

CommDH/Speech(2021)2

Hearing on deinstitutionalisation of persons with disabilities

Committee on Social Affairs, Health and Sustainable Development Parliamentary Assembly

On-line speech by Dunja Mijatović
Council of Europe Commissioner for Human Rights

Tuesday, 16 March 2021, 2 p.m.

About two years ago, I had the privilege of addressing the Parliamentary Assembly on the issue of ending coercion in psychiatry and witnessed the unanimous adoption of its Resolution on this question. This Resolution and the excellent report that underlies it are ground-breaking documents that should have set the tone for the action of the Council of Europe and our member states from then on.

But we know that old habits die hard, especially when they are so deeply rooted in prejudice and centuries-old legal traditions that dehumanise persons with mental health conditions and psychosocial disabilities. It is therefore essential to speak again of involuntary placements in mental institutions, places where some of the worst human rights violations continue to occur throughout Europe. The recent report of the CPT on psychiatric hospitals in Bulgaria should serve as a sobering reminder of that fact. Better safeguards for involuntary placements would have done nothing to prevent those violations, given the endemic culture of abuse which can so easily take root in an institutional setting, as we see over and over again.

When we speak of deinstitutionalisation now, we are doing so in the context of a pandemic: Covid-19 has not only had a devastating impact on mental health, it has also finally exposed to everyone the grave danger institutions represent to the health of their residents.

I published last month an Issue Paper on protecting the right to health through inclusive and resilient health care for all. It includes twelve recommendations to member states, such as universal health coverage, of which mental health services are an essential component; more equality and dignity for patients; the promotion of transparency and accountability in decision-making; and better health communication policies. Although all these recommendations are applicable to mental health, some are more specific to it. I recommended, for example, (i) making mental health services accessible to all, of appropriate quality and affordable; (ii) transitioning from institutions to a community-based model for persons with psychosocial disabilities or mental health conditions; and (iii) eliminating coercive practices in mental health services. Human rights and mental health reform are subjects that are extremely important to me and I intend to complement my Issue Paper by publishing a human rights comment on mental health in the coming weeks.

In my Issue Paper, I also call on governments to pay attention to the essential social determinants of health. These are all the more relevant for mental health and one of the reasons why we are witnessing a rapid evolution from a purely biomedical understanding of mental health to a psychosocial one. This evolution goes hand in hand with a growing consensus within the international community on viewing institutions and involuntary measures as human rights violations. This is in large part thanks to the paradigm shift of the UN Convention on the Rights of Persons with Disabilities, and the efforts of civil society, in particular representative organisations of persons with lived experience of mental health conditions and psychosocial disabilities, to reclaim their rightful place in the debate.

Today a growing number of relevant UN bodies and experts are calling for an end to coercion and their replacement by community-based treatment options based on consent, even saying that coercion and institutionalisation may well amount to torture. This approach is slowly making headways in the medical community as well, as can be seen in the growing body of WHO guidance to states to reduce coercion, establish community-based alternatives, and to integrate mental health into primary care, or a recent position statement of the World Psychiatric Association on the need to reduce coercion. I was glad to see that the European Commission's new disability strategy 2021-2030 also committed itself to issuing guidance to member states on how to de-institutionalise.

This is nothing short of a revolution. It is therefore not surprising that the core human rights instruments of the Council of Europe reflect the attitudes of their times and are somewhat outdated on the issue of mental health and institutionalisation, irrespective of their merits in other areas. It would be a mistake to cling to standards that put the bar lower than the CRPD.

This brings me to a point that I regret to have to make again: it is very unfortunate that work is still continuing in our organisation on a draft Additional Protocol to the Oviedo Convention. This text reflects an outdated, biomedical approach reducing mental health to mental disorders and empowering physicians to forcibly confine and treat persons without consent, with virtually no limit being placed on the duration of this placement or the treatments to be used. I particularly regret the vagueness of the definitions of this draft text and its almost limitless trust in the judgment of a single physician, which appears misplaced given the human rights violations we are still witnessing on a daily basis. The opposition of the Parliamentary Assembly, several UN bodies including the treaty body of the CRPD, the unanimous protests of representative organisations of persons with psychosocial disabilities, and my own opposition to this initiative have been largely dismissed by intergovernmental experts so far.

While such an instrument focusing on safeguards would perhaps have had an added value 20 years ago, today its harm would far outstrip its supposed benefits. Today we know through experience that such safeguards do not work - it would be enough to observe the attitude of judges which invariably only listen to the doctor and not the patient. We know that mental health laws that normalise institutions reinforce the prejudices that perpetuate dehumanisation and ill-treatment. We also know, based on the experience of many member states, that what these laws define as last resort often end up being the first and only one.

I will continue repeating my call on member states to stop such initiatives. If we are unable to nurture the paradigm shift from institutional to community-based care, and from coercive to consent-based care, we should at least do no harm by muddying the waters and creating further confusion and stumbling blocks for our member states, not to mention the very odd message that such a text from the Council of Europe would send in the context of a pandemic.

While I support the project that the DH-BIO started in order to collect good practices, this should not be an afterthought but the main focus. Nevertheless, it shows the growing interest in more human rights- and community-based mental health services at the international level. We will certainly be hearing more of such initiatives in the course of this hearing.

I am looking forward to the outcome of the work of the Parliamentary Assembly on the crucial question of de-institutionalisation, as I believe that our member states cannot truly begin transitioning to a more human rights-based model of mental health care without first making a firm and unambiguous commitment to deinstitutionalise.