treatment in mental health. Just as importantly, it draws attention to the advances that can be achieved through alternative approaches that empower individuals with a mental health condition instead of stripping them of their autonomy.
3. Being fully in agreement with the analysis and recommendations of the rapporteur for report, the committee has focused in this opinion on additional human rights issues that may arise from a non-discrimination perspective.

B. Proposed amendment

Amendment A (to the draft resolution)

At the end of paragraph 2, insert the following sentence:

“Reliance on such coercive measures not only leads to arbitrary deprivations of liberty but, being unjustified differential treatment, it also violates the prohibition on discrimination.”

1. Reference to committee: [Doc. 14334](#), Reference 4309 of 30 June 2017. Reporting committee: Committee on Social Affairs, Health and Sustainable Development. See [Doc. 14895](#). Opinion approved by the committee on 5 June 2019.



C. Explanatory memorandum by Ms Sahiba Gafarova, rapporteur for opinion

1. I wish to congratulate Ms de Bruijn-Wezeman on her comprehensive and balanced report on “Ending coercion in mental health: the need for a human rights-based approach”. It makes clear why ending coercive measures is essential in order to respect the human rights of persons dealing with a mental health condition, and highlights the vicious circle created by stigma and stereotypes, disempowerment and involuntary placement and treatment. It moreover emphasises that alternatives exist, work and should be promoted as a matter of urgency.

2. I fully support the report and have therefore focused in my opinion on some additional human rights issues that may arise in this field, from a non-discrimination perspective. Many of these issues were already set out in detail in the comments of the Committee on Equality and Non-Discrimination on the draft additional protocol to the Convention on Human Rights and Biomedicine (ETS No. 164, “Oviedo Convention”), concerning the protection of human rights and dignity of persons with mental disorder with regard to involuntary placement and involuntary treatment, adopted on 10 October 2018, and which are appended to this opinion.

1. Changing the paradigm

3. The United Nations Convention on the Rights of Persons with Disabilities (CRPD) – which has to date been ratified by all Council of Europe member States except Liechtenstein – today sets the benchmark for human rights standards in the field of disabilities. The CRPD represents a fundamental shift in the approach towards disabilities as it is based on a social, rather than a medical, model of disability. Thus, a medical diagnosis (such as having a mental health condition) does not automatically mean that a person has a (psychosocial) disability. Rather, it is the societal barriers encountered by persons with a mental health condition that may place them in a situation of disability. The CRPD makes clear that it is up to our societies to remove those barriers in order to ensure that everyone is able to participate in society on an equal footing.

4. For too long, individuals with psychosocial disabilities have been viewed as by definition dangerous, deviant and prone to violence. As Ms de Bruijn-Wezeman’s report points out, this stigma has had a marked influence on the ways in which mental health conditions are treated. Crisis situations are most often managed through the lens of minimising the immediate risk of harm to the person concerned or to others – frequently by using involuntary placement, accompanied by involuntary treatment (i.e. coercive measures). Too little attention is generally paid to long-term prevention and management strategies that empower the individual and radically reduce the risk of a crisis situation emerging. Yet Ms de Bruijn-Wezeman’s report shows that such strategies already exist and are working in many member States.

2. Discrimination

5. Many European States have made great strides forward as regards removing barriers to the participation of persons with physical disabilities (for example, by making public buildings and public transport accessible to persons with reduced mobility). Yet when it comes to psychosocial disabilities, old paradigms prevail, coercive measures are still widely used despite their demonstrated harmful effects and the lack of evidence to show that they help to reduce any risk of violence,² and alternative methods that empower the individual and respect their autonomy remain the exception. This different treatment of persons with different forms of disabilities is allowed to persist because of the stereotypes and stigma that surround mental health conditions – yet it is not objectively justified and thus amounts to discrimination.

6. As Ms de Bruijn-Wezeman’s report also stresses, the available research does not support the existence of a direct link between mental health conditions and violence. It is only relevant to associate mental health conditions with violence when there is an accumulation of other risk factors – historical, clinical, dispositional and/or contextual. Despite this, persons with mental health conditions are deprived of their liberty and subjected to involuntary treatment in all Council of Europe member States, on the grounds that there is a need to reduce the risk of harm. This contrasts with the situation of other groups, such as young men drinking alcohol or known perpetrators of domestic abuse, who are not deprived of their liberty even though their propensity to violence (which may clearly pose a risk of harm to themselves or others) has been empirically established.³ Again, this different treatment is unjustified and may be analysed as a form of discrimination.

