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**PACE Committee on Social Affairs, Health and Sustainable Development
PACE Committee on Equality and Non-Discrimination**

***Joint hearing on protecting the rights of people with psychosocial disabilities
with regard to involuntary measures in psychiatry***

Strasbourg, 9 October 2018

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Persons with psychosocial disabilities are one of the most vulnerable groups in Europe.

The UN Convention on the Rights of Persons with Disabilities (the CRPD), ratified already by 46 of our member states, is my reference point regarding this group, as for all persons with disabilities. This convention represents a clear legal progress and a shift from a medical to a social model.

Yet, the medical model is proving particularly persistent when it comes to mental health, especially for involuntary measures. This is perhaps linked to the continuing stigmatisation faced by people with psychosocial disabilities, and the exaggeration of the danger they represent to themselves or others, including sensationalisation in mainstream media.

What is clear is that involuntary placements and treatments remain among the most common and severe interferences with human rights in Europe, and a lot can be done by all member states to drastically reduce their number. I would even say that minimising them should be considered a CRPD obligation, while offering the highest attainable standard of mental health care respecting dignity and autonomy.

This is why I think the Council of Europe is going the wrong direction with the drafting of an Additional Protocol focusing only on legal safeguards for involuntary measures and mostly ignoring the conditions that lead to them. I am in full agreement with the Parliamentary Assembly on this.

Even if it is not its intended goal, I think that this text would potentially prolong the status quo, if not worsen the situation. This is because it relies on an old, pre-CRPD approach and detracts from the urgency of changing the mental health paradigm. I also fear that the Protocol would put our organisation on a collision course with universal human rights standards.

DH-BIO's interpretation of member states' obligations under the CRPD contradicts the opinions of the actual treaty body and UN Special Rapporteurs, other UN bodies, the Fundamental Rights Agency, and disability rights NGOs. The conflict with the CRPD is not limited to the principle of acceptability of involuntary placements: it also concerns: outdated, stigmatising language used in the draft Additional Protocol (such as persons with "mental disorder"); its discriminatory approach; and its neglect of the positive support needs of the persons in question to enforce their human rights.

Lack of added value is another concern: the experience of my Office shows that lacking legal safeguards are very rarely the real problem. The actual issue is that these safeguards are ineffective and even the best ones can be reduced to a formality between the physicians and judges in the daily reality of our legal systems, which remain ill-adapted to the needs of persons with psychosocial disabilities.

Therefore, the protocol is trying to solve the wrong problem. The standards we need urgently today are not more safeguards, but what the states should do as a minimum to avoid involuntary measures in the first place. The Protocol only says that the states should do their best, without defining what the minimum efforts should be. It will therefore not improve the situation on the ground.

When it comes to these efforts, the divergence in practices and recourse to involuntary measures in our member states is remarkable. While only few comparative studies exist, they all point to the fact that the rate of involuntary admissions can vary enormously from one country to another, by up to 35 times. I do not think that this is because some countries have better safeguards than others or have fewer persons with mental health problems.

Even within the regions of the same country situations can be very diverse. For instance, in France certain geographic regions had involuntary admission rates 80% higher than others. Same for coercive measures: studies in Germany, for example, show that their use increases depending on the hospital, perhaps up to ten times.

This to me clearly signals that safeguards for involuntary measures are not the issue and that our member states urgently need clearer guidance on minimum standards concerning alternatives to involuntary measures. This draft Additional Protocol does not address that need, and even overshadows it by its exclusive focus on safeguards.

I also share the concerns of the Assembly on the lack of proper consultation of the persons concerned in the drafting procedure. The history of the human rights of persons with disabilities is all about how they were treated as objects, with no say on their own destiny, and not as subjects of human rights with personal autonomy. This has started changing in recent decades due to their activism, with the motto "nothing about us without us". This approach has triumphed with the CRPD, which also clearly states that no policy should be approved without the full involvement of persons with disabilities in its elaboration.

So why is this being neglected in the drafting of this Additional Protocol? some of the most respected and relevant NGOs working in this area protest that their concerns and opinions have been ignored in the drafting process, despite their consultation by the DH-BIO. I agree that their involvement has been clearly too limited to satisfy the CRPD criteria. I feel that this should justify a fundamental questioning of the soundness of the project as a whole. Dismissing this opposition would be equivalent to saying that persons with psychosocial disabilities do not understand what is in the Protocol or what is good for them. Many similar mistakes made in the past should serve as a warning!

I am not saying that involuntary placements must disappear overnight, but we cannot continue as if the CRPD and its paradigm shift had never happened. Any worthy contribution in this field must rethink the old criteria for involuntary measures by making them non-discriminatory vis-à-vis people with psychosocial disabilities. But it is much more important and urgent to address the general mental health policy context within which these measures occur. The draft does neither of these things.

As to what can be done regarding that general context, there are many factors that seem to have an impact on the need for involuntary measures. Only to name a few: availability and ease of access to community and out-patient treatment; implication of the person's support network in treatment; possibility of giving advance directives when one is feeling better for future crises; specialists working on securing trust and consent ... It is also likely that the amount of stigma around mental health issues and the fear of involuntary measures discourage persons with psychosocial disabilities from seeking treatment at an early stage of mental illness.

So maybe the time has come to regard the use of involuntary measures less as the core of the mental health system, but more as a symptom of its failings.

I would be fully ready to support work in the Council of Europe that would go in the direction of a better respect of the human rights of persons with psychosocial disabilities in Europe, as long as this work is carried out in consultation and co-operation with all relevant actors and in particular the persons most concerned by the need of improving access to mental health care. This could include

for instance developing minimum standards concerning alternatives to involuntary measures in psychiatry.

Under these conditions, I find it very unfortunate that the work on this Protocol is continuing despite the clear warnings given by the Parliamentary Assembly to the Committee of Ministers, and also by my Office which on several occasions pointed out serious human rights concerns.