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COMMITTEE ON BIOETHICS (DH-BIO)

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 by the Secretariat

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Preamble

1. The Preamble highlights the central issues underlying the work to develop the Additional Protocol. The aim of this Additional Protocol is to specify and to develop the standards of human rights protection applicable to the use of involuntary measures, based, in particular, on the case law of the European Court of Human Rights, in a legally binding instrument.

2. The Preamble emphasises the role of the European Convention on Human Rights in the protection of persons with mental disorders. In the context of the Additional Protocol Article 5 (right to liberty and security) and Article 8 (right to respect for private and family life) of that Convention are of particular importance. Other key civil and political rights of persons with mental disorder include the provisions of Articles 3 (which concerns the prohibition of torture and inhuman or degrading treatment or punishment), 10 (freedom of expression), 12 (right to marry and found a family) and 14 (prohibition of discrimination) of the same Convention, as developed and interpreted by the case-law of the European Court of Human Rights.

3. The preparatory work took into account other international work on the protection of the dignity and rights of persons with mental disorders. The Preamble highlights the United Nations Convention on the Rights of Persons with Disabilities; other United Nations instruments such as the International Covenant on Civil and Political Rights (1966) and the International Covenant on Economic, Social and Cultural Rights (1966) are also relevant.

4. The Additional Protocol complements and extends the provisions of the Convention on Human Rights and Biomedicine. It is therefore not necessary to repeat provisions of that Convention in the Additional Protocol. However, the Preamble recalls specific provisions of the Convention that have particular relevance in the context of the Additional Protocol, such as those concerning consent, professional standards and equitable access to healthcare.

5. The Preamble also recalls Rec (2004)10 of the Committee of Ministers to member states concerning the protection of the human rights and dignity of persons with mental disorder. This Protocol has drawn on that Recommendation and experience of its use. The Recommendation is wider in scope than this Protocol, for example covering detailed aspects of treatment and the criminal justice context, and therefore it will continue to have uses in protecting the human rights and dignity of persons with mental disorder after this Protocol comes into force.

6. The Preamble also acknowledges that preparation of the Protocol has drawn on the work of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), and the standards developed by that Committee to protect those deprived of their liberty in psychiatric facilities.

7. The particular importance of ensuring both adequate initial qualification and continuous training of all staff working with persons with mental disorder, as highlighted by the CPT, is also reflected in this Preamble.

8. The Preamble emphasises the need for persons to be supported in order to exercise their autonomy. This is in line with the overall goal of the Council of Europe Disability Strategy 2017–2023 to achieve equality, dignity and equal opportunities for persons with disabilities through ensuring independence and freedom of choice. Although the principle of autonomy is relevant to consent to healthcare interventions, it is a far wider principle that also has relevance to the choices people make in their day to day life.

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9. The Preamble reaffirms the principle of free and informed consent to healthcare interventions. This is particularly important in the context of the use of involuntary measures, which shall always be a last resort. The Preamble emphasises that involuntary treatment used on a person whose ability to decide on treatment is severely impaired must aim at enabling that person to regain such ability or, in case the person's ability to decide was already impaired before involuntary measures had to be envisaged (for example as a result of a previous head injury, or a serious learning disability), to return that person to their previous level of functioning. Furthermore, even if a person is subject to an involuntary measure, attempts shall continue to be made to seek their consent to all aspects of their therapeutic programme.

10. The Preamble recalls that the existence of a mental disorder in itself shall in no case justify an involuntary measure. A mental disorder, as referred to in the Convention on Human Rights and Biomedicine and in this Additional Protocol, can lead to a mental health condition which may seriously impair a person's ability to take a decision.

11. The Preamble recognises that the use of involuntary placement and treatment has the potential to endanger human dignity and fundamental rights and freedoms and said measures must therefore only be used as a last resort. In order to minimise the use of involuntary measures, the primary importance of developing alternatives to such measures, and systematically using such alternatives, is emphasised.