2. See chapter 3 of Ms de Bruijn-Wezeman’s explanatory memorandum, and sources cited therein.

3. Ibid.

7. As the committee has previously pointed out, persons with psychosocial disabilities are frequently disempowered, and coercive measures are the epitome of this disempowerment. The failure to recognise the capacity of persons with psychosocial disabilities to decide for themselves is one of the most fundamental forms of discrimination that they face. When a person's mental capacity is (i.e. their decision-making skills are) impaired, the answer is not to deprive them of their legal capacity: instead, in accordance with the philosophy of the CRPD, special measures (such as supported decision-making, advance directives, etc.) should be set up in order to guarantee that they can enjoy their legal capacity on an equal basis with others.⁴

8. The committee has already set out in detail the discriminatory impact on persons with psychosocial disabilities of coercive measures such as involuntary placement and treatment, in particular as regards arbitrary deprivation of liberty; autonomy, free and informed consent and equal recognition before the law; and exposure to additional human rights violations as a result of the application of coercive measures. I have decided to make these arguments available to all through the inclusion, in an appendix to this opinion, of the committee's 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.

9. I would add, finally, that the European Court of Human Rights has established that the detention of persons of "unsound mind" (in the language of Article 5.1.e of the European Convention on Human Rights (ETS No. 5)) will only be considered lawful under the Court's current case law if it meets a series of stringent criteria. Thus, "[a]ny detention of mentally ill persons must have a therapeutic purpose, aimed specifically, and in so far as possible, at curing or alleviating their mental-health condition". Moreover, "irrespective of the facility in which those persons are placed, they are entitled to be provided with a suitable medical environment accompanied by real therapeutic measures, with a view to preparing them for their ... release". In its judgment, the Court expressly recognised that the absence of a prohibition on detention on the basis of impairment, under Article 5 of the Convention as currently interpreted, contrasts with the position taken on this point by the United Nations Committee on the Rights of Persons with Disabilities.⁵ I wish to stress that States Parties to the CRPD – 46 of the 47 Council of Europe member States – have committed themselves to respecting the universal human rights standards set out by the CRPD in this field, and they must not rely on the less rigorous standards of Article 5.1.e of the Convention as it is currently interpreted in order to escape their duty to fully protect the rights of persons with psychosocial disabilities within their jurisdiction. Moreover, the Court's case law in this field is itself evolving, towards a position ever closer to that of the CRPD.

3. Final remarks

10. As Ms de Bruijn-Wezeman's report shows, the different treatment reserved to persons with psychosocial disabilities – and specifically, the all-too-common insistence on recourse to coercive measures when it comes to treating their mental health condition – is not only harmful to the persons concerned, but also unjustified and discriminatory.

11. Overturning the current trend towards increasing use of coercive practices in the mental health field is a fundamental question of equality and dignity. States must work urgently to overcome the stereotypes and stigmas that surround persons with psychosocial disabilities in society, which are at the root of the harmful practices they face and which trap them in a vicious cycle of exclusion.

12. I welcome the important contribution made by Ms de Bruijn-Wezeman's report in showing that alternative methods of treating mental health conditions exist, work and must be promoted. The focus of such treatment must be on guaranteeing the autonomy and empowerment of persons with psychosocial disabilities, in order to ensure that they can participate in society on an equal footing, despite the additional hurdles they may face.

4. CRPD/C/GC/1, paragraph 13; see also 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, approved on 10 October 2018.

5. *Rooman v. Belgium*, Application No. 18052/11, judgment of 31 January 2019 (Grand Chamber); see in particular paragraphs 205-211.

Appendix – Comments on the draft additional protocol to the Oviedo Convention, concerning the protection of the human rights and dignity of persons with mental disorder, with regard to involuntary placement and involuntary treatment⁶

1. Introduction

1. On 18 June 2018, the Council of Europe Committee on Bioethics (DH-BIO) sent the draft Additional Protocol to the Convention on Human Rights and Biomedicine (ETS No. 164, “Oviedo Convention”), concerning the protection of the human rights and dignity of persons with mental disorder, with regard to involuntary placement and involuntary treatment, to the Parliamentary Assembly for comments. Within the Assembly, under their respective terms of reference, two committees are competent to deal with this matter: the Committee on Social Affairs, Health and Sustainable Development and the Committee on Equality and Non-Discrimination. These committees held a joint hearing on 9 October 2018 on “Protecting the rights of persons with psychosocial disabilities with regard to involuntary measures in psychiatry”, with the participation of Ms Beatrice Ioan, Chairperson of the Council of Europe Committee on Bioethics; Ms Catalina Devandas-Aguilar, United Nations Special Rapporteur on the rights of persons with disabilities; Ms Dunja Mijatović, Council of Europe Commissioner for Human Rights; Mr Christos Giakoumopoulos, Director General of Human Rights and the Rule of Law of the Council of Europe; Ms Olga Runciman, Psychologist and owner of *Psycovery*. The elements put forward by the speakers have been taken into account in the present comments.

