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Ending the detention of "socially maladjusted" persons

Report[1]
Committee on Social Affairs, Health and Sustainable Development
Rapporteur: Mr Stefan SCHENNACH, Austria, Socialists, Democrats and Greens Group

Summary

The right to liberty is one of the most fundamental human rights. It is guaranteed in Article 5 of the European Convention on Human Rights. However, the Convention includes a limitation to the right to liberty specifically on the basis of impairment, drug or alcohol use, or not having a fixed abode. With the formulation in Article 5 (1) (e), persons of "unsound mind, alcoholics or drug addicts or vagrants" can be lawfully detained.

The idea of social control is not compatible with our 21st century understanding of human rights. The time has come to move away from the discriminatory concept of excluding certain groups from human rights protection.

The Parliamentary Assembly should thus, *inter alia,* recommend that the Committee of Ministers consider drawing up an additional protocol to the European Convention on Human Rights and support member States in taking the necessary steps for the full enjoyment of the right to liberty at the national level by the groups referred to in Article 5 (1) (e) of the Convention.

1. Reference to committee: Doc. 15483, Reference 4645 of 28 April 2022.

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A. Draft recommendation[2]

1. The right to liberty is one of the most fundamental human rights. It is guaranteed in Article 5 of the European Convention on Human Rights (ETS No. 5, "the Convention"). However, the Convention includes a limitation to the right to liberty specifically on the basis of mental impairment, drug or alcohol use, or not having a fixed abode. With the formulation in Article 5 (1) (e), reportedly stemming from the eugenics movement, "persons of unsound mind, alcoholics or drug addicts or vagrants" can be lawfully detained. These persons have been referred to as "socially maladjusted" by the European Court of Human Rights, an approach that is considered discriminatory and stigmatising in the human rights community.

2. The Convention is the only international human rights treaty that excludes these groups from the full enjoyment of the right to liberty. This is problematic as detaining such vulnerable persons effectively puts them at higher risk of systematic rights violations, on the sole ground that they might hypothetically pose a danger to others or that their own interest may necessitate their detention. The initial draft of the Convention did not contain a reference to "socially maladjusted" persons – indeed, the Parliamentary Assembly, in 1949, had recommended a text closer to the Universal Declaration of Human Rights.

3. In the last 70 years, there has been a worldwide paradigm shift to a human rights-based approach, as exemplified by the United Nations Convention on the Rights of Persons with Disabilities, ratified by all member States of the Council of Europe except Liechtenstein. The United Nations interpretation of the rights of persons with disabilities and the interpretation given by the Committee on the Rights of Persons with Disabilities do not allow for the deprivation of liberty based on an actual or perceived disability. The interpretation provided by the United Nations is, however, very seldom applied in the context of the European Court of Human Rights, since the formulation of Article 5 (1) (e) does not oblige it to.

4. The idea of social control – whether of persons with psychosocial disabilities, of persons who use drugs or alcohol, or of persons without a fixed abode – is not compatible with our 21st century understanding of human rights. The Assembly underlines the urgent need for the Council of Europe, as the leading regional human rights organisation, to fully integrate the worldwide paradigm shift to a modern human rights-based approach in its work. The time has come to move away from the discriminatory concept of excluding certain groups from human rights protection. The Assembly thus recommends that the Committee of Ministers:

4.1. consider drawing up an additional protocol to the European Convention on Human Rights, which removes "persons of unsound mind, alcoholics or drug addicts or vagrants" from the current formulation of Article 5 (1) (e) of the Convention, and thus guarantees the right to liberty to these persons;

4.2. support member States in taking the necessary steps for the full enjoyment of the right to liberty by the groups referred to in Article 5 (1) (e) of the Convention, in co-operation with the European Union, the United Nations and its agencies (in particular, the World Health Organization), non-governmental organisations and organisations of persons with lived experience, *inter alia*:

4.2.1. in removing discriminatory limitations on the full enjoyment of the right to liberty of the groups referred to from their constitutions, their legislation and their policies;

4.2.2. in developing adequately funded, human rights-compliant strategies for deinstitutionalisation with clear time frames and benchmarks with a view to a genuine transition to independent living for persons with disabilities, mental health problems, and for persons who use drugs or alcohol;

4.2.3. in running public awareness-raising campaigns, in order to overcome stereotypes and prejudice surrounding persons with disabilities, with mental health problems, persons who use drugs or alcohol or who do not have a fixed abode, and promote the full inclusion in society of these persons;

4.3. call on the Council of Europe Development Bank, the World Bank and other social development funds such as the European Structural and Investment Funds to support member States to allocate adequate resources for support services that avoid the detention and/or institutionalisation of persons with disabilities, mental health problems, or persons who use drugs or alcohol – such as the strengthening, creating and maintaining of community-based services (including drug consumption rooms, therapeutic communities and supportive living arrangements);

2. Draft recommendation adopted unanimously by the committee on 18 April 2024.

4.4. in line with the unanimously adopted Recommendation 2158 (2019) “Ending coercion in mental health: the need for a human rights-based approach” and with Recommendation 2227 (2022) “Deinstitutionalisation of persons with disabilities”, adopt guidance to member States promoting voluntary measures in mental healthcare services and pay due attention, in its further consideration of the draft additional protocol to the Convention for the protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine (ETS No. 164, “Oviedo Convention”) concerning the protection of human rights and dignity of persons with regard to involuntary placement and involuntary treatment within mental healthcare services, to ensuring that any Council of Europe guidance is fully in line with the Convention on the Rights of Persons with Disabilities, the guidance of the United Nations and its agencies and the widely-accepted best practice.

