Brief response to Bioethics Department's request for comments on preparation of an "Additional Protocol to the Convention on Human Rights and Biomedicine, concerning the protection of the human rights and dignity of persons with mental disorders with regard to involuntary placement and involuntary treatment".

21 February 2014

Experience and expertise

The Mental Disability Advocacy Center is an international NGO, which has participatory status at the Council of Europe and has special consultative status with ECOSOC. Established in 2002, its mission is to advance the rights of people with intellectual disabilities and psycho-social (mental health) disabilities. It has taken some of the recent leading mental health cases to the European Court of Human Rights, and actively engages with various bodies within the Council to ensure an advancement of human rights.

Process

A proposal for a new international legal instrument is being made. MDAC would expect to see a needs analysis or fuller explication of why this Additional Protocol is being prepared. Such an analysis or explication would answer questions such as: What exactly is the gap which the new instrument is seeking to cover? Who is asking for such an instrument to be developed, and what are the interests of these people/groups? It would be important to understand the needs which this instrument is seeking to address, before the content is decided.

Content

Many of the questions arise, in MDAC's view, from the wrong starting point. The Council of Europe is concerned primarily with democracy, human rights and the rule of law. The Bioethics Convention was adopted in 1997. Almost a decade later the UN Convention on the Rights of Persons with Disabilities was adopted by the UN, and has been ratified by the majority of CoE Member States. The CoE Human Rights Commissioner has taken the CRPD as the starting point, noting that laws allowing for involuntary detention and treatment contribute to the phenomena of institutionalisation (see p. 38 of his 2012 Issue Paper "The right of people with disabilities to live independently and be included in the community").

The CRPD has fundamentally altered the way in which States and international organisations need to approach issues of disability. It is common ground that mental health issues are disabilities for the purposes of a discussion about human rights (see Article 1 of the CRPD). It is far from clear whether involuntary treatment of persons with mental health issues is compatible with the CRPD – and, if there are certain instances where such treatment might be compatible, what criteria and definitions ought to be used to determine them. Article 14(1)(b) of the CRPD is particularly challenging to conventional mental health practice, since, along with the general right to liberty, it provides that 'the existence of a disability shall in no case justify a deprivation of liberty.'

(Art. 14(1)(b)). The Office of the UN High Commissioner for Human Rights has adopted a robust view of this provision, as it applies to psychiatric detention:

> '[48.] … Article 14, paragraph 1 (b), of the Convention unambiguously states that "the existence of a disability shall in no case justify a deprivation of liberty". Proposals made during the drafting of the Convention to limit the prohibition of detention to cases "solely" determined by disability were rejected. As a result, unlawful detention encompasses situations where the deprivation of liberty is grounded in the combination between a mental or intellectual disability and other elements such as dangerousness, or care and treatment. Since such measures are partly justified by the person's disability, they are to be considered discriminatory and in violation of the prohibition of deprivation of liberty on the grounds of disability, and the right to liberty on an equal basis with others prescribed by article 14'.

On this account, 'mental disorder' or 'mental illness', even if it comprises only one of a number of necessary criteria for involuntary detention, makes that set of criteria incompatible with Article 14, that a disability shall in no case justify a deprivation of liberty.

There are a small number of attempts that have been made to chart a way forward that gives central authority to the CRPD while attempting to parse some of the trickier questions that arise both in relation to the complex construct of 'capacity to consent', and in in relation to adjudicating the grounds, if any, on which involuntary treatment might be defensible (See for example http://www.sciencedirect.com/science/article/pii/S016025271300126X). Such attempts make it abundantly clear that the CRPD poses major challenges for a justification for involuntary treatment that is not discriminatory in relation to people with mental disorders, and therefore likewise pose a challenge to the starting points of the CoE consultation that *take for granted* the involuntary placement and/or treatment for people with mental disorders. There is urgent need for much greater conceptual and practical consideration to be given to questions such as:

- How is 'capacity to consent' to be adjudicated? How do we ensure that the criteria used do not discriminate against those with disabilities?
- If a support person is assisting in eliciting the will and preferences of another person (vis-à-vis consent to and/or refusal of treatment), what are the criteria through which to adjudicate the person's 'authentic' will and preferences (especially in cases when there appears to be a difference between those currently expressed as opposed to those previously expressed)?

Given the growing literature on mental health and the CRPD, additional crucial questions for discussion would be to ask questions such as:

- How can an international instrument help States to reduce the compulsion experienced by people labelled with mental health issues? This speaks to the need to immediately implement the right to be free from torture, inhuman and

degrading treatment of punishment (Article 15 of the CRPD, and Article 3 of the ECHR), the right to be free from exploitation, violence and abuse (Article 16 of the CRPD) and the right to physical and mental integrity (Article 17 of the CRPD, and Article 8 of the ECHR).

- provide a range of support services for people with mental health issues in the community are provided, especially in times of 'austerity'. This speaks to the state obligation to provide access to a range of services under Article 19 of the CRPD, and under Article 15(3) of the European Social Charter.
- ensure that people with mental health issues get access to the "same range, quality and standard of free or affordable health care and programmes as provided to other persons"? This speaks to the right to health, as outlined in Article 25 of the CRPD, which is also outlined in the Council of Europe's Revised Social Charter.
- provide access by people with mental health issues to supports they may need in exercising their legal capacity, including in choices relating to medical (including mental health) treatments. This speaks to the right outlined in Article 12(3) of the CRPD.

MDAC is looking forward to remaining engaged in the process as these questions are asked and answers debated.

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