



EU PERSON Project's  
Submission to  
the Council of Europe's  
Oviedo Bioethical Convention:  
Draft Additional Protocol on  
Involuntary Detention and Treatment  
of People with Mental Illness.



This document is produced under the project PERSON (Partnership to Ensure Reforms of Supports in Other Nations). The project is funded by the EU Directorate General for Enlargement as an Instrument for Pre-Accession (IPA). The contents of this publication are the sole responsibility of PERSON project and can in no way be taken to reflect the views of the European Union.

## **Introduction to EU Person project**

EU PERSON is funded by the EuropeAid Framework Partnership Agreement (FPA) programme: initially for 2 years from November 2012 and then obtained further funding until November 2016. The EU PERSON partnership was established to advocate for law reform in the Balkans and Turkey in relation to recognition of legal capacity for persons with disability in accordance with Article 12 of the UN Convention for Rights of Persons with Disabilities (CRPD). Article 12 of the UNCRPD emphatically states that persons with disabilities shall be recognized as equal before the law and that to deprive someone of legal capacity on the basis of a disability is discriminatory. This means that all people, regardless of whether or not they have a disability or regardless of the severity of their impairments, are accorded the status of legal decision makers: people who have the right to any necessary supports they need when it comes to making their own decisions. The people we work with include: people with intellectual disabilities; people with psycho-social (mental health) disabilities; parents and siblings of persons with disabilities; policy-makers; politicians; legislators; judiciary; lawyers; healthcare professionals and public service providers across 6 different countries in the Balkans and Turkey. We believe that it is incumbent on all those who work with people with disabilities to move to a stance of supporting people to make their own decisions rather than having others make decisions on their behalf (substituted decision-making).

The EU PERSON project is coordinated by the Centre for Disability Law and Policy at NUI Galway, Ireland, recognized international experts in human rights and the UNCRPD. It comprises six partner civil society organisations: Mental Disability Rights Initiative (MDRI-S); Union of Association for Assisting people with Mental Disabilities of Federation Bosnia and Herzegovina (SUMERO); Association for Social Affirmation of People with Mental Disabilities (THE SHINE); Institute for Sustainability and Development of Youth (ISDY); Human rights in Mental Health Initiative Association (RUSIHAK) and Albanian Disability Rights Foundation (ADRF).

We welcome the commitment in the Convention on Human Rights and Biomedicine, as defined in Article 1, to *protect the dignity and identity of all human beings and guarantee everyone, without discrimination, respect for their integrity and other rights and fundamental freedoms with regard to the application of biology and medicine*. We welcome the inclusion of the aspiration to be guided by the UN Convention on the Rights of Persons with Disabilities (hereafter CRPD) in this Protocol. We welcome the recognition in the preamble to this Protocol: ‘that the use of involuntary placement and involuntary treatment has the potential to endanger human dignity and fundamental rights and freedoms’.

The present submission relies strongly and follows quite explicitly the line in which the matter of personal liberty, prohibition of discrimination and equality, dignity, integrity and human rights in general of persons with disabilities (including persons with psychosocial disabilities) have been so far observed, regulated and interpreted at the levels of United Nations (namely the CRPD and CAT Conventions, Special Rapporteurs for Torture, the Rights of Persons with Disabilities and the Right to Health and the CRPD Committee), the Council of Europe (namely the Commissioner for Human Rights), and in the scholarship of health and medical law. Stances collected within the EU-funded research projects on the given topic has also been incorporated in the submission.

It also grounds its arguments and intentions in the evolving case law within the Council of Europe mandate, namely the European Court of Human Rights and the European Committee on Social Rights. Especially so in their observations regarding the ill-treatment in psychiatric and social care detention (placement without consent), personal liberty of persons with disabilities under Article 5, and the right to private life, under Article 8 ECHR, as well as the Committee’s standing with regard to living conditions and treatment in psychiatric institutions (Article 11 ESC) and the Council’s Committee for the Prevention of Torture in its work of observing treatment, placement and non-consensual measures imposed on persons with disabilities.