2. The Committee on Equality and Non-Discrimination thanks the Committee on Bioethics for this opportunity to provide comments to the draft protocol in the context of an informal consultation. It recalls that the position of the Assembly has previously been spelt out in [Recommendation 2091 \(2016\)](#) on the case against a Council of Europe legal instrument on involuntary measures in psychiatry, in which it “recommend[ed] that the Committee of Ministers instruct the Committee on Bioethics to: withdraw the proposal to draw up an additional protocol concerning the protection of the human rights and dignity of persons with mental disorder with regard to involuntary placement and involuntary treatment; instead focus its work on promoting alternatives to involuntary measures in psychiatry, including by devising measures to increase the involvement of persons with psychosocial disabilities in decisions affecting their health” and indicated that “[s]hould a decision to go ahead with the additional protocol nevertheless be taken, the Assembly recommends that the Committee of Ministers encourage the Committee on Bioethics to directly involve the disability rights organisations in the drafting process, as recommended by the CRPD and Assembly [Resolution 2039 \(2015\)](#) on equality and inclusion for people with disabilities”.⁷

3. The main thrust of the contribution of the committee in its present comments is on equality and non-discrimination aspects. Its reference is the landmark international instrument worldwide for the protection of the rights of persons with disabilities, the United Nations Convention on the Rights of Persons with Disabilities (CRPD). This Convention, which puts persons with disabilities at its heart and promotes the vision “Nothing about us without us”, has been ratified by 46 of the 47 Council of Europe member States.⁸ The committee emphasises that it would be a matter of serious concern, and dangerous for the rights of all persons with disabilities, if, by adopting new international standards lower than those recognised under the CRPD, the Council of Europe – the leading European human rights organisation – undermined international human rights work in this field. Indeed, the 46 member States that are Parties to the CRPD have not only committed themselves to respecting the letter of the latter’s provisions, but have also made a political commitment to achieving the paradigm shift that this convention represents.

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

6. Approved by the Committee on 10 October 2018.

7. Paragraphs 11 and 12.

8. That is, all Council of Europe member States except Liechtenstein.

2. General considerations

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

1. As was pointed out at the hearing of 9 October 2018, there is agreement that persons subjected to involuntary measures in psychiatry face grave violations of their human rights, and that States must act to stop this. The judgments of the European Court of Human Rights and the reports of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) all too clearly show this reality. Yet many Council of Europe member States have legislation that provides for involuntary measures, and continue to apply it today.
2. There is also consensus that saving lives and supporting persons with psychosocial disabilities, including in situations of extreme crisis or severe distress, is a common goal, and that member States need guidance in order to design and implement effective alternative measures that respect the dignity and rights of persons with psychosocial disabilities.
3. Different approaches exist, however, as to the best means of achieving this goal. As explained by its Chair at the hearing of 9 October 2018, the Committee on Bioethics takes the view that for as long as laws providing for involuntary measures exist and are applied, clear safeguards must be in place to ensure that they are used only as a last resort, as well as to enable persons with psychosocial disabilities to exercise their rights. However, the United Nations Special Rapporteur emphasised that involuntary measures have always been constructed on the basis that they should be exceptional and surrounded by safeguards – yet it is precisely in those States where such legislation is in place that the rate of recourse to involuntary measures is the highest. Thus, in essence, safeguards in this field may introduce more hurdles, but they cannot achieve what is most urgently needed: that is, to overturn the status quo. She and other speakers moreover emphasised that there is no evidence that coercive measures reduce self-harm. To the contrary, as both Ms Runciman and a speaker on behalf of the European Network of (ex-)users and survivors of psychiatry (ENUSP) emphasised, coercive measures destroy the trust of the person subjected to them in the capacity of psychiatry to support them, and lead to their avoidance of all contact with the health care system. This is another reason why, as one speaker stressed, “coercion is not care”.
4. Alternatives to coercion already exist. Examples include home intervention strategies, crisis or respite services, peer-run initiatives and advance planning. While little academic writing yet exists in this field, a literature review published in October 2018 shows that such alternatives can be highly successful, and are worthy of considerably more attention from States.⁹
5. It is important to emphasise that persons with psychosocial disabilities are frequently disempowered, and that coercive measures are the epitome of this disempowerment. The failure to recognise the capacity of persons with psychosocial disabilities to decide for themselves is one of the most fundamental forms of discrimination that they face, as discussed further below. The stereotypes and stigmas that surround persons with psychosocial disabilities in society moreover lead to widespread perceptions that all persons with psychosocial disabilities are dangerous, both to themselves and to others. This in turn leads all too rapidly to their exclusion from society. All of these factors heighten the discrimination faced by persons with psychosocial disabilities. As Ms Runciman made clear, it is crucial to listen to the stories of persons with psychosocial disabilities to understand their lived history, and to understand why they are insistent that what is needed is not more of the same, but a paradigm shift.
6. One element of this paradigm shift is to cease to use the term “persons with mental disorder”, as they are referred to in the title and text of the draft protocol, and to take on board and use the terminology of the CRPD Committee, i.e. “persons with psychosocial disabilities”. Indeed, the choice of the term is not neutral. It reflects a different approach to the matter, or an emphasis on different aspects and concerns. While “persons with mental disorder” reflects the approach long used in psychiatry, “persons with psychosocial disabilities” is the accepted human rights terminology.

