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Committee on Social Affairs, Health and Sustainable Development

Minutes

of the hearing on the Draft Additional Protocol to the Convention on Human Rights and Biomedicine concerning the protection of human rights and dignity of persons with regard to involuntary placement and involuntary treatment within mental healthcare services, held in Helsinki on Friday 16 May 2025

Ms Saskia Kluit, Chairperson of the Committee, opened the hearing organised in the framework of the preparation of the Committee's opinion on the Draft Additional Protocol (Ms Carmen Leyte, rapporteur for opinion) and welcomed the experts: Mr John Patrick Clarke, Vice President, European Disability Forum and Prof. Martina Rojnić Kuzman, European Psychiatric Association (online).

Mr John Patrick Clarke, Vice President, European Disability Forum

Mr Clarke began by expressing his gratitude for this invitation and stressed the importance of including the voices of those directly impacted by the proposed Draft Additional Protocol. He represented the persons with disabilities and mental health problems, including survivors of psychiatry.

He described the European Disability Forum (EDF) as a pan-European umbrella organisation with 115 member organisations at national, regional, and local levels, collectively representing over 100 million persons with disabilities across Europe. Its mission was to protect and promote the rights of persons with disabilities through advocacy and capacity building at European, EU, and international levels.

Mr Clarke then outlined the long-standing opposition of EDF to the Draft Additional Protocol. He referenced the collaborative #WithdrawOviedo Campaign, which had united various stakeholders — including persons with disabilities and mental health problems, mental health advocates, care providers, and human rights institutions — for over a decade. Their core concerns had remained consistent throughout this time.

He listed the main concerns with the Draft Additional Protocol:

- Human rights violations: The protocol endorsed involuntary treatment and placement in psychiatric settings, which violated the UN Convention on the Rights of Persons with Disabilities (CRPD). Thus, the protocol legitimised practices that are proven to be harmful to people: profound psychological and traumatic effects, hindered recovery, and negatively affected both mental and physical health — without demonstrating clinical benefits for the patients.
- Reinforcement of institutionalisation: The protocol risked entrenching outdated systems of institutional care and prompting further investment in such systems at a time when countries were moving toward deinstitutionalisation.
- Increased coercion in mental healthcare: Evidence from several countries (England, France, Croatia, Netherlands) showed that legal reforms similar to those in the protocol had led to a rise in involuntary placement, lowering standards of care.
- Legal incompatibility: Ratifying the protocol would create legal conflicts with states obligations under the CRPD (all Council of Europe member States had ratified the CRPD), enabling state parties to effectively bypass the CRPD by imposing lower human rights standards and violating principles of international law,

[1] The minutes were approved and declassified by the Committee on Social Affairs, Health and Sustainable Development at its meeting on 24 June 2025.

including the Vienna Convention on the Law of Treaties. Coercion in mental health settings often lead to inhuman and degrading treatment, conditions for with no derogation was permitted.

Mr Clarke proposed a constructive alternative: support for the draft Recommendation on respect for autonomy in mental healthcare. While not fully CRPD-compliant, this recommendation aimed to eliminate coercion and advance autonomy-based practices. He referenced positive resources such as:

- The Council of Europe's Compendium of good practices promoting autonomy in mental healthcare;
- The WHO QualityRights Initiative, which supported human rights-based health systems through training and reform;
- Testimonies from mental healthcare professionals and social workers advocating for care over coercion.

Mr Clarke concluded with a clear call to action. He urged the Committee to adopt a negative opinion on the Draft Additional Protocol, consistent with PACE's historical stance against coercive practices in mental health settings, and encouraged support for the recommendation promoting autonomy, viewing it as a path forward that strengthens human rights protections in mental healthcare.

Prof. Martina Rojnić Kuzman, European Psychiatric Association (online)

Ms Rojnić Kuzman opened the presentation by introducing the European Psychiatric Association (EPA), which she described as the leading association representing psychiatry in Europe. She highlighted that the EPA brought together more than 78 000 psychiatrists through 44 national associations in 41 countries. The mission of the association focused on improving care for individuals with mental disorders and fostering professional development in psychiatry. EPA's internal structure included 24 scientific sections and 7 specialised committees such as the Committee on Ethics and the Early Career Psychiatrists Committee. The association was active in research, publications, policy advocacy, and public engagement, promoting ethical standards and mental health awareness across Europe.