Finally, strong arguments for the opinion formed within the present submission can be found within the International Covenant of Economic, Social and Cultural Rights, more prominently in its absolute prohibition of discrimination, particularly in the domain of the right to health (Article 12 ICESCR).

### **Compliance with UN Convention on the Rights of Persons with Disabilities**

The present Protocol contravenes the emerging jurisprudence on the CRPD, especially General Comment number 1 on **Article 12 CRPD** which states that people with disabilities, including mental health conditions (hereafter referred to as psychosocial disabilities in line with the CRPD) are to be recognized as equal subjects

before the law and that to discriminate against such people solely on the basis of a diagnosis is prohibited.

**Article 25 CRPD** on the right to health protects the rights of people with disabilities to the highest attainable standards of health without discrimination on the basis of disability. **Article 25 (d)** requires healthcare professionals to provide care ‘on the basis of free and informed consent’. **Article 5 CRPD** asserts that people with decision-making support needs are equally entitled to the benefits and protections afforded by the principle of free and informed consent.

In addition, the UN Committee on the Rights of Persons with Disabilities (2011: para 36) has called for measures to ensure that healthcare services, including all mental-health-care services: ‘... are based on the informed consent of the person concerned’. **Article 14 CRPD** prohibits deprivation of liberty on the basis of disability. **Article 17 CRPD** requires respect for the physical and mental integrity of persons with disabilities on an equal basis with others, which has been interpreted to include freedom from forced psychiatric treatment.

Also, the CRPD prohibits decisions taken about people with disabilities by others on out-dated patronising concepts such as ‘best interests’ rather than respect for people’s own decisions informed by their will and preference. People may need support in decision-making in times of distress, and the CRPD asserts that people have the right to support to exercise legal capacity, i.e. supporting people to make their own decision based on their will and preferences rather than others’ determination of their best interests.<sup>1</sup>

Also, **Article 5 of the European Convention on Human Rights** guarantees the right to personal liberty and provides that no-one should be deprived of their liberty in an arbitrary fashion. *We hold that mental health laws are arbitrary and unjust and not based on best available evidence on mental health treatment. The labelling of persons as being of ‘unsound mind’ or having a ‘mental disorder’ as a basis for psychiatric detention is inherently subjective, value-laden and therefore arbitrary*<sup>2</sup>.

Not only does this protocol fail to implement Articles of the UN CRPD, it also upholds a medical model of disability, long discredited in other areas of disability law and policy.<sup>3</sup> The reliance on doctors alone to make decisions about detaining and treating people is not in accordance with human rights norms.<sup>4</sup>

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<sup>1</sup> Gooding P, 'Supported decision-making: A rights-based disability concept and its implications for mental health law' (2013) 20 *Psychiatry, Psychology and Law* 431

<sup>2</sup> See for example *Stanev v. Bulgaria [GC]* App No 36760/06 (EC 17.1.2012 [GC])  
See also Pilgrim D, 'Some implications of critical realism for mental health research' (2013) 12 *Social Theory & Health* 1; Rose N, 'What is Diagnosis For' (2013) 4 Lecture given at the Institute of Psychiatry (London) on Conference on DSM--5 and the Future of Diagnosis 4 June 2013.

<sup>3</sup> Stein MA, 'Disability Human Rights' (2007) 95 *California Law Review* 75

<sup>4</sup> See for example *X and Y v. Croatia, App No 5193/09 (EC 03.2.2012.)* In para 85. the Court explicitly states that “it is the judge and not a physician, albeit a psychiatrist, who is to assess all relevant facts concerning the person in

**General Comment no. 1** issued by the UN Committee on the Rights of Persons with Disabilities, on Article 12 of the UN CRPD Convention, has offered an authoritative interpretation on both the content of the right to legal capacity of persons with disabilities and States' duties in this regard.<sup>5</sup> Article 12 CRPD is the main bearer of the “paradigm shift” brought in this revolutionary universal human rights treaty. It is insistent on full equality regarding the right to universal legal capacity and ‘recognizes that persons with disabilities enjoy legal capacity on an equal basis with others in all areas of life’.<sup>6</sup>

