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**Draft Explanatory Report to the Additional Protocol
to the Convention on Human Rights and Biomedicine
concerning the Protection of human rights and dignity of persons
with mental disorder with regard to involuntary placement and involuntary treatment**

Prepared under the responsibility of the Secretariat

Draft Explanatory Report
to the Additional Protocol to the Convention on Human Rights and Biomedicine
concerning the Protection of the Human Rights and Dignity of Persons
with Mental Disorder with regard to Involuntary Placement and Involuntary Treatment

Chapter I – Object and scope

Article 1 – Object

1. The first paragraph sets out the aim of the Additional Protocol, which is to protect the dignity, identity, human rights and fundamental freedoms of all persons with mental disorder with regard to the use of involuntary placement or involuntary treatment. The Protocol does this by promoting the use of alternatives to involuntary measures; by providing safeguards to ensure that involuntary measures are only used as a last resort, and that if such measures are used then the person concerned benefits from appropriate protection and procedural safeguards that enable them to effectively exercise their rights. A person may be subject to involuntary placement, to involuntary treatment, or to both: the person would be within the scope of the Protocol in all three cases.

2. The first paragraph emphasises that this protection should take place without discrimination. As the Preamble and the work of the United Nations underline, the existence of a mental disorder, in itself, shall in no case justify the use of involuntary measures.

3. The second paragraph of the Article makes clear that States may provide more extensive protection to persons with mental disorder than required by the Additional Protocol, which is concerned with measures that are against the will of the person concerned. For example, persons with advanced dementia may not have the ability to make a decision on placement, but do not object to a placement others think necessary for them. In some countries such a measure would be considered “involuntary”. Although such persons are not covered by the Protocol, paragraph 2 makes clear that States could choose to apply the provisions of the Additional Protocol to such persons, but could also choose to provide alternative mechanisms to protect the rights and interests of such people. Similarly, although minors are not covered by this Protocol (see paragraph 6 below), States may choose to apply the provisions of this Protocol to them.

Article 2 – Scope and definitions

4. The first paragraph of the Article specifies that the Additional Protocol applies to involuntary placement and to involuntary treatment of persons with mental disorder. The circumstances in which it may be necessary to use such measures in the context of mental health care are specified in Articles 10 and 11.

5. The first paragraph also recognises that developments in mental health care mean that it is not always necessary for a person to be subject to a placement in order to receive treatment for a mental disorder. The Additional Protocol applies to all forms of involuntary treatment for mental disorder wherever that treatment is delivered. Thus, treatment given on an involuntary basis in the patient’s home is included.

6. Paragraph 2 excludes minors from the scope of the Additional Protocol. Member states have different definitions of a “minor” and of their legal status. With regard to this Additional Protocol, it is for member states to define how the term is to be interpreted. The fact that minors are not included within the scope does not mean that they are not also in need of protection. Rather, their vulnerability means that they need particular protection. Recognising the different legal context that applies to minors, States should ensure that their legal provisions take account in a suitable manner of the need to protect minors.

7. This protocol does not apply to placement and treatment for mental disorder imposed in the context of a criminal law procedure. Additional considerations apply in such contexts that are not relevant in the civil context.
8. Paragraph 3 of the Article defines certain key terms used in the Additional Protocol.
9. “Mental disorder” is defined broadly in accordance with internationally accepted medical standards.
10. An example of an internationally accepted medical standard is that provided by Chapter V of the World Health Organization’s *International Statistical Classification of Diseases and Related Health Problems*, which concerns *Mental and Behavioural Disorders* (ICD-10). This method of defining mental disorder aims to prevent idiosyncratic approaches to diagnosis. It also follows the jurisprudence of the European Court of Human Rights, for example in its judgement in the *Winterwerp* case, that: “... Article 5.1e [of the European Convention on Human Rights] obviously cannot be taken as permitting the detention of a person simply because his views or behaviour deviate from the norms prevailing in a particular society.”¹
11. As noted in paragraph 3 above, the definition of “involuntary” for the purpose of this Protocol refers to an involuntary placement or treatment measure applied to a person with a mental disorder who objects to the measure. Involuntary measures should not be equated with forced measures. Although the person may comply with a measure, it may still be unacceptable to him or her. If the person is aware that a refusal to take oral medication would result in the person being restrained and injected with medication, the person may take the medication to avoid that consequence. That should not be interpreted as meaning the person is voluntarily accepting treatment. If the person is not in a position to refuse treatment, he/she should receive the protection of being subject to involuntary treatment, if the criteria and procedures set out in the Protocol are met. The proportion of patients subject to involuntary treatment who actively resist treatment is small. Similarly, if a person is placed in a facility and wishes to leave but is not allowed to, the person should receive the protections applicable to involuntary placement.
12. The reference to “objects” in the definition emphasises that it is the person’s current attitude to the measure that should be assessed. The fact that a person has, for example, accepted or refused a proposed measure some time ago does not mean that it should be assumed that the person would accept or refuse a renewed offer of the same measure.
13. The reference to “placement or treatment” makes clear that the person’s attitude to placement and to treatment are separate questions. A person might object to a proposed placement, but agree to the proposed treatment, or vice-versa.
14. The scope of this definition does not prevent the use of involuntary measures in circumstances where a person recurrently changes his or her mind about whether or not to accept a measure, as a result of which a consistent therapeutic programme cannot be maintained, if the relevant criteria and procedures for the measure concerned are satisfied.
15. Placement refers to the action of being placed in a specific environment for a particular purpose or purposes. Article 10, paragraph ii requires a placement to have a therapeutic purpose, but it may have other purposes (such as the protection of others) in addition.
16. The definitions of “treatment” and “therapeutic purposes” are applicable wherever the intervention is delivered and whether or not the person is also subject to an involuntary placement. Some mental disorders, such as dementia, are not curable at the present time. However, in some cases it may be possible to slow down the rate of deterioration. Other disorders, such as bipolar affective disorder, may be recurrent. Although it may not be possible to cure the disorder, an acute

¹ *Winterwerp v The Netherlands*, judgment of 24 October 1979, Application number 00006301/73

episode of mania or depression can be treated and the person returned to a normal level of functioning. Both of these examples would be covered by the reference to “management” in the definition of therapeutic purposes used in this Additional Protocol. Similarly, interventions that aim to limit the impact of deficits in functioning as a result of chronic psychotic disorders on a person’s life (normally referred to as rehabilitation) would also be covered by the same reference.