B. Explanatory memorandum by Mr Stefan Schennach, rapporteur

1. Introduction

1. The right to liberty is one of the most fundamental human rights. It is guaranteed in Article 5 of the European Convention on Human Rights (ETS No. 5, "the Convention"). However, the Convention includes a limitation to the right to liberty specifically on the basis of mental impairment, drug or alcohol use, or not having a fixed abode. With the formulation in Article 5 (1) (e), persons of "unsound mind, alcoholics or drug addicts or vagrants" can be lawfully detained. These persons have been referred to as "socially maladjusted"[3] by the European Court of Human Rights ("the Court").[4] As such the Convention is the only international human rights treaty that excludes these groups from the full enjoyment of the right to liberty. This is problematic, as detaining such vulnerable persons effectively puts them at higher risk of systematic rights violations, on the sole ground that they might hypothetically pose a danger to others or that their own interest may necessitate their detention. The language itself is also considered discriminatory and stigmatising in the human rights community.

2. On 17 March 2022, the Committee on Social Affairs, Health and Sustainable Development tabled a motion for a recommendation on "Detention of the 'socially maladjusted'".[5] The motion points out that "[t]he wording of the Convention, reportedly stemming from the eugenics movement, suggests that the right to liberty is not shared equally by [these] persons". Referring to the worldwide paradigm shift to a human rights-based approach on the issue, the Parliamentary Assembly has already unanimously called for an end to coercion in mental health. In this regard, there is still a lot of work left to do for the Council of Europe and its member States.

3. At its meeting on 22 May 2023, the committee considered an introductory memorandum and held a public hearing with the participation of:

– Mr Marius Turda, Professor of 20th Century Central and Eastern European Biomedicine, Oxford Brookes University, United Kingdom,

– Ms Boglárka Benko, Registry of the European Court of Human Rights, Council of Europe,

– Mr Thomas Kattau, Deputy Executive Director, Pompidou Group (Council of Europe International Co-operation Group on Drugs and Addictions),

– Ms Laura Marchetti, Policy Manager, Mental Health Europe, Brussels.

4. The minutes of the hearing have been declassified and are available on the committee's webpage.[6]

5. I carried out a fact-finding visit to Portugal – a good practice example – on 20-22 November 2023, visiting the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA, now European Union Drugs Agency (EUDA)), the Santa Casa da Misericórdia de Lisboa, the General-Directorate for Intervention on Addictive Behaviours and Dependencies (SICAD), meeting parliamentarians active on the health committee and members of the delegation to the Assembly, two NGOs (Associação Ares do Pinhal and Comunidade Vida e Paz), and visiting a drug consumption room run by the former. My sincere thanks go to all my interlocutors, and to the Secretariat of the Portuguese delegation to the Assembly and the EUDA who organised my visit so well.

6. This report looks at how developing and promoting alternatives to the detention of "socially maladjusted" persons could help the Council of Europe and its member States to move with the times and away from the discriminatory concept of excluding certain groups from human rights protection. The report draws on multiple sources in addition to information collected during the hearing and the fact-finding visit, particularly on the work of the NGOs European Disability Forum (EDF) and Mental Health Europe, which underline the importance of abolishing the possibility for the detention of persons with psychosocial disabilities or struggling with mental health issues. On this basis, the report formulates recommendations to the

3. *Guzzardi v. Italy*, no. 7367/76, para. 98, 6 November 1980.
4. The Convention's and the Court's language are considered discriminatory, stigmatising and/or archaic in the human rights community.
5. Doc. 15483. The motion was referred to the Committee on Social Affairs, Health and Sustainable Development for report and I was appointed rapporteur on 21 June 2022.
6. AS/Soc(2023)PV04add.

Committee of Ministers on how to change the terminology in Article 5 (1) (e) of the Convention, but also to member States on other necessary steps for the full enjoyment of the right to liberty by the groups referred to in Article 5 (1) (e).

2. The historical background

7. The initial draft of the European Convention on Human Rights did not contain a reference to "socially maladjusted" persons – indeed, the Assembly, in 1949, had recommended a text closer to the Universal Declaration of Human Rights. In the drafting process of the Convention, however, the Swedish and the United Kingdom representatives proposed for the first time the introduction of the restriction on the rights of "socially maladjusted" persons into Article 5 of what would become the European Convention on Human Rights, inspired by an amendment presented by Australia, Denmark, France, Lebanon, and the United Kingdom to Article 9 of the draft International Covenant on Human Rights in 1949.[7]

8. The terminology dates back to the eugenics movements stemming from the late 19th century. The eugenics concepts originating in the United Kingdom aimed to improve the genetic quality of a human population by excluding groups that were deemed inferior. This also entailed the coerced sterilisation of persons with low income or disabilities,[8] and social control of the "inferior".[9]