Ms Rojnić Kuzman referenced the EPA EU Elections Manifesto launched in December 2023 which outlined strategic priorities for mental health development from 2024 to 2029, including harmonisation of mental healthcare delivery, workforce support, ethical standardisation, innovation in mental health approaches, and strengthened public health measures.

She elaborated on the updated EPA Code of Ethics (2024-2025) which emphasised that involuntary (compulsory) measures must be used strictly as a last resort to provide adequate care and ensure patient and/or others safety, and only when no available alternatives existed. Such interventions must follow national legislation, and patient conditions must be reviewed regularly. Even when patients lack decision-making capacity, psychiatrists were encouraged to maintain communication, show respect, and support their reintegration into shared decision-making as soon as possible.

Ms Rojnić Kuzman stressed the EPA's alignment with the UN's position on disability rights and mental health as a global priority. EPA was committed to shared decision-making but rejected the false description of the dominance of biomedical approach that might justify coercion or lead to neglect. The EPA advocated for the development of alternatives to institutionalisation, warning against abrupt closure of facilities without proper support structures. Coercive treatment represented a last-resort exception to the model of shared decision-making and must always be subject to rigorous scrutiny and challenge. Its elimination without adequately resourced, recovery-oriented non-coercive alternatives would cause harm to service-users and others.

Drawing on the "EUNOMIA study" (2011) and other European data in 2020 and 2022, she discussed the legal and clinical preconditions for involuntary treatment, the roles of medical professionals and the judiciary, and variations in practice across countries. The EPA underlined the need for practices grounded on the predominant model in Europe of shared clinical decision making, medical necessity rather than social protection aspects, ethical considerations, and respect for cultural and individual diversity.

Several clinical scenarios with the need for medical treatment were presented to illustrate circumstances in which involuntary treatment may be necessary, such as cases of a patient with dementia experiencing nighttime delirium who became physically aggressive towards family members due to disorientation and refused any form of treatment, severe mania or psychosis, or substance-related aggression. These examples supported her argument for maintaining a cautious but pragmatic stance on coercive measures.

Ms Rojnić Kuzman highlighted measures to reduce involuntary placement and treatment and gave examples of successful models of community mental health care in countries like the Netherlands and Finland. These systems emphasised human rights, recovery, and integration into society. She referred to evidence-based strategies, such as staff training and peer involvement, which had been shown to reduce the use of coercion by up to 60%.

In conclusion, **Ms Rojnić Kuzman** expressed the EPA's full support for the Draft Additional Protocol as an essential instrument for setting a unified standard across Europe, ensuring guidance on how to improve the current practices, including the importance of using it as a last-resort measures, supporting access to legal counsel, and promoting the development of alternatives to coercive care. The EPA supported provisions that call for continuous staff education, impaired ability to decide on the measure and the need of medical treatment of the person, in addition to the risk to others, and measures to address the use of involuntary treatment outside mental health institutional settings.

Ms Kluit thanked the experts and opened the floor for remarks.

Discussion

Mr O'Reilly expressed his gratitude to the speakers and acknowledged their contributions. He began by referencing a number of tragic cases in Ireland involving individuals with severe psychosis who committed acts of violence, including parricide and familicide. He also described an anecdote about an alcoholic woman from a supportive, middle-class background who developed a severe psychological condition. Despite her family's efforts, she chose to live on the streets and ultimately died from hypothermia.

He asked Mr Clarke how he reconciles such real and tragic cases with his idealistic stance against institutionalisation. He acknowledged that historically in Ireland, as in other countries, institutionalisation was misused to marginalise unwanted family members.

Finally, he asked to Ms Rojnić Kuzman, about the current status of electroconvulsive therapy (ECT). He recalled how ECT was involuntarily administered during his youth and noted that more recent medical and psychiatric research seems to suggest negative outcomes associated with it. He asked whether she believes that institutionalisation and forced treatment are sometimes ultimately necessary.

Mr Libicki raised the issue of legal incapacitation, noting that many countries, especially those in the former communist bloc, had struggled with outdated regulations in this area. He asked how these countries could move away from old legal frameworks and adopt more modern systems. He explained that in Poland, there had been ongoing debate about institutionalisation for years, but no real legal progress had been made. He asked what advice Mr Clarke could offer to help such countries resolve this challenge.

Mr Fridez explained that he was a general practitioner with a year of psychiatric training and served as a physician in an institution for patients with mental and physical disabilities, including many cases of autism. He believed that, in some way, he represented a middle-ground solution between the perspectives presented by the two previous speakers.