17. The definition of “treatment” refers to physical and psychological interventions. Pharmacological interventions are an example of physical interventions.

18. When a person comes into contact with mental health services for the first time, it is not always possible or appropriate to make an exact diagnosis immediately. If necessary, a provisional diagnosis is made which can then be reviewed in the light of further observation, including where relevant the person’s response to treatment offered on the basis of the provisional diagnosis. This would fall within the reference to “management” in the definition of “therapeutic purposes”.

19. A “representative” is a person provided for by law or appointed through a legal process. The general principle set out in the Convention on Human Rights and Biomedicine is that when a person does not have the capacity to consent, authorisation for a proposed measure is sought from a representative, authority, person or body provided for by law. However, if the person objects to a proposed treatment or placement measure he or she falls within the scope of Chapter III irrespective of the views of the representative, authority, person or body.

20. In some countries, the representative is referred to as the “legal representative” to reflect the fact that the person’s role and responsibilities are recognised by law. However, this does not mean that the person has to be a lawyer and nor does it mean that the person is remunerated for the role. The fact that a person is entitled to a representative does not mean that the person is also entitled to legal aid, which is a separate issue.

21. As part of the promotion of a person’s autonomy, a representative should seek to assist and support the person to make choices about issues that affect him or her. However, as a matter of law, those choices may need to be supported by the representative in order to be valid.

22. Different states may have different names for the role of a “person of trust” as defined in this Additional Protocol. They are to be differentiated from the representative or a lawyer; for example, a person of trust is not able to take legally binding decisions on behalf of the person concerned. The definition highlights the importance of the active choice of the person with mental disorder to designate the person of trust, and of the person chosen being willing to provide the necessary assistance and support. When a valid choice has been made it should be appropriately documented.

23. The characteristics of a “court” must be interpreted in line with the case law of the European Court of Human Rights. Article 6 of the European Convention on Human Rights refers to “an independent and impartial tribunal established by law”. The same requirements apply to the “court” in the meaning of Article 5, paragraph 4 of the European Convention on Human Rights. According to the European Court of Human Rights, the “tribunal” is characterised by the fact that it is a body with a judicial function, namely determining matters within its competence on the basis of rules of law and after proceedings conducted in a prescribed manner. The tribunal must satisfy the following conditions:

- a. is established by law and meets the requirements of independence and impartiality;
- b. can determine all aspects of the dispute or charge to which Article 6 applies and hence give a binding decision on the matter before it;
- c. is accessible to the individual concerned.

24. For the purposes of this Protocol “competent body” refers to the person or body provided for by law which can take a decision on an involuntary measure. The aim is to provide protection

against arbitrary decisions. There are different ways in which this can be achieved. Article 12, paragraph 1 makes clear that the court or competent body must reach its decision on the basis of a medical examination.

25. References to “responsible authority” in the Additional Protocol refer to the authority responsible for the facility in which the patient is placed, or where the patient is receiving treatment without being subject to voluntary or involuntary placement, the authority with administrative responsibility for the doctors supervising the treatment.

Chapter II – General Provisions

Article 3 – Legality

26. This Article follows the requirements of Articles 5 and 8 of the European Convention on Human Rights, as well as those of Articles 7 and 26 of the Convention on Human Rights and Biomedicine. To satisfy this condition, the legal basis for an involuntary measure must be sufficiently accessible and foreseeable. It means that the procedure for applying such a measure must be “prescribed by law”. As the case of *X v Finland*² emphasises, the law must provide adequate safeguards against arbitrary application of a measure, or of its continuation.

Article 4 – Necessity and proportionality

27. These general principles also reflect the requirements of the European Convention on Human Rights and the case law derived from it, as well as the requirements of the Convention on Human Rights and Biomedicine. With respect to involuntary placement, for example, this means that other measures less severe than deprivation of liberty must have been considered and deemed insufficient with regard to the risk entailed.

28. The principle of least restriction is a fundamental principle, recognised internationally by Principle 9(1) of the United Nations Resolution A/RES/46/119 concerning *The protection of persons with mental illness and the improvement of mental health care*, which was reaffirmed in Article 8 of Recommendation (2004)10 of the Committee of Ministers of the Council of Europe concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder. It is derived from the principles of necessity and proportionality and hence is covered by this Article, but its importance in mental health care is such that it is set out explicitly in the second sentence of this article.

29. Furthermore, Principle 15(1) of the same United Nations resolution emphasises that if admission to a mental health facility is required “every effort shall be made to avoid involuntary admission.” In December 2014, the Human Rights Committee of the United Nations emphasised in its General Comment No. 35 on the International Covenant on Civil and Political Rights³ that involuntary placement “must be applied only as a measure of last resort.” If involuntary placement is required, the person with a mental disorder should be kept safe and their rights and freedoms should in other ways be restricted as little as possible.

30. The principle of least restriction has important implications for the use of seclusion and restraint in mental health care. Attention is drawn in particular to the recommendations made in the published reports of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) included in the *CPT Standards* concerning the use of restraint and seclusion. This Report is informed by those *Standards*.