9. As Professor Turda pointed out during the hearing, eugenicists argued that society needed to be protected from the growing numbers of those labelled "unfit", "maladjusted", "unsound of mind", "feebleminded", "dysgenic" and "sub-normal" due to their physical and mental disabilities. Moreover, they believed it was appropriate to control the reproduction of persons of "unsound mind", thus sterilisation and marriage laws were consequently introduced in many countries, including in some US States, Switzerland, and Denmark.[10]

10. Even after the Second World War, the eugenic movement re-planted itself and continued to attract political and scientific support for its proposals. The notion of "unsound mind" was re-scripted into the concept of "maladjustment" in the post-war years, and then applied more broadly to justify and advance inequitable social relations across a range of social identities. The link between mental disability and social unfitness remained unchallenged. The concept of "unsound mind" has historically played a significant role in shaping eugenic thinking and practice. It was deployed in a variety of ways to stigmatise and dehumanise individuals and to advance discriminatory practices and marginalisation of individuals, including those with learning disabilities.[11]

11. I agree with Professor Turda that it is highly problematic that this eugenic mindset is reflected in the current version of the European Convention on Human Rights, more than 70 years after its drafting. The thinking as well as the terminology are outdated, and not in accordance with current human rights law standards. The time has come to confront the lingering adherence to eugenics after the Second World War.

12. Today, 33 countries in the world still refer to "socially maladjusted" persons in their constitutions. 30 of these countries are former British colonies and their constitution has been influenced by the outdated British eugenics movement and thinking. The other three countries are Singapore, Armenia, and Estonia. The latter two countries use the same formulation as the Convention.[12]

3. The case law of the European Court of Human Rights

13. The European Court of Human Rights has justified the use of Article 5 (1) (e) of the Convention for the detention of "socially maladjusted" persons[13] several times in its case law on the basis that "they have to be considered as occasionally dangerous for public safety [or] that their own interests may necessitate their detention".[14] The Court emphasises the supposed dual function of Article 5 (1) (e) of the Convention: "on the one hand, the social function of protection, and on the other hand, a therapeutic function".[15]

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7. European Commission of Human Rights, Preparatory work on Article 5 of the European Convention on Human Rights, Strasbourg, 8 August 1956, DH (56) 10. See also: Report of the Fifth Session of the Commission on Human Rights to the Economic and Social Council, UN Doc. E/1371 (Supp.), pp. 31-3.
8. See Resolution 1945 (2013) "Putting an end to coerced sterilisations and castrations".
9. English Heritage, Eugenics in Britain.
10. AS/Soc(2023)PV04add, op. cit.
11. Ibid.
12. Barret, Damon, "'Drug Addicts' and the ECHR", European Journal of International Law (EJIL): Talk, 3 September 2018.

14. As was pointed out during the hearing, the UN interpretation of the rights of persons with disabilities and the interpretation given by the Committee on the Rights of Persons with Disabilities do not allow for the deprivation of liberty based on an actual or perceived disability. This interpretation provided by the UN is very seldom applied in the context of the Court. The case law of the Court allows the deprivation of liberty of persons with mental disabilities both in the civil law context (such as forced hospitalisation and commitment to social care facilities) and in the criminal law context.[16]

15. The underlying approach of the Court is nevertheless that the right to liberty is such an important element of self-determination, and that the deprivation of liberty is such a serious measure that it has to be restricted to the strict minimum (*Alajos Kiss v. Hungary*) and is only to be resorted to if less severe measures were not possible (*Karamanof v. Greece).*[17] The Court verifies that national courts have assessed and scrutinised the pertinent issues thoroughly[18] and amongst others, it must be reliably shown that the person is of "unsound mind".[19]

16. In order to establish whether detention of a person of "unsound mind" is lawful, the Court bases the assessment on three cornerstone criteria developed in the case of *Winterverp v. the Netherlands*. First, the person has to be reliably shown to be of "unsound mind" based on objective medical expertise. Second, the individual's mental disorder has to be of a kind that warrants compulsory confinement. Third, the mental disorder has to persist throughout the period of detention. From there, the Court gradually developed additional criteria. In *Litwa v. Poland*, the Court held that the deprivation of liberty had to be the last resort. This requires that one has to consider other treatments that a person could benefit from (such as outpatient care and care in the community) so that recourse to deprivation of liberty is unnecessary. The second additional element is the question of placement in an appropriate institution, developed in the case of *Rooman v. Belgium*. The Court held that detention must hold therapeutic purpose for it to be lawful. The third element is that national legislation has to ensure procedural safeguards and contain guarantees against arbitrariness, as held in the case of *Shtukaturov v. Russia*.[20]

17. The original purpose of allowing for the deprivation of liberty of persons of "unsound mind" was to protect society. Later, the Court moved over to an understanding that Article 5 should also be used to protect the person from him - or herself. In the case of *Stanev v. Bulgaria,* the Court found that the protection of the welfare of the person could justify his detention. The Grand Chamber held that the need for social protection and the need for housing itself were not sufficient grounds to deprive a person of their liberty, but on the other hand, the fact that someone had been unable to take care of themselves, could be a justification to deprive that person of their liberty. In the case of *Plesó v. Hungary*, the Court said that a balance must be struck between the interest of society and the interest of the person to their right to self-determination.[21]