‘Article 12, paragraph 3, recognizes that States parties have an obligation to provide persons with disabilities with access to support in the exercise of their legal capacity. States parties must refrain from denying persons with disabilities their legal capacity and must, rather, provide persons with disabilities access to the support necessary to enable them to make decisions that have legal effect.’<sup>7</sup>

The very next paragraph of the General Comment reads that ‘support in the exercise of legal capacity must respect the rights, will and preferences of persons with disabilities and should never amount to substitute decision-making.’

The concept of legal capacity as a human right of persons with disabilities (including psychosocial) does not only refer to legal status and the official recognition of legal capacity before the law. It moreover emphasizes the importance of giving impact, effect and recognition to actions, decisions and will and preference of a person, regardless of her/his disability and especially detached from his or her given medical diagnosis. This right also includes rights of persons to take risks and make mistakes.<sup>8</sup>

The CRPD, as seen in the authoritative interpretation of the CRPD Committee in the General Comment no. 1, foresees that States have a duty to refrain from any action that deprives persons with disabilities of this right. They also have a duty to prevent other actors from endangering or limiting this right.

Persons with disabilities must not be subjected to any form of substitute decision making where their will and preference are not respected fully, but should be given an option of supported-decision making, in line with choices of the persons in question. These kinds of support in exercising the right to legal capacity must not be used as

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question and his or her personal circumstances” when referring to issues of deprivation of legal capacity. This shows that European Court of Human Rights also departs from exclusive medical approach.

<sup>5</sup> Committee on the Rights of Persons with Disabilities, General Comment No.1 – Article 12: Equal Recognition Before the Law (April 2014) UN Doc. No. CRPD/C/GC/1, adopted at the 11<sup>th</sup> Session

<sup>6</sup> ‘Legal capacity includes the capacity to be both a holder of rights and an actor under the law. Legal capacity to be a holder of rights entitles a person to full protection of his or her rights by the legal system. Legal capacity to act under the law recognizes that person as an agent with the power to engage in transactions and create, modify or end legal relationships.’ (GC no.1, para.12)

<sup>7</sup> *ibid*, para.25

<sup>8</sup> *ibid*, para.22

justification of limiting other rights of persons with disabilities.<sup>9</sup> Also, States must abolish all provisions and practices that are discriminatory in the sense that they deny persons with disabilities the right to make legally effective decisions, based on their disability (e.g. state of mental health).<sup>10</sup>

The right to legal capacity is also read in light of Article 5 CRPD, where discriminatory action would mean “any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms”.<sup>11</sup>

Such a paradigm shift has as the main objective of restoring the autonomy and respect of dignity of persons with disabilities in all areas of their lives, and as such, the right to legal capacity is indivisibly interrelated with the freedom to make one’s own choices and decisions.

The CRPD Committee, in its interpretation of Article 12 in General Comment no.1, has established a legally binding stance regarding the involuntary actions against persons with disabilities in health care and social care setting. It has urged States to abolish all practices and grounds of arbitrary and discriminatory deprivation of liberty by placing persons with disabilities in a residential setting without their express consent. Paragraph 40. of the General Comment no. 1 reads as follows:

‘The 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, is an ongoing problem. This practice constitutes arbitrary deprivation of liberty and violates articles 12 and 14 of the Convention. States parties must refrain from such practices and establish a mechanism to review cases whereby persons with disabilities have been placed in a residential setting without their specific consent.’