31. The CPT emphasises the importance of minimising the use of restraint and seclusion. Seclusion and/or restraint should never be used for the convenience of staff or as a means of coercion, discipline, or punishment. Seclusion or restraint of patients should only be used in the

² Application No. 34806/4

³ CCPR/C/GC/35 (16 December 2014) General Comment No. 35: Article 9 (Liberty and security of person), paragraph 19

context of clearly defined institutional policies, and the involuntary status of a patient should never be used to alter the threshold for their application

Article 5 – Alternative measures

32. Under this Article States are required to promote the development and use of alternatives to involuntary placement and involuntary treatment. Involuntary measures should, as the Human Rights Committee of the United Nations emphasises with regard to placement (see paragraph 29 above), be a last resort. Examples might include home treatment or crisis intervention services that can prevent the need for involuntary placement.

Article 6 – Person of trust

33. The definition of “person of trust” emphasises the role of the choice of the individual concerned, and of the chosen person’s willingness to provide the necessary assistance and support (see paragraph 22 above). Any person who is or may be subject to an involuntary measure shall have the right to choose a person of trust. The issue is one of trust: this means that it is not appropriate for another person, including the representative, to select a person to fulfil this role. The role of the person of trust is different from that of the representative, who has a formal legal role set out in the definition in Article 2.

34. The person of trust should be someone the individual concerned trusts to assist and support him or her. This might include supporting the person in his or her interactions with professionals, or bearing witness to what the person’s wishes regarding placement or treatment would be when the person is not able to do so him or herself. It is a role of considerable moral responsibility and thus one that the individual concerned must have clearly accepted. The person of trust could be someone close to the person concerned, such as a family member or friend, or a person provided by an advocacy service or voluntary body who has been trained to take up this role and that the person trusts. The possibility of a lawyer acting in this non-legal role is not excluded. A valid choice of a person of trust should be appropriately documented. Although a person has the right to change his or her person of trust, previously expressed wishes with regard to such a choice may be of assistance in ensuring the person is able to access support promptly in the future.

35. Just as there is potential for conflict of interest between the person concerned and his or her family, or with other persons, so there may be potential for conflict between the person of trust and the patient’s representative (if any), family members and other persons. Those concerned with decision-making procedures and with care and treatment should be alert to such conflicts.

Article 7 – Legal assistance

36. The European Court of Human Rights has emphasised the need for persons to be able to defend their rights effectively in court proceedings. In particular, the Court has commented that there may be a need for procedural safeguards in order to protect the interests of persons who are not able to fully protect those interests as a result of mental disabilities.⁴ In the case of *Nenov v Bulgaria*⁵, the absence of legal aid for a person with mental disorder prevented him acting effectively in proceedings concerning his interests, which meant that the proceedings were not fair.

37. Appeals and reviews of involuntary measures take place in a planned manner and therefore it should always be possible for consultation with a lawyer to take place, should the person so wish. On the other hand, the initial procedure to subject a person to an involuntary measure often takes place at short notice, or even as an emergency. Whilst the person should have the right to consult his or her lawyer, if any, during these procedures, this Article does not provide a right to have any proceedings to subject a person to an involuntary measure delayed in

⁴ *Megyeri v Germany*, judgment of 12 May 1992, Application number 13770/88

⁵ *Judgment of 16 October 2009, Application number 33738/02*

order that the person concerned can consult a lawyer. That might involve unacceptable risk to the person or to others. The person will be able to appeal promptly against any involuntary measure applied, and will be able to consult a lawyer during that process.

Article 8 – Professional standards

38. Article 4 of the Convention on Human Rights and Biomedicine requires that any intervention in the health field be carried out in accordance with relevant professional obligations and standards. This principle therefore applies to interventions on persons with mental disorder subject to involuntary placement or involuntary treatment. Article 11 of REC (2004) 10 *concerning the protection of the human rights and dignity of persons suffering from mental disorder* set out good practice requirements in terms of professional standards in mental health care. These include the need for professional staff to have appropriate qualifications and training to enable them to fulfil their role. It is good practice for professional staff to be registered with a professional body that can attest their qualifications. The need for professional staff to have training or other opportunities to keep up to date with developments in professional practice (sometimes referred to as continuing professional development) in order to maintain their professional standards should be recognised. Professional staff should regularly review their practice. Such review may include both regular updating of knowledge, taking into account international developments, and review and audit of the professional's clinical practice in order to ensure high quality care.

39. Continuing professional development is also important in order to ensure that professionals know about new developments, for example, new less intrusive forms of treatment that are as, or more, effective than the treatment currently used. The CPT has also highlighted the risk of staff in psychiatric facilities becoming isolated, and considers it highly desirable that staff is offered training opportunities outside their own facility, as well as secondment opportunities.

40. Both initial qualifications and further training should address the ethical dilemmas that may arise in mental health care. Promoting autonomy of the persons with mental disorder and protecting their dignity, human rights and fundamental freedoms is a fundamental professional obligation.

Article 9 – Appropriate environment

41. The range of persons who may be subject to involuntary placement highlights the importance of diversity of provision. Older patients may be physically frail, and hence placement in a facility that also accepts younger acutely psychotic patients may present risks to them rather than the protection to which they are entitled. Furthermore, the demands of caring for acutely ill people may mean that if patients in need of rehabilitation are placed in the same part of a facility then the needs of the latter group may receive insufficient attention.

42. A range of facilities providing high, medium, and low levels of security are necessary in order that persons can be placed in facilities which are appropriate to their health needs and the need to protect the safety of others according to their progress during their treatment.

43. As the Preamble emphasises, the vulnerability of persons who are subject to involuntary placement should never be forgotten. The fundamental means necessary to support life (food, warmth, and shelter) must always be provided.