18. Regarding "alcoholics", the Court decided on a very wide definition. Detention is permitted in order to prevent alcohol abuse and to prevent dangerous conduct by persons following the consumption of drink.[22] The person does not need to be someone in a clinical state of alcoholism.[23]

19. The term "drug addicts" was, however, never defined by the Court, as it has not been necessary so far.[24] However, it is important to mention that, as stated by the Pompidou Group (Council of Europe International Co-operation Group on Drugs and Addictions), persons with drug use disorders have to be considered as having a health disorder and need to be treated in full compliance with human rights standards and health care standards.[25]

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13. *Guzzardi v. Italy*, no. 7367/76, para. 98, 6 November 1980.
14. *Enhorn v. Sweden*, no 56529/00, para. 43, 25 January 2005.
15. *Rooman v. Belgium*, no. 18052/11, para. 210, 31 January 2019.
16. AS/Soc(2023)PV04add, op. cit.
17. Ibid.
18. *Anatoliy Rudenko v. Ukraine*, no. 50264/08, para. 101, 17 April 2014.
19. *Winterwerp v. the Netherlands*, 24 October 1979, para. 39 Series A no. 33.
20. Ibid.
21. Ibid.
22. *Kharin v. Russia*, no. 37345/03, para. 34, 3 February 2011; *S. v. Germany*, no. 3300/10, para. 83, 28 June 2012.
23. *Witold Litwa v. Poland*, no. 26629/95, para. 61, ECHR 2000-III.
24. The only two cases have rather been linked to mental health (*Aerts v. Belgium*, No. 25357/94) and the lawful detention of a person after conviction by a competent court (Case of *Ciulla v. Italy*, No. 11152/84).
25. Pompidou Group, "Standards for treatment of people with drug use disorders in custodial settings".

20. As was pointed out during the hearing, the Pompidou Group has highlighted for many years at the political level that the concept of "drug addicts" and the wording has evolved over time[26] and is outdated. The prevailing view in this field of research, amongst practitioners, and also increasingly in the legal sphere of the Council of Europe member States, is that it is also seen as discriminatory and stigmatising.[27]

21. Even though, to date, the Court has not rendered any judgment on "drug users" – which may or may not indicate that the conditions to be met for a deprivation of liberty to be decided in such cases are very strict[28] – many people who use drugs are worried about being institutionalised. There is very little guidance to first responders, who are aware of the fact that they have the duty to protect. The tension lies in the fact that the person has the right to liberty, but first responders have a legal obligation to protect life. The consequence is that a person in distress or in need of medical assistance sometimes shies away from seeking help, so as not to be locked up or be subjected to coercive measures.[29]

22. Finally, the term "vagrant" is of an archaic nature. Therefore, although the Court gives it a narrow interpretation, such wording should no longer be used.

4. The worldwide paradigm shift to a human rights-based approach

4.1. As regards mental health conditions and psychosocial disabilities

23. The fact that the detention of "socially maladjusted" persons is not in line with the modern understanding of human rights law can be seen on an international as well as a national scale. On the international level, the UN Convention on the Rights of Persons with Disabilities (CRPD), ratified by 45 member States of the Council of Europe,[30] is of special importance as regards current human rights standards. It reflects the paradigm shift to a human rights-based approach to disability, moving from a biomedical approach to a psychosocial model of disability.

24. In this connection, it is worth citing paragraphs 24 to 26 of the 2022 report of our former colleague Ms Reina de Bruijn-Wezeman (Netherlands, ALDE) entitled "Deinstitutionalisation of persons with disabilities"[31]:

> *- The most developed articulation for the right to live in the community of persons with disabilities is found in the UN Convention on the Rights of Persons with Disabilities. As laid down in Article 19, persons with disabilities, without exception, have the right to live independently and receive appropriate community-based services. This applies no matter how intensive the support needs. An important aspect of quality service provision is that persons with disabilities should be supported within their community.*
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> *- The overarching objective of Article 19 is full inclusion and participation in society. Its three key elements are: choice (sub-paragraph a); individualised supports that promote inclusion and prevent isolation (sub-paragraph b); and making services for the general public accessible to persons with disabilities (sub-paragraph c).*
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> *- Article 19 is closely connected to provisions in other human rights treaties, including the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights and the Convention on the Rights of the Child. The right to live independently and to be included in the community is also recognised in regional instruments such as the Council of Europe European Social Charter (ETS No. 35) and has strong connections to the right to liberty and security and the right to a private and family life as laid down in the European Convention on Human Rights (ETS No. 5).*

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26. The appropriate wording is "people who use drugs".
27. AS/Soc(2023)PV04add, op. cit.
28. During the high-level Conference "Of Unsound Mind: Convention-compliant approaches to the execution of judgments concerning involuntary detention and treatment on mental health grounds", held in Strasbourg on 27 March 2024, it was pointed out that having no cases before the Court may not mean that the system is perfect, and that there are no violations, but that, on the contrary, persons whose rights have been violated may not have effective access to the court system.
29. Ibid.
30. All Council of Europe member States with the exception of Liechtenstein.
31. Doc. 15496.

25. Article 4 of the CRPD requires that "States Parties undertake to ensure and promote the full realization of all human rights and fundamental freedoms for all persons with disabilities without discrimination of any kind on the basis of disability". Moreover, Article 14 of the CRPD stresses the obligation of States Parties to ensure that if persons with disabilities are deprived of their liberty, the process happens on an equal basis with others. However, Article 5 (1) (e) of the Convention as it stands today, is not in line with this obligation.