Probably the most evident prohibition of involuntary placement and treatment is given in reading of Article 12 CRPD in conjunction with Article 25 CRPD on the right to health, through insisting that no treatment shall take place without prior informed consent of the person with disabilities. Paragraph 41 of the General Comment no. 1 reads as follows:

‘The right to enjoyment of the highest attainable standard of health (art. 25) includes the right to health care on the basis of free and informed consent. States parties have an obligation to require all health and medical professionals (including psychiatric professionals) to obtain the free and informed consent of

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<sup>9</sup> *ibid*, para. 29f

<sup>10</sup> *ibid*, para.25

<sup>11</sup> *ibid*, para.32

persons with disabilities prior to any treatment. In conjunction with the right to legal capacity on an equal basis with others, States parties have an obligation not to permit substitute decision-makers to provide consent on behalf of persons with disabilities. All health and medical personnel should ensure appropriate consultation that directly engages the person with disabilities. They should also ensure, to the best of their ability, that assistants or support persons do not substitute or have undue influence over the decisions of persons with disabilities.’

**The Council of Europe Commissioner for Human Rights** has quite eloquently and expressly addressed the urgent need for European States to identify and amend laws and measures regarding compulsory psychiatric care and treatment of persons with disabilities, in light of the adopted international standards, with particular reference to CRPD Article 12.<sup>12</sup>

Furthermore, again in an explicit manner, he has called States to ensure that persons with disabilities enjoy the right to consent to or reject medical interventions, on an equal basis with others.<sup>13</sup>

He moreover stated that placement of persons with disabilities in any residential setting without their true consent should always be seen as a deprivation of liberty under Article 5 of the European Convention on Human Rights.<sup>14</sup>

Finally, he urges the States to put in force means of supported decision making with full respect for a person’s will and preferences, while abolishing forms of substitute decision making in their national systems.<sup>15</sup>

## **Comments and findings vis-à-vis particular provisions of the Draft Protocol**

### Article 2 – Scope and definitions

#### Definitions

-“ ‘mental disorder’ is defined in accordance with internationally accepted medical standards.”

Comment: Accepting and incorporating solely *international medical standards* and terminology thereof is problematic and inadequate in a human rights source such as this Protocol to the Convention, especially bearing in mind that human rights standards and sources/treaties relevant in that particular area have been proclaimed as

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<sup>12</sup> Council of Europe Commissioner for Human Rights, “Who gets to decide? Right to legal capacity of persons with intellectual and psychosocial disabilities”, Recommendations, para. 2.

<sup>13</sup> Ibid, para. 4

<sup>14</sup> Ibid, para. 6.

<sup>15</sup> Ibid, para. 8.

important in drafting of the present Protocol (e.g. the UN CRPD). Therefore, a suggestion is made that human rights terminology should replace this terminology, especially by avoiding the term “mental disorder” and replacing it with the term “psychosocial difficulties (disability)”, or alternatively “mental health problems/difficulties”, as used in the UN discourse on disability rights.

#### Article 3 – Legality

- “Measures for involuntary placement and involuntary treatment shall only be applied in conformity with the provisions set out in domestic law, and in accordance with the safeguards established in this Protocol.”

Comment: To base the Protocol’s provisions’ legality solely on standards in domestic legal systems and the present Protocol will not suffice. Namely, given the rising standards in international law and the international community, and that the achievements of the CRPD (a treaty with binding force, with the official support of a vast majority of EU countries, including the European Union itself) have inspired the principles underpinning the present Protocol, the article in question should explicitly include a formulation “standard adopted in international law”, which would strongly and explicitly state the intentions of the Protocol to have its provisions and values in line with universal human rights standards which are legally binding.

#### Article 4 – Necessity and proportionality

- “Measures for involuntary placement and involuntary treatment shall only be used in accordance with the principles of necessity and proportionality. Persons subject to involuntary placement and/or involuntary treatment shall be cared for in the least restrictive environment available and with the least restrictive or intrusive treatment available, taking into account their health needs and the need to protect other persons from harm.”

Comment: It is of utmost importance to differentiate, in the most comprehensive way possible, “*health needs*” and “*needs in an urgent situation*”.