44. Particular attention should be paid to paragraphs 34 to 36 of the 8th general report on the activities of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) (document CPT/Inf (98)12) which drew attention to a number of factors which can create a positive therapeutic environment for persons placed as involuntary patients in a psychiatric establishment. These include:

- sufficient living space per patient as well as adequate lighting, heating and ventilation;

- decoration of both patients' rooms and recreation areas;
- the provision of bedside tables and wardrobes and individualisation of clothing;
- allowing patients to keep certain personal belongings;
- the preservation of a degree of privacy, in particular, large-capacity dormitories depriving patients of all privacy should be avoided;
- patients who so wish should be allowed to have access to their room during the day rather than being obliged to remain assembled together with other patients in communal areas;
- adequate food from the standpoint of quantity and quality, provided under satisfactory conditions; catering arrangements should also take into account patients' customs and beliefs and the needs of those with disabilities. The problem of malnutrition must be avoided. However, in some societies obesity (with its resultant health effects) is an increasing problem and it is good practice to provide food choices for patients that enable them to satisfy their appetite whilst maintaining a healthy weight.

45. According to Article 20.2, facilities designed for the involuntary placement of persons with mental disorder should be registered with an appropriate authority. This requirement is designed to ensure that such environments can be subject to monitoring, which is an important safeguard for persons who may be placed in such environments.

Chapter III – Criteria for involuntary placement and for involuntary treatment

46. In line with the United Nations Convention on the Rights of Persons with Disabilities and the comments of the United Nations Human Rights Committee, the Preamble emphasises that the existence of a mental disorder shall not in itself justify a deprivation of liberty. This is of fundamental importance. The provisions of this Chapter aim to ensure that involuntary measures are only used in a manner that is necessary and proportionate in relation to the risk posed by a person's mental health condition. The use of involuntary measures should always be a last resort.

47. The criteria and procedures that shall be fulfilled in order for a person to be subject to an involuntary measure are the same whether or not the person is in the community or in hospital (having entered the hospital on a voluntary basis) at the time the decision is sought.

48. As has been highlighted previously in this Report, involuntary measures should be a last resort. Thus efforts shall be made to enable a person to accept voluntary placement or voluntary treatment, as appropriate, before implementing involuntary measures. The principle of least restriction set out in Article 4 implies that use of such measures should be minimised as far as possible. This means that it is important that appropriate alternatives to involuntary placement and involuntary treatment are available, as emphasised by Article 5.

49. Similarly, even if an involuntary measure has been applied, continuing efforts should be made to apply the measure on a voluntary basis.

Article 10 – Criteria for involuntary placement

50. This Article stipulates that a person with a mental disorder may be subject to involuntary placement only under certain circumstances: when the person's mental health condition represents a significant risk of serious harm to the person himself/herself or to a third party, when the placement has a therapeutic purpose, and when no less restrictive means of addressing the risk are available. Involuntary placement is in general only considered appropriate with regard to certain types of mental disorder, for example psychoses or other severe mental disorders. On first contact with mental health services, it may not be possible or appropriate to make an exact diagnosis immediately: for example, it may be evident that the patient is psychotic, but establishing whether this may be the result of the use of drugs, or reflect a brief reaction to difficult circumstances in a person with borderline personality disorder, or may be the first episode of a schizophrenic illness may take more time. The criteria only require that the person has a mental disorder rather than a final diagnosis, nor would the later revision of an initial diagnosis render an involuntary measure invalid.

51. The first indent means that an assessment of risk must be made. Risks of harm can be physical or psychological. Risk assessment is complex and difficult, and perfect accuracy in prediction cannot be achieved. Considering the necessity of treatment may be helpful. For example, in assessing the risk to the person's own health, if the person's condition requires immediate care combined with close medical supervision, either in hospital or in the community, then the relevant criterion is likely to be met.

52. The ways by which harm may occur are very varied. As well as direct threats of harm to others or to the person him or herself, or behaviours that lead others to believe that they are at significant risk of harm, other actions may present indirect risks of serious harm to persons. Some examples include the burning of cars (the possibility that a small child is in the car cannot be excluded), setting fires in forests (in which people may be trapped) or a person running naked down the street whose speech or other behaviour suggested mental disorder (where there may be a potential risk to the person's health). In some States, these examples would be covered by a provision concerning public safety, public order or the environment. Nevertheless, the underlying principle is that of risk to persons and hence such risks are covered by the second indent. However, if the only risk is a financial one – for example when a pathological gambler spends his family's money – then involuntary measures designed to address mental disorder are not appropriate for addressing economic risk to others.

53. The concept of health should be understood in a broad sense and covers both physical and mental health. Although a significant risk of suicide is an obvious risk to health, a person who is so gravely disabled by mental disorder that the person is unable to care for him or herself can also be viewed as putting his or her health at risk. However, whether the degree of self-neglect was sufficient to fulfil the requirements of indent i. would need to be assessed in the light of the particular situation. As noted above, a person who behaves in such a way as to make another person believe that they are at risk of physical harm may damage that person's mental health without any physical damage having occurred.

54. Indent one makes a distinction between those who present risk to others, and those who only pose risks to themselves, in respect to the person's ability to decide on placement. This follows the approach of the Convention on Human Rights and Biomedicine. Paragraph 50 of the Explanatory Report to that Convention explains that Article 7 (Protection of persons who have a mental disorder) constitutes an exception to the general rule of consent for persons who are, according to law, able to consent but whose ability to decide on a proposed treatment is severely impaired by their mental disorder. Paragraph 42 of the same Report explains the diversity of legal systems in Europe with regards to capacity, which the Convention (and hence this Additional Protocol) do not seek to harmonise. A person whose ability to decide on an intervention is seriously impaired might be considered, under some legal systems, as *de facto* incapable of giving consent, irrespective of whether as a matter of law in that country they are considered legally capable.