26. At the hearing, Ms Marchetti of Mental Health Europe spoke about the human rights dimension of the detention of persons with psychosocial disabilities. She noted that this was the term they preferred to use, as the wording in Article 5 (1) was stigmatising. There had been a paradigm shift of the biomedical approach towards persons with psychosocial disabilities and mental health. The focus used to be on individual characteristics which were the result of a mental health condition, on the impairment and on what a person could and could not do. People with psychosocial disabilities and mental health problems were often considered to be inferior, inadequate or even dangerous for society. Policies and laws legitimised exclusion and deprivation of liberty – at best some minimal level of care was provided, including by coercion.[32]

27. Following the civil and human rights movements in the second half of the last century, the biomedical approach was increasingly criticised. The psychosocial approach to disability posits that the problems and exclusion that persons with psychosocial disability and mental health problems face are not caused by their mental impairments, but rather by the way society is organised and the topic is understood. This model also draws attention to the fact that human experiences are varied and there are a series of determinants that impact an individual's life. Societal structures and practices as well as socio-economic and environmental determinants are seen as bigger influences than an individual's mental impairment. These factors are shown to disable people from taking part in everyday life. Ms Marchetti noted that these were barriers that needed to be removed and that they were the responsibility of society as a whole.[33]

28. The new World Health Organization (WHO) definition recognises mental health as a basic human right and an integral component of health.[34] Mental health is described as a state of mental well-being that enables people to cope with the stresses of life and realise their abilities. This approach has led to the closure of certain mental health institutions (such as "lunatic asylums") and efforts have been made to replace coercion and forced treatments with support that is more human rights-compliant and respectful of a person's dignity.[35]

29. In October 2023, WHO and the Office of the United Nations High Commissioner for Human Rights (OHCHR) published comprehensive guidance on "Mental health, human rights and legislation".[36] In it, the two organisations "envision a world where everyone can lead healthy lives and have access to affordable, high-quality mental health services that use a mental health paradigm based on rights, centred around each person; and where persons with mental health conditions and psychosocial disabilities can fully engage in their own recovery and participate in all areas of life. The Convention on the Rights of Persons with Disabilities is a crucial instrument in this regard, calling for a shift away from substituted decision-making and coercion, towards equality and non-discrimination, supported decision-making, free and informed consent, effective and meaningful participation, and community inclusion".[37] They understand their publication as a "call to action to realize such a vision. It offers a blueprint for laws that promote human rights in mental health, supports legal and attitudinal change, and encourages reforms that protect the rights of all persons interacting with mental health systems. It proposes steps towards establishing mental health services that are respectful of human dignity and comply with international human rights norms and standards".[38]

30. The Council of Europe's Disability Strategy 2017-2023 carried out by the Council of Europe, its member States and other stakeholders both at national and local levels was aimed at guiding and supporting the work and activities targeted at implementing the CRPD. The strategy was based on five priority areas: equality and non-discrimination, awareness raising, accessibility, equal recognition before the law, and freedom from exploitation, violence, and abuse.[39] I regret that the Council of Europe no longer has a department on Disability which could develop a new strategy for the coming years and thus could help make the vision of

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32. AS/Soc(2023)PV04add, op. cit.
33. Ibid.
34. The WHO QualityRights initiative can provide essential guidance on the implementation of mental health services and on community-based responses from a human rights perspective. "QualityRights materials for training, guidance and transformation" (who.int).
35. AS/Soc(2023)PV04add, op. cit.
36. www.who.int/publications/i/item/9789240080737.
37. Ibid, foreword.
38. Ibid.
39. Human rights: a reality for all – Council of Europe Disability Strategy 2017-2023.

WHO and the OHCHR a reality. However, as national parliamentarians, we can and should do so: the guidance of the two organisations includes extensive recommendations on how national legislation can be reformed, and what the new laws can say.

31. In this context, we should recall the Assembly's Resolution 2431 (2022)[40] "Deinstitutionalisation of persons with disabilities". The resolution stresses that all human beings are born free and equal in dignity and rights, which also includes the right to liberty. It recommends amongst others that the Council of Europe member States develop human rights-compliant strategies for deinstitutionalisation and repeal legislation contrary to these principles.

32. Furthermore, the European Union (EU) has launched its own disability rights strategy titled "Union of Equality: Strategy for the Rights of Persons with Disabilities (2021-2030)". One of the main goals of the strategy is the protection of the right of persons with disabilities and especially the protection of their rights from discrimination and violence, including the right to liberty.

33. The human-rights centred approach is also noticeable on a national level, as States are changing their existing laws to align with current human rights standards, such as the CRPD. This includes the creation of justice systems that are universal and do not create separate proceedings or outcomes on the basis of disability; efforts to include persons with disabilities by providing adequate and accessible support, to address and remove barriers that persons with psychosocial disabilities face, and to involve persons with disabilities and organisations that represent them in the design, implementation and monitoring of policies and legislations.[41]

34. Whether at local or national level, new initiatives, policies and laws are putting an end to the coercion of persons with disabilities. Amongst others, Italy has passed a law which ordered the closure of the psychiatric hospitals at national level in the framework of their deinstitutionalisation process. In Georgia, the 2015 amendment of the Civil Code entailed a reform of legal capacity provisions; plenary guardianship has been abolished while supported decision making has been established.[42]

35. However, more can still be done, as Ms Marchetti pointed out during the hearing: "when putting measures in place to include persons with mental health illnesses in society, it is important to understand the purpose. If the purpose is for the person to be included in society, then measures have to be built around this. It is important to support decision making. Advance directives (such as "living wills") should also be taken into consideration. Patients should be able to choose beforehand, when they have a lucid episode, how to be treated in case their condition deteriorates."