12. As the Convention system is intended "to guarantee not rights that are theoretical or illusory but rights that are practical and effective[1]" the preamble stresses the importance of enabling persons concerned by involuntary measures effectively to exercise their rights.

13. The Preamble finally emphasises the importance of monitoring the use of involuntary measures. People who have experienced mental health problems can make an important contribution to improvements in the quality of health services and to monitoring processes. Advocacy services can also contribute to such improvements.

Chapter I – Object and scope

Article 1 – Object

14. The first paragraph sets out the aim of the Additional Protocol, which is to protect the dignity, identity and other rights and fundamental freedoms of persons with mental disorder with regard to the use of involuntary placement or involuntary treatment, wherever such treatment is administered. The term "involuntary measures" used in the Additional Protocol and in this Explanatory Report covers the use of involuntary placement, involuntary treatment or both. The Protocol achieves its object in three ways. Firstly, by promoting the use of alternatives to involuntary measures. Secondly, by providing safeguards to ensure that involuntary measures are only used as a last resort, and thirdly, by ensuring that if such measures are used then the person concerned receives appropriate protection and procedural safeguards that enable them to effectively exercise their rights.

15. The first paragraph emphasises that this protection shall take place without discrimination. As the Preamble underlines, the existence of a mental disorder, in itself, shall in no case justify the use of involuntary measures.

16. In line with Article 27 of the Convention on Human Rights and Biomedicine, the second paragraph makes clear that States may provide more extensive protection 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

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[1] Artico v. Italy, judgment of 13 may 1980, application number 6694/74, para. 33

the ability to make a decision on placement, but may 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 (see paragraph 22 below), 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. If after having been placed the person indicates objection to the placement then the relevant provisions of the Additional Protocol must be applied.

Article 2 – Scope and definitions

17. The first paragraph of the Article specifies that the Additional Protocol applies to involuntary placement and to involuntary treatment of persons with mental disorder and thus delimits the measures to which the safeguards laid down in the following Chapters apply. It should be noted that this Article does not lay down any criteria under which recourse to involuntary placement and/or involuntary treatment would be considered acceptable. The criteria for the use of such measures are specified in Articles 10 and 11.

18. 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 them. Article 1, paragraph 2 enables a State to choose to apply the provisions of the Additional Protocol to minors.

19. 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. However, such persons may be particularly vulnerable and States should ensure that their human rights (including that of equitable access to health care) and dignity receive appropriate protection.

20. Paragraph 4 of the Article defines certain key terms used in the Additional Protocol. “Mental disorder” is defined in accordance with internationally accepted medical standards. 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. This method of defining mental disorder aims to prevent idiosyncratic approaches to diagnosis. However, the professional classification is very broad and includes many categories for which involuntary measures would never be appropriate, such as gender identity disorders, sleep disorders and sexual dysfunctions. Diagnosis of a mental disorder according to a professional classification is never, of itself, a justification for the use of involuntary measures. It also follows from the case law of the European Court of Human Rights, for example in its judgment 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."[2]

21. When a person comes into contact with mental health services for the first time, it is not always possible or appropriate to make a final diagnosis immediately. If necessary, a provisional diagnosis is made which can then be reviewed in the light of further observation.

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[2] *Winterwerp v The Netherlands, judgment of 24 October 1979, Application number 6301/73*

A provisional diagnosis made in accordance with internationally accepted medical standards is included within the term “mental disorder”.

22. The definition of “involuntary” for the purpose of this Protocol refers to a placement or treatment applied to a person with a mental disorder who objects to the measure, even if that person has a legal representative who is prepared to authorise it. This applies irrespective of the legal capacity of the person as defined by national law.

23. 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. Similarly, if a person has been admitted to a facility on a voluntary basis and later on wishes to leave but is not allowed to, the person should receive the protections applicable to involuntary placement.

24. The reference to “objects” in the definition emphasises that it is the person’s current attitude to the measure that is to 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. The reference to “placement or treatment” makes clear that the person’s attitudes 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.