55. If a person's ability to decide is not severely impaired, and the risk is to the person alone, then the principles of autonomy and respect for private life entitle them to take that risk without interference. On the other hand, if the person's mental health condition poses a significant risk of serious harm to others, the rights of others have to be balanced against the person's rights to autonomy. Article 26 of the Convention on Human Rights and Biomedicine enables an exception to be made to the principle of consent in the interests of, inter alia, public safety and the protection of the rights and freedoms of others.

56. The second indent requires that a placement has a therapeutic purpose. Provisions concerning involuntary placement of persons with mental disorder should not be used solely to achieve custodianship. The existence of a therapeutic purpose does not require that complete cure is envisaged; in some cases, this may not be achievable. As specified in the definitions in Article 2, therapeutic purposes include management of the disorder (for example, by reducing the level of

symptoms the patient has) and rehabilitation (for example, activities that aim to improve the person's ability to live independently). However, the fact that a placement may have additional purposes, such as the protection of others, is not excluded by this indent.

57. Further, a "therapeutic purpose" should not be equated with invasive medical treatment. When a person is subject to involuntary placement a treatment plan should be established as soon as possible with the person concerned and the person's person of trust or representative, if any. The treatment plan may also address behaviour arising as a consequence of the patient's mental disorder. In an emergency situation, the initial plan may be directed at resolving that situation, after which the plan will be further developed.

58. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) considers that a treatment plan in the context of involuntary placement should contain a wide range of therapeutic and rehabilitative activities.

59. Although the person may be offered a range of measures that may potentially benefit their condition, a person subject to involuntary placement is not compelled to accept such offers. On the other hand, if no therapeutic offers were made to a person that would be evidence of the lack of a therapeutic purpose to a placement. Similarly, lack of therapeutic success should not be equated with lack of therapeutic purpose. For example, if a range of methods of treatment have been tried without success, a therapeutic purpose still exists if the person is receiving therapeutic offers, even if the available treatments may not be able to completely cure the person's condition.

60. The third indent covers both the situation in which under no circumstances would it be possible to care for a person, taking into account the risk to the person or to others, other than by using involuntary placement; and the situation in which it might be theoretically possible to care for a person in a less restrictive manner but that the means to do so are not available. The concept of care in this indent is broad, covering both the provision of care for the person's mental disorder and ensuring the safety of the person, or where relevant others, whilst such care is provided. As noted in paragraph 48 above, efforts shall be made to obtain the person's consent or agreement to voluntary measures before an involuntary placement is considered. The reasons why less restrictive measures than involuntary placement cannot be used should be recorded in a manner that enables the use of such measures to be monitored. The importance of monitoring is emphasised in Article 20 of this Additional Protocol.

Article 11 – Criteria for involuntary treatment

61. The first indent of this Article parallels that of Article 10, and paragraphs 50-55 above are therefore also relevant to this Article.

62. The second indent emphasises the need to consider whether less intrusive means of providing care to the patient - for example by the use of psychotherapy or other psychological interventions - would be sufficient to address the identified risks taking into account the risk to the person or to others. In accordance with the principle of least restriction, such measures shall be considered before resorting to involuntary treatment, and as stated previously, involuntary measures should always be a last resort.

63. As required by Article 4 of the Convention on Human Rights and Biomedicine and reiterated in Article 8 of this Protocol, any health care intervention must be carried out in accordance with relevant professional obligations and standards. REC(2004)10 *concerning the protection of the human rights and dignity of persons suffering from mental disorder* set out principles governing the use of involuntary treatment. It should:

- a. address specific clinical signs and symptoms, which may include behaviour arising from a mental disorder;
- b. be proportionate to the person's state of health;
- c. form part of a written treatment plan;

- d. be documented;
- e. where appropriate, aim to enable the use of treatment acceptable to the person as soon as possible.

Chapter IV – Procedures concerning involuntary placement and involuntary treatment

Article 12 – Standard procedures for taking decisions on involuntary placement and on involuntary treatment

64. Although involuntary placement and involuntary treatment are covered in this Article because of the similarity of the relevant procedures, the intention is that these measures shall be considered separately. However, the fact that both types of measure might be considered at the same time is not excluded. If involuntary placement and treatment are addressed in one single decision, in accordance with the case law of the European Court of Human Rights, separate legal bases are needed and the possibility of appeal shall be provided regarding each measure individually.

65. Paragraph 1 requires the person concerned to be examined by at least one doctor in accordance with applicable professional obligations and standards. When standard procedures are used at least one doctor would usually be a psychiatrist, a medical doctor with special expertise and qualifications in the assessment, diagnosis and treatment of mental disorder. The doctor(s) shall have the necessary competencies and experience to perform the task. The task should be approached objectively. Thus, it is not appropriate for doctors who are closely related to the patient to undertake this examination. One of the most important competences required is in assessing the risk to the person concerned or to others if an involuntary measure is not applied. The provision does not exclude the relevant doctor(s) receiving information from other health care professionals who have personally examined the patient. The provision reflects the case law of the European Court of Human Rights, which requires involuntary detention to be based on objective medical expertise.

66. As noted in Article 1, paragraph 2, member states are able to grant a wider measure of protection than specified in this Protocol. An example of such protection would be to require that the patient is examined by a doctor and another specialist, and that there is concordance between those who have examined the patient on the need for an involuntary measure.