The latter holds its scope over situations where danger is immediate and where danger is to be avoided through some form of intervention aimed at averting immediate danger to the person or others. It includes the doctrine of medical necessity, which allows for emergency intervention in certain situations, for example, where a person is unconscious, and no informed consent can be given. However, it is important to note that the doctrine of medical necessity has also given rise to the violation of the rights of persons with disabilities, including its use to justify forced sterilisation. Therefore, this doctrine requires careful scrutiny to ensure that it is not abused to justify the violation of the rights of persons with disabilities. The use of the term ‘health needs’ to justify intervention has a wider scope and transcends to all medical treatments including, but not limited to compulsory placement – i.e. every medical intervention and treatment



while a person is in compulsory placement due to a prior urgent situation. This can lead to multiple violations of the individual's human rights. A person may be subjected to other forms of treatment without respecting the person's right to consent in health care. Therefore, the formulation "health needs" should be removed from this article. Otherwise, a person in question will be deprived of his/her right to consent or refuse other medical or other treatment while kept against her/his will.

As noted in the introductory paragraphs, the right to informed consent is valued as a norm of high importance in the area of human rights of persons with disabilities, as it embodies personal autonomy, physical and mental integrity and prevents persons from being subjected to involuntary treatment, coercive measures of different kinds and abuse and ill-treatment. Furthermore, as a means of self-determination, this right is to preserve dignity of patients. From the perspective of medical law and patients' rights, all recent literature and studies conducted regarding conditions of involuntary placement/treatment of psychiatric patients emphasizes the importance of the right to consent, and preserving that right to the highest attainable extent, regardless of diagnosis, mental state or other circumstances.<sup>16</sup> Regardless of any specific circumstance that would imply limited capacity to understand or participate in decision making regarding health treatment, medical professionals should continuously make efforts to inform the patient fully and obtain consent to any treatment in involuntary conditions.<sup>17</sup>

*There is strong evidence of limited therapeutic effects and benefits of involuntary treatment and coercive approach in psychiatry. Building a strong network of community-based services and support networks brings more benefit even to those in distress, in urgent situations and need of help and assistance.*<sup>18</sup>

The UN Special Rapporteur on the Prohibition of Torture has taken a strong stance that coercive and involuntary actions undertaken by health professionals and masked as "good intentions" (e.g. protecting the interests of a person) fall under the prohibition of torture from the UN CAT Convention.<sup>19</sup>

## Article 5 – Alternative measures

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<sup>16</sup> See Méndez JE, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, 2013); McSherry B and Freckelton I, *Coercive Care: Rights, Law and Policy* (Routledge 2013); Newbigging K and others, *Independent Mental Health Advocacy-The Right to Be Heard* (Jessica Kingsley 2015)

<sup>17</sup> Even the European Commission funded EUNOMIA study on coercive measures in psychiatry insists that one of the main principles in this context has to be preservation of informed consent. See

<sup>18</sup> See Allen and Smith, "Opening Pandora's Box: The Practical and Legal Dangers of Involuntary Commitment", in *Psychiatric Services*, 52/3, 2001

<sup>19</sup> See Interim report of the Special Rapporteur on Torture, A/63/175, at <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N08/440/75/PDF/N0844075.pdf?OpenElement> section B and A/HRC/22/53 at <http://109.74.198.40:8087/jspui/bitstream/123456789/294/1/UN%20Special%20Rapporteur%20on%20Torture.pdf> para. 61-62

Comment: The present article needs to be illustrative of alternative options and manners of using alternatives to compulsory placement and / or treatment. Namely, insisting on employing an existing support network, services within the out-patient facilities, counselling and other available less intrusive options should be illustrated as a guidance to the State parties.

While we also welcome Article 5 of this Protocol which asserts that alternatives to involuntary detention and treatment should be developed, we draw your attention to the fact that routine and widespread practice is to deny funding and resources for research on alternative responses, which address social/emotional and other environmental conditions that cause, or otherwise play significant roles in the development of psychosocial distress.<sup>20</sup> There is emerging and robust evidence of the role that prior trauma plays in causing distress and indeed psychosis, which require different responses than those proposed by bio-psychiatric aetiology.<sup>21</sup> In addition, the new paradigm shift of the CRPD calls for a re-imagining of supports offered to people.<sup>22</sup> We suggest that the Protocol could support this direction by endorsing the diversion of resources towards supporting alternatives, which can reduce the need for involuntary detentions. Examples of practices which have been demonstrated to support people and reduce hospitalisations and the reliance on medication could named in this Article as guidance for mental health services.