Both Mr Clarke and Ms Rojnić Kuzman had expressed very reasonable viewpoints. There was a need to find a compromise between them. Mr Fridez shared that, in his country, he had personally carried out deprivation of liberty measures for assistance purposes—specifically, in cases where patients, as described by Ms Rojnić Kuzman, needed to be temporarily deprived of certain freedoms in order to receive treatment. At the same time, in the institution where he worked, the general approach had been to make every effort to respect the choices of the patients or, when that wasn't possible, the choices of their families. The goal was always to provide personalised care tailored to individual needs, rather than standardised solutions.

He stated that in difficult situations, especially when lives were at risk, it was essential for therapists to remain respectful. He also emphasised the importance of legal oversight, explaining that in Switzerland, whenever someone was deprived of their freedom, a judge had to intervene within hours or days to ensure that the law had been followed.

Mr Amraoui, as a doctor who had also held administrative responsibilities, explained the difficulty of balancing the right to freedom with the need for treatment in severe psychiatric cases. Free and informed consent was a fundamental principle of bioethics. For him, the most important aspect was that care be provided in a respectful environment without harm to physical or moral integrity, and with strong community—not just family—support.

He described the situation in Morocco, where a critical report by the National Human Rights Council on mental health had led to a proposed law placing judges at the centre of the hospitalisation process. However, the bill had been blocked in Parliament for nearly eight years. He noted that the judicial involvement made psychiatric practice extremely difficult.

He questioned how, in European countries where only doctors hold responsibility, the role of justice was handled. He stressed that no psychiatrist hospitalised a patient lightly and insisted on the importance of care quality and the avoidance of physical coercion.

Ms Bilozir shared Ukraine's experience during the ongoing war. The war had not only destroyed infrastructure but had also deeply affected people's mental health. Over 80% of Ukrainians reported suffering from anxiety, stress, panic attacks, and emotional exhaustion. She emphasised the need for a systematic national response.

Ukraine had launched a national mental health programme “How are you?” led by First Lady Olena Zelenska. The programme aimed to help people recognise their mental state, manage it, and seek help without stigma. All ministries in Ukraine were involved. The Ministry of Health trained family doctors to provide initial psychological support. The Ministry of Social Affairs established resilience centres in every community to support veterans, victims, and families of the fallen. The Ministry of Education and Science integrated emotional skills into the school curriculum and trained teachers. The Ministry of Internal Affairs and Emergency Services trained crisis psychologists to respond to victims of attacks. The Ministry of Economy promoted mental well-being in the workplace by training staff in large companies.

She concluded by stressing that mental health was now considered part of Ukraine's national resilience and even a defence strategy, as mental strength was vital for the country's survival and recovery.

Mr Clarke responded to Mr O’Reilly by acknowledging the high-profile cases mentioned but pointed out that many of those individuals had not been part of the mental health care system beforehand. He noted the saying “hard cases make bad law,” emphasising that exceptional cases should not dictate general policy. He explained that in Ireland, there had been a significant shift away from institutionalisation in recent years, which had proven successful. He stressed that the country was closing institutions and focusing more on community-based care, a model that should be encouraged across Europe.

He stated that community-based care should have been the norm and the ultimate goal in mental health services. Both in Europe and internationally, there had been a shift toward a more human rights-based approach, which he believed should have remained the focus. He emphasised that there should have been no compromise when it came to human rights in mental health care.

He praised the draft recommendation presented to the panel, which had been developed in collaboration with organisations such as the European Disability Forum, Mental Health Europe, users, ex-users, and survivors of psychiatry. The document had been widely agreed upon, including by members of the CDBIO committee.

He expressed hope that efforts to promote autonomy and respect in mental health care would continue. He contrasted this vision with recent incidents, such as the case of a woman who died from hypothermia, and another involving a politician found intoxicated in public. He argued that such situations could and should have been addressed within a community-based care framework.

Ms Kluit recalled the two remaining topics: the ECT and the role of the judge versus the one of the doctor.

Ms Rojnić Kuzman explained that ECT, despite its historical stigma, was still practiced in many countries. However, it was now performed under much stricter and safer medical protocols. It was only used for very specific and severe psychiatric conditions, such as when other treatments had failed or in cases of life-threatening syndromes like neuroleptic malignant syndrome. ECT could no longer be administered involuntarily: it required the patient’s informed consent, or, in cases where the patient could not consent, the permission of a legal representative. The procedure had evolved to become safer, with significantly reduced side effects, and remained one of the most effective treatment options in those exceptional cases.