67. As a matter of professional obligations and standards, the doctor should consider the opinion of the person concerning the use of placement or treatment. This acknowledges that, in particular when the decision concerns risk to the patient him or herself, certain patients may recognise the risk and still prefer to take it than be subject to involuntary placement. The balance between respecting self-determination and the need to protect a person with mental disorder can be difficult, and hence it is important that the person's own opinion should be explicitly considered on the issues relevant to the possible placement. For example, particularly where there is concern about the risk to the person him- or herself, s/he may have views both about the level of risk and how it might be best to address it. Because many serious mental disorders are recurrent, when the person concerned is not acutely ill, it may be possible to discuss their preferences for placement and treatment in the event of a future relapse. Paragraph 2 indent iii. clarifies that such wishes shall be taken into account as well as any current views of the person concerned.

68. Similarly, the right to exercise autonomy is particularly important in the context of long-term use of medication. Some patients may prefer not to take medication at all, but to live with some symptoms of their illness. Others may be willing to take a certain amount of medication, but live with some symptoms (such as hearing voices), if complete symptom control required a higher level of medication associated with a level of sedation the person found unacceptable. A difficult balance has to be struck, and the person's opinion on the different therapeutic alternatives must play a full part in finding that balance. This does not imply that the patient's opinion must always be followed.

69. Paragraph 2 requires the decision on placement to be taken by a court or another competent body. The underlying principle is that a party that is independent of the person or body proposing the measure takes an independent decision. The body that takes the decision must be satisfied that the criteria in Articles 10 or 11 are met, as appropriate to the measure concerned.

70. If a person is not to be subject to involuntary placement, the court or competent body must take the decision to subject the person to involuntary treatment, and must be satisfied that the criteria in Article 11 are met. However, if the person is subject to involuntary placement, paragraph 3 of this Article provides an alternative means of taking a decision on the use of involuntary treatment. If the national legal system requires the decision to be taken by a court or competent body the provision does not require the court or other competent body to approve, for example, each individual dose of medication to be given.

71. The indents of paragraph 2 emphasise that the court or competent body shall act in accordance with procedures provided by law. These should comply with the guarantees of the European Convention on Human Rights and shall be based on the principle that the person concerned shall be heard in person. Such consultation of the person concerned enables the court or other competent body to form an independent view of the situation. This contact could be delegated to an official of the court or competent body and would not have to take place in the courtroom or at the site of the competent body, but could be in the person's home or in another place of safety. Although the court or competent body is not required to search for evidence of any previously expressed wishes of the person concerned that may be applicable to the situation, if evidence of such wishes is drawn to the attention of the court or competent body it shall be taken into account.

72. The intention of paragraph 2, indent v is that if the person concerned, or those close to him or her, informs the doctor or the competent body that the person has a representative who has been appointed by law to take decisions on behalf of, and represent the interests of, the person concerned then that representative shall be consulted about the person's condition and about the proposed measure. An exhaustive search to attempt to determine whether such a person exists is not required. Reasonable efforts to contact a representative if one is known to exist should always be made. However, there is no intention to render the procedure unlawful if in fact contact cannot be made (for example if the representative is on holiday and no contact details are available). If the person already has a person of trust then, if the person so wishes, it would be good practice to allow the person of trust to support the person during the relevant procedures. Whether or not the person of trust, if any, shall be consulted in the context of the procedure is a matter for national law.

73. If the doctor responsible for the care of a person subject to involuntary placement is allowed by law to take decisions about involuntary treatment then that doctor would previously have seen and consulted the person. However, the law might provide that only particular doctors, for example the chief doctor of a hospital, could take such decisions. Such a doctor might have had no prior contact with the person concerned, and therefore paragraph 3 includes a reference to examining that person to ensure the person has the opportunity of expressing his or her views. The doctor shall also take into account any relevant previously expressed wishes of the person concerned but (see paragraph 71 above) is not required to search for evidence of such wishes other than in the available case notes.

74. Paragraph 4, which provides that a review period for a decision shall be specified, implies that the validity of any decision must be subject to a time limit, which must be set by national law. However, this is without prejudice to the person's rights to appeals and reviews in accordance with the provisions of Article 16.

Article 13 – Procedures for taking decisions in emergency situations

75. In an emergency situation an immediate serious risk to the person concerned or to others appears to exist and the delay entailed in applying normal procedures would therefore be unacceptable. Procedures designed for such situations shall not be used in other circumstances, or to avoid the use of the procedures set out in Article 12. In such situations it may not be possible to obtain an opinion from a psychiatrist. In these situations, paragraph 1.i. permits the decision to be based on a medical examination appropriate to the measure concerned taking into account the circumstances. The case law of the European Court of Human Rights specifically identifies involuntary placement in emergency situations as not requiring thorough medical examination prior to the placement⁶.

76. Therefore the examination may be brief, but nevertheless sufficient information must be obtained to satisfy the criteria for the measure concerned. In some countries, assessment may be performed by a specialist mental health professional such as a psychologist accompanied by a medical doctor. This combination of expertise would meet the requirement for a medical assessment in these circumstances.

77. Although the decision to subject a person to an involuntary measure may be taken by a competent body, the initiation of medical treatment remains a medical decision. The case law of the European Court of Human Rights provides that an initial period of placement can be authorised by an administrative authority, as long as it is of short duration and the person can appeal promptly to a judicial body.⁷

78. In some cases, the requirement for an involuntary measure may be very brief. As specified by Article 15.1, if any of the criteria for a measure are no longer met the measure shall be terminated. It is thus possible, at least theoretically, for a measure to be terminated before the court or another competent body could have taken a decision in accordance with Article 12.

79. Paragraph 1.i. emphasises that an involuntary measure applied under emergency procedures shall be for a short period of time (for example, a maximum of 48 or 72 hours). Paragraph 2 requires that the exact maximum in a country is specified by the law. If the measure needs to be continued beyond that time, the procedures set out in Article 12 shall be followed and therefore steps should be taken to initiate those procedures without delay, once the emergency measure is in force.