Some of the alternatives which could be listed in Article 5 include the following non-exhaustive list. Crisis houses operating with an alternative ethos (little or no medication, or prescribed medication used as demanded by the individual) have been found to be just as effective as inpatient units, and result in reports of higher patient satisfaction.<sup>23</sup> Additionally many projects focusing on widening communication networks beyond the individual, (for example, ‘open dialogue’ as practiced in Finland); social inclusion through education<sup>24</sup> and/or fulfilling employment (for example Ontario Council of Alternative Businesses)<sup>25</sup> have been found to reduce hospitalisations, as

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<sup>20</sup> See Muñoz RF and Ying Y-W, ‘The prevention of depression: Research and practice’ (JHU Press 2002); Fava GA, ‘The Intellectual Crisis of Psychiatric Research’ (2006) 75 *Psychotherapy and Psychosomatics* 202; Faulkner A, ‘Being There in a Crisis: A report on the learning from eight mental health crisis centres’ (2002) Mental Health Foundation

<sup>21</sup> See Read J and Dillon J (eds), *Models of Madness: Psychological, Social and Biological Approaches to Psychosis* (Second edn, Routledge 2013); Read J and others, ‘Childhood trauma, psychosis and schizophrenia’ (2005) 112 *Acta Psychiatrica Scandinavica* 330.

<sup>22</sup> Bartlett P, ‘The United Nations Convention on the Rights of Persons with Disabilities and the future of mental health law’ (2009) 8 *Psychiatry* 496; Mégret F, ‘The Disabilities Convention: Towards a Holistic Concept of Rights’ (2008) 12 *The International Journal of Human Rights* 261.

<sup>23</sup> Doughty C And Tse S, ‘Can Consumer-Led MHS be Equally Effective? An Integrative Review of CLMH Services in High-Income Countries.’ (2011) 47 *Community Mental Health Journal* 252; Solomon P, ‘Peer support/peer provided services underlying processes, benefits and critical ingredients’ (2004) 27 4 *Psychiatric Rehabilitation Journal* 392; Johnson S and others, ‘Acute in-patient psychiatry: residential alternatives to hospital admission’ (2007) 31 *Psychiatric Bulletin* 262.

<sup>24</sup> Delman J, Delman, D.R., Vezina, B.R., & Piselli, J., ‘Peer led Recovery Learning Communities: Expanding Social Integration Opportunities for People with Lived Experience of Psychiatric Disability and Emotional Distress’ (2014) 5 *Global Journal of Community Psychology Practice* 1

<sup>25</sup> Diamond S, ‘What Makes Us a Community?’ in LeFrançois B MRaRG (ed) *Mad Matters: A Critical Reader in Canadian Mad Studies* (Canadian Scholars Press Inc 2013) at 65

well as improving the quality of life of people with psychosocial distress.<sup>26</sup> None of these alternatives are given due weight and fair trials in mental health systems focused on involuntary detention and treatment, as this becomes the default system response.<sup>27</sup>

Many alternative projects can be classified as supported decision-making regimes, in that various strategies are used to support people in crisis to make choices that can help avoid hospitalisation. The UN Committee on the CRPD describes various forms of supported decision-making as:

Those assisting a person may communicate the individual's intentions to others or help him/her understand the choices at hand. They may help others to realize that a person with significant disabilities is also a person with a history, interests and aims in life, and is someone capable of exercising his/ her legal capacity . . . The individual is the decision maker; the support person(s) explain(s) the issues, when necessary, and interpret(s) the signs and preferences of the individual. Even when an individual with a disability requires total support, the support person(s) should enable the individual to exercise his/her legal capacity to the greatest extent possible, according to the wishes of the individual.<sup>28 29</sup>