36. Speaking of the process of deinstitutionalisation, Ms Marchetti regretted that many countries had unsuccessful stories in this regard. The complexity of the topic was that measures put in place had to be followed by sufficient budget allocation for outpatient and community care – and this was often lacking. Willingness within the system was also necessary to co-operate and provide a continuum of care. Sometimes professionals in hospitals were disillusioned about what to do with people with mental health illnesses. There were thus many measures that could be put in place, but it required political will and adequate funding.

37. I agree with Ms Marchetti that forced hospitalisation is a human rights violation which can amount to life imprisonment although the person concerned has not engaged in any criminal activity. "Socially maladjusted" persons within the meaning of the Convention have in common that they could pose a risk of danger from the perspective of medical or judicial bodies, and national judicial bodies usually leave it to medical personnel to assess that danger.[43]

38. Unlike the CRPD, the Convention does not contain a prohibition of detention on the basis of mental impairment. Human rights protection may thus be in danger of fragmentation, since the CPRD does not contain an enforcement mechanism on par with the European Court of Human Rights.[44] In my opinion, a revision of Article 5 (1) (e) of the Convention is necessary; either *de facto* through more enlightened case law,

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40. Adopted with only one vote against.
41. AS/Soc(2023)PV04add, op. cit.
42. MHE, Promising practice.
43. In the High-level Conference "Of Unsound Mind: Convention-compliant approaches to the execution of judgments concerning involuntary detention and treatment on mental health grounds", Marie Kmecová, a member of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), pointed out that one of the reasons for the substantial risk of ill-treatment of patients in psychiatric hospitals and institutions was that procedural safeguards were often not accessible and effective in practice: the expert medical opinion often came at too late a stage, and the courts often simply mirrored the treating doctor's opinion.
44. AS/Soc(2023)PV04add, op. cit.

or *de jure* through the preparation of an additional (or amending) protocol to the Convention. As long as the paradigm shift of the CPRD is not integrated into the Council of Europe human rights system, Europeans with mental health issues or psychosocial disabilities will continue to be at risk of lawful detention – which may be "Convention-compliant", but not "human rights compliant".[45]

4.2. As regards persons who use drugs or alcohol

39. "Portugal is an example of a country that [recently] decided not to put drug users in jail. … Portugal's 'decriminalisation' of drug use in 2001 falls within the (UN) Convention parameters: drug possession is still prohibited, but the sanctions fall under the administrative law, not the criminal law."[46]

40. During my fact-finding visit to Portugal in November 2023, I had the honour and pleasure of meeting with the Director of SICAD, the Portuguese Ministry of Health's General-Directorate for Intervention on Addictive Behaviours and Dependencies,[47] Mr João Goulão. The directorate's mission is to work towards the reduction of addictive behaviours: alcohol, drugs (both legal and illegal), overuse of screentime, gambling, etc., with a view to reducing harm and promoting a healthier lifestyle. Prevention, treatment, harm reduction, social reintegration and dissuasion are key, but the cornerstone of Portugal's success is the above-mentioned "decriminalisation" of drug use more than 20 years ago.

41. The reason why Portugal was able to go ahead with this policy while much of the world was still engaged in a "war on drugs" was its specific historical circumstances, as Director Goulão pointed out. During Portugal's Salazar dictatorship (the longest in Western Europe, 1933-1974), Portuguese society had been a very closed and controlled society: there was no widespread drug use, no student movement, no hippies. However, most young Portuguese men had served as soldiers in Portugal's colonies, and alcohol and cannabis use was tolerated and sometimes even encouraged in the army. These young men developed habits which were hard to shake. Following the democratic revolution in 1974, the country opened up to the world, and many young tourists came to visit, bringing hippie drug culture with them. At the same time, over one million soldiers and settlers returned to mainland Portugal during the decolonisation process, bringing their alcohol and drug habits with them. Criminals quickly saw the opportunities and introduced hitherto unknown substances, including heroin.

42. It was the perfect storm: drug use exploded in the naïve Portuguese population, cutting across all social groups. It is estimated that more than 1% of the population was using drugs in the early 1990s, including more than 100 000 persons using heroin in a problematic way; there were many overdose deaths, HIV/AIDS cases, and petty crime became rampant. Since everyone knew someone who was grappling with these problems, it quickly became a social and political priority to help (rather than punish) these persons. Treatment and public health programmes were developed under the aegis of the Ministry of Health with the support of the Ministry of Social Affairs, and practically no one was detained or sent to prison for drug use without being offered the possibility of following a treatment process.