9. Goodings P. et al. (2018), *Alternatives to Coercion in Mental Health Settings: A Literature Review*, commissioned by the United Nations Office at Geneva to inform the report of the United Nations Special Rapporteur on the Rights of Persons with Disabilities, Melbourne Society Equity Institute.

3. Specific issues concerning equality and non-discrimination

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

12. *Equal recognition before the law (Article 12 of the CRPD)*: The rights of all persons with disabilities, including those with psychosocial disabilities, to recognition everywhere as persons before the law, and to enjoy legal capacity on an equal basis with others in all aspects of life, are enshrined in Article 12 of the CRPD. The CRPD Committee has drawn attention to the importance of distinguishing between a person’s legal capacity (legal standing and legal agency) and their mental capacity (decision-making skills).¹⁰ Where a person’s mental capacity is impaired, special measures may be needed in order to guarantee their right to enjoy their legal capacity on an equal basis with others, in accordance with Article 12 of the CRPD. Depriving them of their legal capacity is however not compatible with their right to equal recognition before the law under the CRPD.

13. *The right to liberty and equal recognition before the law (Articles 14 and 12 of the CRPD)*: The CRPD provides that “the existence of a disability shall in no case justify a deprivation of liberty” (Article 14(b)). The CRPD Committee has moreover made clear that “denial of the legal capacity of persons with disabilities and their detention in institutions against their will, either without their consent or with the consent of a substitute decision-maker, constitutes arbitrary deprivation of liberty and violates articles 12 and 14 of the [CRPD]”.¹¹ Involuntary placement is discriminatory because, quite simply, it ignores the legal capacity of the person concerned. Special measures are instead needed in order to guarantee the right to equality and respect for the principle of non-discrimination, such as providing support in decision-making on health-related matters or alternative service models that are respectful of the will and preferences of the person.¹² Such measures eliminate the “need” to have recourse to involuntary placement.

14. *Autonomy, free and informed consent and equal recognition before the law (Articles 25 and 12 of the CRPD)*: As part of States’ recognition that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability, Article 25(d) of the CRPD requires that health care be provided to persons with psychosocial disabilities on the basis of their free and informed consent. As the United Nations has recognised, free and informed consent to treatment is meaningless unless the person concerned also has the right to refuse it.¹³ There is no justification for treating persons with psychosocial disabilities differently from others in this respect: again, ignoring their legal capacity is not compatible with their right to equal recognition before the law, and special measures should instead be implemented wherever necessary to guarantee access to supported decision-making processes.

15. *Exposure to additional human rights violations once subjected to involuntary placement and/or treatment (Articles 15 and 17 of the CRPD and Articles 3 and 13 of the European Convention on Human Rights)*: Broad agreement exists that there is an “unacceptably high prevalence of human rights violations in mental health settings” and that immediate measures to bring about change in this field are needed.¹⁴ In addition to the violations of the right to equal recognition before the law outlined above, persons with psychosocial disabilities are exposed to further human rights violations when they are placed involuntarily in mental health settings. In particular, they may disproportionately experience violations of their right to physical integrity, notably due to the use of force, restraints (whether physical or chemical, including sedation), isolation or seclusion, in breach of Article 17 of the CRPD and (in particular where the use of such measures is prolonged) in breach of the prohibition on torture and inhuman or degrading treatment under Article 15 of the

10. CRPD/C/GC/1, paragraph 13.

11. CRPD/C/GC/1, paragraph 40.

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

13. Ibid., and UN document E/CN.4/2006/120, paragraph 82.

14. Report of the United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 28 March 2017, A/HRC/35/21.

CRPD and Article 3 of the European Convention on Human Rights.¹⁵ The World Health Organization itself recognises that “psychiatric institutions ... are associated with gross human rights violations including inhuman and degrading treatment and living conditions”, and that these violations “often occur behind closed doors and go unreported”¹⁶ – meaning that no investigation into such violations is carried out, and no redress can be granted. Persons with psychosocial disabilities thus face specific and serious violations of their rights under both the substantive and procedural arms of Article 3 and under Article 13 of the European Convention on Human Rights, as well as under Articles 15 and 17 of the CRPD. In short, the involuntary placement and/or treatment of persons with psychosocial disabilities based solely on their disability is also discriminatory because it exposes them to a series of grave human rights violations to which other persons are not subjected.

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

Conclusions

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

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

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

16. www.who.int/mental_health/policy/legislation/en/.