Supported decision making programmes have been implemented through developments such as the PO Ska'ne in Sweden<sup>30</sup>, or the use of Advance Healthcare Directives (AHD).<sup>31</sup> Many people with mental health difficulties have the experience to know what helps their recovery and want their advance decisions respected. Advance Healthcare Directives would ensure that people are treated in the manner they chose, and which they have found helpful in the past. A submission made on the topic of AHD by the Centre for Disability Law and Policy NUIG outlines how they may be incorporated into capacity and mental health legislation.<sup>32</sup>

#### Article 10 – Criteria for involuntary treatment

- “Involuntary placement of a person with a mental disorder may only be used if the following criteria are met:

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<sup>26</sup> Delman J, Delman, D.R., Vezina, B.R., & Piselli, J., 'Peer led Recovery Learning Communities: Expanding Social Integration Opportunities for People with Lived Experience of Psychiatric Disability and Emotional Distress' (2014) 5 Global Journal of Community Psychology Practice 1; Stastny P and Lehmann P (eds), *Alternatives Beyond Psychiatry* (Peter Lehmann Publishing 2007); Seikkula J and others, 'Five-year experience of first-episode nonaffective psychosis in open-dialogue approach: Treatment principles, follow-up outcomes, and two case studies' (2006) 16 Psychotherapy Research 214.

<sup>27</sup> Thomas P, *Psychiatry in Context: Experience, Meaning & Communities* (PCCS Books 2014)

<sup>28</sup> Cited by Gooding 2013 at 432

<sup>29</sup> The Vulnerable Persons Living with a Disability Act (Manitoba C.C.S.M. c.V90), s 6(1).

<sup>30</sup> Morrissey F, 'The United Nations Convention on the Rights of Persons with Disabilities: a new approach to decision-making in mental health law' (2012) 19 European journal of health law 423; Donskoy A-L and Pollard K, 'Interprofessional working with service users and carers' (2014) *Interprofessional Working in Health and Social Care: Professional Perspectives* 35

<sup>31</sup> Council of Europe, European Committee on Legal Co-operation, CM (2009) 1073, December 9, 2009, available at <https://wcd.coe.int/ViewDoc.jsp?id=1529977&Site=CM> [Last Accessed October 19, 2015].

<sup>32</sup> A Submission to the Department of Health on the Draft General Scheme for Advance Healthcare Directives for Incorporation into the Assisted Decision-Making (Capacity) Bill 2013 <available at >

- i. a) the person's mental health condition represents a significant risk of serious harm to his or her health and his or her ability to decide on placement is severely impaired or
- b) the person's mental health condition represents a significant risk of serious harm to others;
- ii. the placement has a therapeutic purpose; and
- iii. no less restrictive means of addressing the risk are available.”

Comment: The formulation contained in the present Article is discriminatory as a whole *on the basis of psychosocial disability*, and contrary to UN CRPD Convention standards (as described in Introductory observations). To foresee a possibility for involuntary placement by making an explicit connection to persons with mental disorder and disorder itself is discriminatory and therefore prohibited by the standards contained in the abovementioned document.

The formulation that reads “the person's mental health condition represents a significant risk of serious harm to his or her health or her ability to decide on placement is severely impaired” is *discriminatory in its language and spirit*. Namely, the given formulation foresees that a medical condition, a diagnosis or a label of a mental health problem suffices for involuntary placement. It does so by explicitly (i. a) and b)) proclaiming person's “mental health condition” as basis for legitimate involuntary placement. UN CRPD Convention prohibits discrimination on the basis of disability and therefore prohibits that disability is used as grounds for differing treatment of any sort.

A person's mental disorder or health problem does not have a potential to present harm or threat to anyone or anything on its own, without the occurrence of tangible consequences. Therefore, the current proposal of the given Article is both discriminatory and contrary to common human rights reasoning. The same argumentation should be applied to Article 11 on involuntary treatment.