43. This public health-oriented approach was formulised via a group of specialists in the late 1990s, following a big conference in Lisbon on the legal response to drug use. The government nominated that group to draw up a national strategy to tackle the drugs problems. It was decided to attack the demand side by decriminalising drug possession for personal use, by focusing on voluntary treatment (1 600 beds in therapeutic communities), by creating the Commissions for the Dissuasion of Drug Addictions to apply administrative sanctions and guide users into the system. Opiate substitution therapy was made widely available, the universal health system offering it free of charge. The Commissions advocate for an integrated approach, centred on health promotion and encouraging motivation to behaviour change of persons referred by security forces or courts in the context of an episode of possession or use of illicit psychoactive substances. The commissions are local structures, composed of three members appointed by the Ministries of Health and Justice, and advised by multidisciplinary teams of legal experts, social workers and psychologists:

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45. The NGO activist and expert by experience Hege Orefellen of We Shall Overcome (Norway) was reportedly disinvited from the High-level Conference "Of Unsound Mind: Convention-compliant approaches to the execution of judgments concerning involuntary detention and treatment on mental health grounds". Her presentation, which brings up several problems I have also mentioned in this report – the "unacceptable language", the fact that "Convention-compliant" does not equal compliance with the applicable norms of international law, and that human rights cannot be guaranteed within a paternalistic medical model – is available here: https://wso.no/2024/03/survivours-of-psychiatry-silenced-at-council-of-europe-high-level-conference/.

46. United Nations Office on Drugs and Crime (UNODC), "World Drug Report 2009", cited in the brochure "SICAD – General-Directorate for Intervention on Addictive Behaviours and Dependencies, Ministry of Health – Portugal".

47. As of 1 January 2024, this part of the Portuguese Ministry of Health, decentralised into 6 parts in 2012, was reunited again as "ICAD".

the focus is on help and dissuasion, not punishment. I was very much impressed by the work of the NGOs integrated into this system: from low-barrier emergency interventions, over treatment (including therapeutic communities, as well as a mobile methadone clinic I visited) to harm reduction (including a drug consumption room I visited).

44. This "Portuguese way" has proven effective: since 1999 there has been a clear drop in addictive behaviours, especially heroin use and drug-induced deaths. However, addictive behaviours (in particular gambling and screen use) in the 30-40-year-old age cohort are currently on the rise, following the financial crisis, the pandemic, and the current cost of living crisis.

45. Portugal has been recognised as a best practice example by the UN since 2016. And so it should: involuntary measures such as detention and forced treatment rarely work for persons who use drugs or alcohol, since the root problem is often a health and/or social one. As was pointed out by the representative of the Pompidou Group during the hearing, a person who uses drugs or alcohol but is in distress sometimes shies away from taking action and approaching the authorities, so as not to be locked up or be subjected to coercive measures. The Portuguese public health-oriented approach has proven its superiority to the outdated approach of the Convention when it comes to effectiveness as well as with regard to upholding the human rights and dignity of persons who use alcohol or drugs.

4.3. As regards persons without a fixed abode

46. The United Kingdom itself, where the eugenic movement originated, demonstrated the change to a human rights-based approach by repealing the Vagrancy Act 1824 and relating legal provisions in 2022, because of their outdated character of "social control" related to the eugenics movement.

5. Conclusions and recommendations

47. I strongly believe that there is no justification for treating certain groups differently on the basis of mental impairment, drug or alcohol use, or not having a fixed abode, and for taking away a human right from them, as all humans are equally entitled to the full enjoyment of their fundamental human rights. The idea of social control is not compatible with our 21st century understanding of human rights.

48. Unlike the Convention on the Rights of Persons with Disabilities, the European Convention on Human Rights does not contain a prohibition of detention on the basis of mental impairment. Human rights protection may thus be in danger of fragmentation, since the CRPD does not contain an enforcement mechanism on par with the European Court of Human Rights. Instead of enumerating and legitimising limitations on the rights of people who belong to the group of persons listed in the Convention's Article 5 (1) (e), those of "unsound mind, alcoholics or drug addicts or vagrants", the Court could clarify the safeguards that apply in the context of persons belonging to these groups by foregrounding positive obligations towards them.[48] After all, the Convention is a living instrument, and – as NGO activist and expert by experience Hege Orefellen has pointed out – should align with developing international human rights standards: "It will require a fundamental change of approach in these cases, but the Court can achieve this and has done so before. The Court has consistently underscored that the Convention is to be interpreted in light of societal development, which means that the Court throughout time has changed and adjusted its practice in various areas of law".[49]

49. Furthermore, the terminology used in Article 5 (1) (e) has to be looked at from a critical point of view. The article contains very wide and undefined concepts such as of "persons of unsound mind". The Court has not provided a "definitive interpretation"[50] of this concept, but it rather left a margin of discretion to national authorities in deciding if a person is of an "unsound mind".[51] Furthermore, this wording – as well as that of "alcoholics or drug addicts or vagrants" – is considered discriminatory and stigmatising in the human rights community.

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48. "Of course, Article 5(1)(e) may be seen as no more than *grounds* for detention to which the wider safeguards the Court has set out must then be applied. Those safeguards are certainly important to make clear in the context of drug use. But this needs to be done explicitly, because at this stage drugs have in fact become exceptional. Perhaps the wider application of the ECHR to drug policies is a good place to start, foregrounding positive obligations towards, as opposed to enumerating limitations on the rights of, people who use drugs". "'Drug Addicts' and the ECHR" – EJIL: Talk! (ejiltalk.org).