25. 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.

26. The definition of “involuntary measure” in the Additional Protocol covers the use of involuntary placement, involuntary treatment or both.

27. “Placement” refers to the action of being placed in a specific facility for a particular purpose or purposes. The term “facility” should be understood in a broad sense, and includes, for example, psychiatric units in general hospitals as well as psychiatric hospitals of all types and of all levels of security. Article 10, paragraph ii requires a placement to have a therapeutic purpose, but it may also have additional purposes (such as the protection of others).

28. The definitions of “treatment” and “therapeutic purpose” are applicable wherever the intervention is delivered and whether or not the person is also subject to an involuntary placement. “Treatment” refers to physical and psychological interventions in relation to the person’s mental disorder. Pharmacological interventions are an example of physical interventions**.** Health problems unrelated to the mental disorder should be treated in accordance with Articles 5 and 6 of the Convention on Human Rights and Biomedicine, with the exception of medically necessary interventions in emergency situations governed by Article 8 of that Convention.

29. The definition of “therapeutic purpose” sets out appropriate aims of treatment. The term “controlling symptoms” covers a wide range of interventions. For example, this would cover interventions aimed at maintaining and facilitating autonomy as far as possible. It would also include the treatment of an acute episode of mania or depression so that the person is returned to a normal level of functioning even if they remain at risk of relapse in the future. Some mental disorders are not curable at the present time. However, in some cases

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it may be possible to slow down the rate of deterioration. “Rehabilitation” refers to interventions that aim to limit the impact of deficits in functioning as a result of chronic psychotic disorders on a person’s life.

30. The definitions of “seclusion” and “restraint” are based on the work of the CPT. For the purposes of the Additional Protocol, whether or not the door to the room in which a patient is secluded is locked is not relevant; the definition makes clear that what matters is that the person is kept alone, against his or her will, in an area which the person cannot leave. The term “restraint” covers various measures aimed at immobilising a patient, such as manual control (i.e. holding of a patient by using physical force), mechanical restraint (i.e. application of instruments of restraint) and chemical restraint (i.e. involuntary administration of medication for the purpose of controlling a patient’s behaviour).

31. A “representative” is a person provided for by law or appointed through a legal process. In accordance with the general principle set out in Article 6 (3) of the Convention on Human Rights and Biomedicine, when a person, according to law, 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.

32. Different states may have different names for the person fulfilling the role of a “person of trust”. 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. Unlike the representative, a person of trust cannot take decisions on behalf of the person concerned, but can support and assist that person to make decisions him or herself.

33. The characteristics of a “court” must be interpreted in line with the case law of the European Court of Human Rights. This means that it 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 relevant dispute and hence give a binding decision on the matter before it;
c. is accessible to the individual concerned.

34. 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. 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 physicians supervising the treatment. References to a physician in the Additional Protocol and in this Report mean a person with a medical qualification.

Chapter II – Alternative measures

Article 3 – Alternative measures

35. Under this Article States undertake to ensure that alternatives to involuntary placement and involuntary treatment are developed and used. The use of involuntary measures may be perceived as very traumatic by the person concerned, and this trauma may exacerbate their mental health condition and make their recovery more complex and difficult. As emphasised in the Preamble, involuntary measures must only be used as a last resort.

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36. The provision of home treatment and crisis intervention services and the promotion of advance directives can prevent the need for involuntary placement during an acute episode of illness. Given that many serious mental disorders are recurrent, minimising the risk of relapse, for example by addressing a person's need for appropriate housing and social support as well as their healthcare needs, also contributes to the minimisation of the use of involuntary measures and are covered by this Article.

Chapter III – General Provisions

Article 4 – Legality

37. 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[3] emphasises, the law must provide adequate safeguards against arbitrary application of a measure, or of its continuation.

Article 5 – Proportionality and necessity

38. In legal terms, necessity is included within the concept of proportionality. However, the term is included within the Additional Protocol to emphasise that the use of involuntary measures must be a last resort.