Observations of the Special Rapporteur on Torture confirm the same line of thought, relying heavily on provisions in both UN CAT and UN CRPD. Namely, in his Report, the Rapporteur emphasizes the absolute prohibition of discrimination on the basis of disability in health care settings, derived from the provisions of the UN CRPD Convention, and in line with the UN CAT Convention.<sup>33</sup>

#### Article 12: Standard procedures

Comment: Basing the court decision primarily on the results of medical examination is the consequence of employing the medical approach (medical model) to disability and is therefore problematic.

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<sup>33</sup> See A/63/175 at <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N08/440/75/PDF/N0844075.pdf?OpenElement>

Also in reading of the UN CRPD, no deprivation of liberty regarding a person with disability may be based on the diagnosis given. Such a practice is outdated, discriminatory, and not in line with human rights standards. Again, we are facing exclusion and compulsion based solely on medical views of a disorder, not on someone's behavior or real/objective circumstance or consequence and means of protection, or objective evaluation of potential danger or harm. Even in situations where the person is in grave danger, or causing harm to others, we contend that involuntary detention and forced treatment are not proportionate responses. Alternative methods must be used, and as illustrated above, these are more effective than involuntary treatment at preventing harm. Where the person is causing harm to others, this requires an engagement of the criminal justice system, which must also be reformed to ensure that effective access to justice is provided to persons with disabilities. The same argumentation applies to Article 13 and 14 on procedures for taking decisions and termination of placement/treatment.

Article 16 – Appeals and reviews concerning the lawfulness of involuntary placement and/or involuntary treatment

Comment: States must ensure that mechanisms of effective rights protection (e.g. through an instance for patients' rights protection) is easily accessible to the person in question, and that no procedural or obstacles of other nature exist regarding the person's right to easily and effectively approach these mechanisms, in order to challenge a deprivation of liberty. In order to ensure that persons with disabilities have effective access to justice, legal aid and representation must be made available to challenge unlawful and arbitrary deprivations of liberty, including any detention in psychiatric hospitals, social care homes, or other congregated settings.

Article 18 – Right to communication of persons subject to involuntary placement

Comment: If a person is unlawfully and arbitrarily deprived of liberty, there may be no restrictions whatsoever in any means of communication of the person with the outside world.<sup>34</sup> The extent of inclusion of other persons in the process of decision-making concerning healthcare treatment should depend solely on the will of the person. Safeguards should be foreseen however, to honour and include the relationships of trust created for this purpose, based on will and preference of the person in question.

Article 20 Monitoring

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<sup>34</sup> This is also set out as an absolute standard within the results of the EUNOMIA study: "The contacts of the patient with people outside the ward cannot be limited by anyone; in particular, letters written by the patient cannot be censored." See in Fiorillo et al. "How to improve clinical practice on involuntary hospital admissions of psychiatric patients: Suggestions from the EUNOMIA study", *European Psychiatry*, 26/4, 2011, section 3.3

Comment: A new paragraph should be inserted stating that any monitoring body must have full and active involvement of persons with psychosocial disabilities. The active and informed participation of individuals, communities and populations is an integral component of the right to the highest attainable standard of health enshrined in Article 12 of the International Covenant on Economic, Social and Cultural Rights. This right includes participation in identifying overall health strategy, agenda-setting, decision-making, prioritization, implementation and accountability.<sup>35</sup> According to Article 4 (3) and Article 33(3) of the CRPD, direct involvement of persons with disabilities and their representative organizations should also be ensured. This is further endorsed by the EU Framework on the CRPD, which has identified monitoring of implementation as one of three strategic priorities.<sup>36</sup> There is active and resourced involvement of civil society organizations of people with disabilities. In accordance with this provision this needs to be made explicit under Article 20 of this protocol.

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<sup>35</sup> Potts H, *Participation And The Right To The Highest Attainable Standard Of Health* (Human Rights Centre, University of Essex 2008)

<sup>36</sup> 'Seventh Disability High Level Group Report On The Implementation Of The Un Convention On The Rights Of Persons With Disabilities' (2015) <available [ec.europa.eu/social/BlobServlet?docId=14328&langId=en](http://ec.europa.eu/social/BlobServlet?docId=14328&langId=en)> see pages 110-113