80. As noted in paragraph 75 above, the person may have not been seen by a psychiatrist prior to the use of the emergency measure. Once the measure is in force the person should receive a specialist assessment as soon as possible.

81. The emergency situation may necessitate an initial placement in a facility which may not be the most appropriate to the person's health needs. The person should be transferred to an appropriate psychiatric facility as soon as possible.

82. The fact that a decision has been made in an emergency situation does not limit the right of the person concerned to appeal against the lawfulness of the measure according to Article 16 of this Additional Protocol.

Article 14 – Extension of involuntary placement and/or involuntary treatment

83. When a decision is made according to Article 12 to subject a person to involuntary placement and/or involuntary treatment this will be for a defined period. In many cases, the person's mental health will improve during that period and the measure will be terminated. In other

⁶ *X v United Kingdom*, judgment of 5 November 1981, Application number 00007215/75

⁷ Summarised in *MH v United Kingdom*, judgment of 22 October 2013, Application number 11577/06

cases as the period of the measure comes towards its end it may be evident that the measure cannot be safely terminated.

84. Efforts should continue to be made to enable the person to accept treatment on a voluntary basis, but if these do not succeed this Article makes clear that the procedures to extend the measure should be the same as those set out in Article 12 and hence the person's rights receive the same level of protection.

Article 15 – Termination of involuntary placement and/or involuntary treatment

85. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment specifies that involuntary placement should cease as soon as it is no longer required by the patient's mental state. This Article follows that principle, which is based on the case law of the European Court of Human Rights⁸. Thus, it is important that the patient's mental state is assessed frequently, particularly during times when it is changing rapidly.

86. As noted in paragraph 25 above, the reference to "the responsible authority" in paragraph 3 refers to the authority responsible for the facility in which the patient is placed, or where the patient is receiving treatment without being subject to voluntary or involuntary placement, the authority with administrative responsibility for the doctors supervising the treatment.

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

87. An appeal is a challenge against the decision to apply a measure. A review is a challenge to the continuing legality of the measure, for example because the applicant's mental state has improved. The case law of the European Court of Human Rights makes clear that a person has the right to appeal against, or to have reviewed, decisions concerning involuntary placement or involuntary treatment (or, if applicable, both) at reasonable intervals⁹. It also makes clear that appeal and review could be undertaken by a specialist body that has the characteristics of a court – for example, if it has the necessary independence, offers appropriate procedural safeguards, and is able to decide on the lawfulness of the measure and order its termination if necessary.¹⁰

88. In respect of deprivation of liberty, this Article takes into account the requirements of Article 5 of the European Convention on Human Rights, and the standards laid down by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, in particular with regard to the right to review, and the comments of the United Nations Human Rights Committee referred to in paragraph 29 above. In respect of involuntary treatment, the right to appeal against, or have reviewed, decisions concerning such treatment derives from Article 6 of the European Convention on Human Rights.

89. Whether an interval is "reasonable" has to be considered in the context of the particular circumstances, taking into account the complexity of the case, and the conduct of the applicant. For example, if a person subject to an involuntary measure has requested a review or such a review has taken place *ex officio* and the review has concluded that the measure should be continued, if the applicant makes another application for review the day after the decision of the first review, account has to be taken of the likelihood of a new review reaching a different conclusion within a short time-frame in the context of the patient's condition.

90. Any review or appeal should use adversarial procedure (which refers to the opportunity for a party to have knowledge of and comment on the observations filed or evidence adduced by the other party).

⁸ *Winterwerp v The Netherlands*, judgment of 24 October 1979, Application number 00006301/73

⁹ *Stanev v Bulgaria*, judgment of 17 January 2012, Application number 36760/06

¹⁰ *Winterwerp v The Netherlands*, judgment of 24 October 1979, Application number 00006301/73

91. It is good practice to inform the doctor responsible for the person's care of the relevant proceedings and of the doctor's right to participate in them. This would normally be done by the administrative staff responsible for organising the proceedings.

92. The court should, in full knowledge of the relevant factual and legal issues, review whether the relevant procedural requirements and criteria for a measure or its continuation are all met.

93. The person should always be entitled to be supported by his or her person of trust (if he or she has one), whether or not that person has (according to national law) any formal role in the proceedings. Although the case law of the European Court of Human Rights emphasises the importance of the right of the person to be heard in person, it also acknowledges that if necessary the person may be heard by means of a representative. This might occur, for example, if the person's mental state was too disturbed to be able to participate in proceedings, or if the person's participation might entail a significant risk of harm to other persons participating in the proceedings.

94. In respect of paragraph 2, review at reasonable intervals is important in ensuring compliance with the European Convention on Human Rights. The case law of the European Court of Human Rights makes clear that special procedural safeguards may be necessary to protect those who are not capable of acting for themselves¹¹. The Court has been concerned to protect the rights of patients who may not be able to act for themselves and to ensure they are not disadvantaged if they do not, for example, have family or friends who could prompt a review.

95. The law may allow the responsible authority (see paragraph 25 above) to delegate the task of informing the court to the doctor responsible for the person's care.

96. This Article covers civil and administrative proceedings. In such contexts, paragraph 4 refers to the possibility in exceptional cases of certain information being withheld from the patient on grounds of the confidentiality and safety of others in accordance with national law. In particular, this is designed to ensure that those close to the patient can give information to the clinical team about the patient's condition (for example if the patient has had a period of home leave) in confidence if they wish to do so. In some cases, a person with mental disorder may react violently to a family member who has disclosed information that suggests the patient is not as well (and hence not as suitable for discharge) as the patient would like to appear.