49. Ms Orefellen gave LGBT+ rights as an example of one such area that has gone through significant developments in the Court's jurisprudence: https://wso.no/2024/03/survivours-of-psychiatry-silenced-at-council-of-europe-high-level-conference/.

50. *Winterwerp v. the Netherlands*, 24 October 1979, para. 37, Series A no. 33.

51. *H.L. v. the United Kingdom*, no. 45508/99, para. 98, ECHR 2004-IX.

50. The full enjoyment of human rights is closely linked to mental health and vice versa. Poor mental health is a predisposing factor for poor physical health and a much-reduced life expectancy. However, most often the only support available is in psychiatric institutions which are associated with gross human rights violations such as degrading treatment and abuse.[52]

51. Article 5 (1) (e) of the Convention supports this cycle by allowing the detention of people of "unsound mind" and discriminating against them on the grounds of their mental health issues. In addition, the unclear definition of the Court creates a risk of abuse of deprivation of liberty by member States. Indeed, the Assembly has taken a stance three times already against involuntary measures (detention and forced treatment) in psychiatry,[53] as have successive Council of Europe Commissioners for Human Rights and the relevant UN treaty bodies and human rights mechanisms.

52. The public health-oriented approach in use in Portugal for more than 20 years for persons with addictive behaviours (including persons who use drugs) has proven both its effectiveness and its moral superiority over the "war on drugs". Detention and coercive treatment of persons who use drugs simply does not work, as well as being a deprivation of these persons' rights to liberty. Even if Article 5 (1) (e) is rarely – if ever – invoked to justify their detention (or that of persons without a fixed abode) before the Court these days, it is high time that this possibility is eliminated.

53. In conclusion, I cannot underline enough the urgent need for the Council of Europe, as the leading regional human rights organisation, to fully integrate the worldwide paradigm shift to a modern human rights-based approach in its work. The time has come to move away from the discriminatory concept of excluding certain groups from human rights protection. The Assembly should thus recommend that the Committee of Ministers:

– consider drawing up an additional protocol to the European Convention on Human Rights, which removes persons of "unsound mind, alcoholics or drug addicts or vagrants" from the current formulation of Article 5 (1) (e) of the Convention, and thus guarantees the right to liberty to these persons;

– support member States in taking the necessary steps for the full enjoyment of the right to liberty by the groups referred to in Article 5 (1) (e) of the Convention, in co-operation with the European Union, the United Nations and its agencies (in particular, WHO), NGOs and organisations of persons with lived experience, *inter alia*:

  - in removing discriminatory limitations on the full enjoyment of the right to liberty of the groups referred to from their constitutions (Armenia, Estonia), their legislation and their policies (most member States);

  - in developing adequately funded, human rights-compliant strategies for deinstitutionalisation with clear time frames and benchmarks with a view to a genuine transition to independent living for persons with disabilities, mental health problems, and for persons who use drugs or alcohol;

  - in running public awareness-raising campaigns, in order to overcome stereotypes and prejudices surrounding persons with disabilities, with mental health problems, persons who use drugs or alcohol or who do not have a fixed abode, and promote the full inclusion in society of these persons;

– call on the Council of Europe Development Bank, the World Bank and other social development funds such as the European Structural and Investment Funds to support member States to allocate adequate resources for support services that avoid the detention and/or institutionalisation of persons with disabilities, mental health problems, or persons who use drugs or alcohol – such as the strengthening, creating and maintaining of community-based services (including drug consumption rooms, therapeutic communities and supportive living arrangements).

54. I have been representing the Assembly in many of the meetings of the Steering Committee for Human Rights in the fields of Biomedicine and Health (CDBIO, formerly DH-BIO) as concerns their work on voluntary and involuntary measures in mental healthcare services. CDBIO is currently wrapping up a draft

52. UN, "Mental health and human rights".
53. Recommendation 2091 (2016) "The case against a Council of Europe legal instrument on involuntary measures in psychiatry", Resolution 2291 and Recommendation 2158 (2019) "Ending coercion in mental health: the need for a human rights-based approach", and Resolution 2431 and Recommendation 2227 (2022) "Deinstitutionalisation of persons with disabilities".

recommendation for the Committee of Ministers containing guidance to member States promoting voluntary measures in mental healthcare services. This draft recommendation is being prepared closely with the relevant NGOs, and it looks like the final text will be one that the Assembly can welcome.

55. However, the CDBIO is militating for a joint adoption of this draft recommendation by the Committee of Ministers with the draft additional protocol to the Convention for the protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine (ETS No. 164, “Oviedo Convention”) concerning the protection of human rights and dignity of persons with regard to involuntary placement and involuntary treatment within mental healthcare services. Yet, the latter text continues to be widely opposed due to its incompatibility with the CRPD, its incapacity to protect persons with mental health conditions or psychosocial disabilities from violations of their human rights, and the fact that it would make the transition to a human rights-based approach in mental healthcare services more difficult. The Assembly should thus make a recommendation to the Committee of Ministers to ensure that any Council of Europe guidance is fully in line with the CRPD, the guidance of the UN and its agencies and the widely accepted best practice.