On the second topic, she discussed the balance between medical and legal authority in involuntary treatment. She referred to a 2020 survey analysing 40 European countries, showing that roughly half operated on a medical-based model (where psychiatrists alone could initiate involuntary treatment) and the other half followed a legal-based model (where judicial oversight was necessary). Using Croatia as an example, she described how a psychiatrist could initiate a 48-hour emergency detention if a patient posed a danger to themselves or others. During this period, a court hearing had to be arranged. The hearing included the patient’s psychiatrist, a judge, a lawyer representing the patient’s rights, and an independent medical expert appointed by the court. If the judge approved the treatment, the patient could be treated involuntarily for up to 30 days. A second hearing could extend this period to 90 days if needed, although in her experience, most cases did not go beyond the initial 30 days.

She emphasised the importance of involving both medical and legal professionals in these decisions to ensure the protection of patients’ rights while still providing necessary care. Involuntary treatment had become less common thanks to the development of community-based mental health services across Europe. However, she cautioned against eliminating it entirely, arguing that the right to health - including receiving care when severely ill and unable to recognise it - was also a fundamental human right.

Ms Leyte emphasised that the primary goal was always the protection of people, especially the most vulnerable, including those suffering from mental illness. She acknowledged the diversity of opinions shared regarding the Draft Additional Protocol and thanked the contributors, stating that their input would help improve the report. She noted

that several letters critical of the additional protocol to the Oviedo Protocol have been received. While respecting all views, she stressed that it was the responsibility of the committee to evaluate them carefully and produce a report that would prevent bad practices.

She reaffirmed the belief that people with mental illness should not lose their rights or personal autonomy. The protocol established a legal framework for involuntary hospitalisation and treatment, strictly limited to critical situations where the individual or those around them were in danger. Condemning arbitrary practices, she highlighted that the protocol required safeguards such as regular reviews, legal representation, and the right to appeal.

She noted that although the CRPD emphasised autonomy, the protocol recognised that some individuals might, due to their condition, be unable to make informed decisions. In such cases, intervention was allowed, but always with protective measures. The protocol also aimed to harmonise laws across the Council of Europe, helping to ensure minimum standards and prevent legal disparities between countries.

Finally, she pointed out that individuals with severe mental disorders might refuse treatment precisely because of their condition, and in extreme situations, the protocol permitted intervention to ensure they received necessary care. She concluded with a comparison: if someone lost consciousness due to an accident, medical services would act without consent to save the person’s life. Likewise, in psychiatry, immediate care was sometimes essential. She invited opposing associations to propose alternatives and expressed hope for a balanced and well-structured final report.

Ms Kluit thanked the participants and closed the hearing.

List of presence / *Liste de présence*

(The names of members who took part in the meeting are in bold /
Les noms des membres ayant pris part à la réunion sont en caractères gras)