97. As noted in paragraph 64 above, the appropriateness of involuntary placement and of involuntary treatment shall be considered separately, but where a person is subject to both types of measure it may be convenient for a review or appeal to review both measures at the same time.

Chapter V – Information and communication

Article 17 – Right to information

98. When a person is either placed or treated for mental disorder on an involuntary basis, he or she may be referred to as a "patient" and shall be informed of his or her rights.

99. When a person is subject to an involuntary measure it is good practice to give the patient information about their rights both verbally and in written form. It is important that any language barriers are addressed, for example by providing interpretation in the person's native language. However, written information should not be regarded as a substitute for information given face-to-face, but as a supplement to such information. Written information should be in accessible formats, including easy to read text, where needed. This information must include information on their rights to reviews and to appeal against the measure concerned according to Article 16 of this Additional Protocol. Some patients may be illiterate and it is important to ensure that they are not

¹¹ *Winterwerp v The Netherlands*, judgment of 24 October 1979, Application number 00006301/73

disadvantaged in exercising their rights for this reason. In accordance with the European Court on Human Rights, a person subject to involuntary placement shall also be promptly informed about the reasons for the involuntary placement¹².

100. At the time the person is subjected to an involuntary measure their state of health may make it difficult for them to understand information about their rights. The person should be provided with as much information as their state of health permits, and the information may need to be repeated (perhaps more than once) as the person's health condition improves. It is important that the person understands their rights in respect of involuntary measures as soon as possible.

101. When the person has a representative or a lawyer, the information shall also be provided to them. Although as noted above the information may need to be repeated to the patient several times, the Article does not require repetition of standard information to the lawyer and representative. The lawyer and representative require information about the reasons for the decision in order to be able to, where appropriate, challenge it effectively. The information may also be given to the person's person of trust, if any, depending on whether national law permits this. Again, it would be good practice to provide the information both verbally and in writing and in appropriately accessible formats.

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

102. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) has highlighted the importance of those subject to involuntary placement being able to communicate with the outside world, both from a therapeutic standpoint and as a safeguard against abuse. It is not envisaged that it would ever be appropriate to restrict communication with the persons or bodies listed in the first sentence. Appropriate authorities include those charged with monitoring compliance with the provisions of this Additional Protocol according to Article 20 and international bodies such as the European Court of Human Rights and the CPT. The patient's right to receive information from outside the placement facility should not be restricted.

103. Restrictions on the right to communicate with other persons shall be exceptional. Communication is important in ensuring that the persons maintain, if possible, social and family ties that are important to them. Such restrictions should only aim to:

- protect the rights of others (for example if the patient is making or sending repeated unpleasant telephone calls or letters to members of the family or other acquaintances);
- prevent harm to the future prospects of the person concerned (for example if a mentally ill person indicates that s/he intends to resign from his or her job, but is not considered to have the capacity to make that decision);
- prevent offences (for example if the patient was suspected of drug-trafficking, some degree of censorship might be imposed). The patient should be informed of any such restrictions in order to allow him or her to challenge them in a court or before a competent body.

Chapter VI – Record-keeping and monitoring

Article 19 – Record-keeping

104. Article 10 of the Convention on Human Rights and Biomedicine states that "Everyone has the right to respect for private life in relation to information about his or her health" and this principle is equally applicable to persons with mental disorder. Thus, the principles of the existing data protection instruments of the Council of Europe, including the Convention for the Protection of Individuals with regard to Automatic Processing of Personal Data (1981; ETS 108) and Recommendation R (97)5 of the Committee of Ministers to member states *on the protection of*

¹² *van der Leer v The Netherlands*, judgment of 21 February 1990, Application number 00011509/85

medical data, will be applicable to persons subject to involuntary placement or involuntary treatment. Data concerning a person's mental disorder or concerning a person's treatment for that disorder are forms of sensitive data and are entitled to a high level of protection. The data are entitled to the same level of protection wherever they are recorded.

105. Comprehensive medical records are always important, and administrative records are also required when a person is subject to an involuntary measure. When patients are subject to involuntary measures, the records required by this Article can form the basis of reviews of the lawfulness of each measure and the justification for its continuation. These records should be carefully drawn up in accordance with each member state's regulations and with professional obligations and standards. They should contain the relevant diagnostic information and provide an on-going record of the patient's state of physical and mental health, including an account of all therapeutic and placement-related decisions taken, with reasons, based on objective observed or reported facts.

106. The conditions governing access to this information by patients, their representatives and where appropriate their families shall be clearly specified by law, in accordance with the relevant principles of access to medical data of the instruments noted in paragraph 104 above. Similarly, there should be clear guidance about the duration for which records should be kept.

Article 20 - Monitoring

107. Quality assurance and monitoring are important in ensuring the protection of the human rights and dignity of persons with mental disorder, in ensuring the delivery of high quality care for such persons and in ensuring compliance with the relevant legal standards, including those set by this Additional Protocol. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment Standards specify that the Committee "attaches considerable importance to psychiatric establishments being visited on a regular basis by an independent outside body". In particular, it emphasises that the body should be authorised to talk in private to patients and to receive any complaints that they may have.

108. States may have different methods for quality assurance and monitoring. For example, in some States a single body may carry out monitoring of legal, technical and professional standards. In other States one body may be responsible for legal standards and another body for professional and technical standards. The Article does not prescribe a particular approach.

109. The requirement for the registration of facilities in the second paragraph of this Article aims to facilitate the appropriate inspection and review of such premises. The term "facility" shall be understood in a broad sense as encompassing health establishments and units in which a person with mental disorder may be placed. Appropriate oversight of facilities helps to ensure that all patients receive dignified, humane and professional treatment in which they are protected from abuse and that their human rights are fully respected.