Chairperson / *Président·e:*

Ms / *Mme* Saskia Kluit	

Vice-Chairpersons / *Vice-Président·e·s :*

Ms / *Mme* Danuta Jazłowiecka	
Mr / *M.* Armen Gevorgyan	
Lord Don Touhig	

Members / *Membres*	**Country / *Pays***	**Alternates / *Remplaçant·e·s***
Ms Jorida Tabaku	Albania / *Albanie*	Zz...
Mr Cerni Escalé	Andorra / *Andorre*	Mme Bernadeta Coma
Mr Armen Gevorgyan	Armenia / *Arménie*	Ms Hripsime Grigoryan
Mr Stefan Schennach	Austria / *Autriche*	Ms Doris Bures
Mr Andreas Minnich	Austria / *Autriche*	Ms Agnes Sirkka Prammer
Ms Anne Lambelin	Belgium / *Belgique*	Mr Andries Gryffroy
M. Benoît Lutgen	Belgium / *Belgique*	Mme Véronique Durenne
Ms Darijana Filipović	Bosnia and Herzegovina / *Bosnie-Herzégovine*	Mr Šemsudin Dedić
Ms Atidzhe Alieva-Veli	Bulgaria / *Bulgarie*	Zz...
Ms Petya Tsankova	Bulgaria / *Bulgarie*	Zz...
Ms Zdravka Bušić	Croatia / *Croatie*	Ms Rada Borić
Ms Christiana Erotokritou	Cyprus / *Chypre*	Mr Constantinos Efstathiou
Ms Ivana Mádlová	Czechia / *Tchéquie*	Mr Aleš Juchelka
Ms Michaela Šebelová	Czechia / *Tchéquie*	Mr Ondřej Šimetka
Ms Camilla Fabricius	Denmark / *Danemark*	Ms Karin Liltorp
Ms Hanah Lahe	Estonia / *Estonie*	Zz...
Ms Minna Reijonen	Finland / *Finlande*	**Ms Miapetra Kumpula-Natri**
Mme Sophia Chikirou	France	Ms Sabrina Sebaihi
M. Alexandre Dufosset	France	Mme Liliana Tanguy
M. Alain Milon	France	M. Alain Cadec
Mme Maud Petit	France	M. Jean Laussucq
Zz...	Georgia / *Géorgie*	Zz...
Ms Heike Engelhardt	Germany / *Allemagne*	Ms Franziska Kersten
Mr Andrej Hunko	Germany / *Allemagne*	Ms Catarina Dos Santos-Wintz
Mr Christian Petry	Germany / *Allemagne*	Ms Martina Stamm-Fibich
Mr Harald Weyel	Germany / *Allemagne*	Ms Katrin Staffler
Ms Maria Syrengela	Greece / *Grèce*	Ms Maria-Nefeli Vasileiou Chatziioannidou
Mr Georgios Stamatis	Greece / *Grèce*	Mr Alexis Tsipras

Ms Mónika Bartos	Hungary / *Hongrie*	Mme Katalin Csöbör
Ms Mónika Dunai	Hungary / *Hongrie*	Ms Zita Gurmai
Mr Ragnar Þór INGÓLFSSON	Iceland / *Islande*	Ms Kolbrún Áslaugar
Mr Joseph O'Reilly	Ireland / *Irlande*	Mr Rónán Mullen
Ms Elena Bonetti	Italy / *Italie*	Mr Roberto Rosso
Ms Aurora Floridia	Italy / *Italie*	Mr Giuseppe De Cristofaro
Mr Alessandro Giglio Vigna	Italy / *Italie*	Mr Graziano Pizzimenti
Mr Stefano Maullu	Italy / *Italie*	Mr Francesco Zaffini
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Mr Peter Frick	Liechtenstein	Ms Franziska Hoop
Ms Orinta Leiputė	Lithuania / *Lituanie*	Mr Zigmantas Balčytis
Mme Stéphanie Weydert	Luxembourg	M. Paul Galles
Mr Michael Farrugia	Malta / *Malte*	Mr Joseph Beppe Fenech Adami
Mr Ion Groza	Republic of Moldova / *République de Moldova*	Ms Diana Caraman
Mme Christine Pasquier-Ciulla	Monaco	Mme Béatrice Fresko-Rolfo
Mr Miloš Konatar	Montenegro / *Monténégro*	Mr Boris Mugoša
Ms Saskia Kluit	Netherlands / *Pays-Bas*	Ms Elly Van Wijk
Ms Carla Moonen	Netherlands / *Pays-Bas*	Mr Theo Bovens
Mr Bekim Kjoku	North Macedonia / *Macédoine du Nord*	Mr Sadula Duraki
Ms Lisa Marie Ness Klungland	Norway / *Norvège*	Ms Linda Hofstad Helleland
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Mr Jan Filip Libicki	Poland / *Pologne*	Ms Magdalena Biejat
Mr Ryszard Petru	Poland / *Pologne*	Zz…
Ms Jamila Madeira	Portugal	Mr Nuno Fazenda
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Representative of the Turkish Cypriot Community (*) / *Représentant de la communauté chypriote turque (*)*

Mr / *M.* Oğuzhan Hasipoğlu

(*) In accordance with Resolution 1376 (2004) / *Conformément à la Résolution 1376 (2004)*

Secretariat of the Parliamentary Assembly / *Secrétariat de l'Assemblée parlementaire*

Ms / *Mme* Louise Barton, Director of Committees / *Directrice des commissions*
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Committee on Social Affairs, Health and Sustainable Development /
Commission des questions sociales, de la santé et du développement durable

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Ms / *Mme* Aiste Ramanauskaite ..... Secretary to the Committee / *Secrétaire de la commission*
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