39. The principle of least restriction is a fundamental principle that has been recognised internationally in the context of mental health care for many years. It is derived from the principle of proportionality and its importance in mental health care is such that it is set out in the second sentence of this Article. It implies that when several appropriate options are possible that could contain the risk posed by a person's mental health condition, or that may provide effective treatment for the person, the least restrictive and/or intrusive should be used first; for example treatment as an outpatient rather than an inpatient. With respect to involuntary placement this means that other measures and modalities less severe than deprivation of liberty must have been considered and deemed insufficient with regard to the risk entailed.

40. Although availability of services may vary between States, Article 3 of the Convention on Human Rights and Biomedicine requires that measures shall be taken to ensure patients equitable access to health care of appropriate quality. Such health care includes access to alternatives to involuntary measures covered by Article 3 of this Additional Protocol, which emphasises that such alternatives should be used before involuntary measures. The principles of proportionality and necessity have important implications for the use of seclusion and restraint in mental health care. This is developed further in Article 17 of the Additional Protocol (see paragraph 106 below).

Article 6 – Person of trust

41. Any person with mental disorder shall have the right to choose a person of trust. This implies that it would not be appropriate for another person, including the representative, to select a person to fulfil this role. However, this does not exclude that domestic law provides for the person of trust being formally appointed by a competent body, as long as the right of the person to choose is respected.

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[3] Application No. 34806/4

42. The person of trust has to be someone the individual concerned trusts to assist and support him or her, for example in his or her interactions with professionals, or by bearing witness to the person's wishes regarding placement or treatment when the person is not able to do so him or herself. 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.

43. Most people with mental disorder will never be subject to involuntary measures, but for those who are or who may be (for example a person who is being examined because the question of the need for an involuntary measure has been raised), having a person of trust may provide invaluable support at a very stressful time. Thus, a person who has been recently diagnosed with a mental disorder might wish to choose a person of trust, in case the support of such a person is subsequently needed.

44. A valid choice of a person of trust (i.e. one where the nominated person has agreed to act in the role) 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 help to ensure the person is able to access support promptly in the future.

45. If a person is unable to find a person of trust him or herself, attempts should be made to put the person in contact with those who might be able to assist him or her in this way (for example, a person from a voluntary body or another organisation that is functionally independent from the psychiatric facility or service provider).

46. 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 involved in the decision-making procedures and with care and treatment should be alert to such conflicts and national law should provide appropriate means to address such conflicts. In rare cases the question of restrictions to communication with the person of trust may arise and this is discussed in paragraph 125 below.

Article 7 – Legal assistance

47. The European Court of Human Rights has emphasised the need for persons to be able to defend their rights effectively in court proceedings.[4] In the case of *Nenov v Bulgaria*[5], the absence of legal aid for a person with mental disorder prevented him from acting effectively in proceedings concerning his interests, which meant that the proceedings were not fair.

48. The first paragraph of this Article makes clear that the person concerned shall have the right to benefit effectively from legal assistance. This requires that those providing legal assistance must have sufficient qualifications and experience to fulfil the role. If they are not recognised as lawyers according to the national legal system, they should be subject to the same duties to the person concerned and to the court as a lawyer. The right of communicating with the person providing legal assistance, which is a prerequisite of effective legal assistance, is provided in Article 19 (1). Interpreters and other communication aids may be needed to ensure that the person can participate fully in the consultation with those providing legal assistance.

49. The second paragraph foresees that in procedures for taking decisions on involuntary measures, as well as in appeal and review proceedings, legal assistance has to

[4] See, for example, *Megyeri v Germany, judgment of 12 May 1992, Application number 13770/88, para. 22 and Winterwerp v. the Netherlands judgment of 24 October 1979, para. 60*
[5] *Judgment of 16 October 2009, Application number 33738/02*

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be provided free of charge. It is important that persons are not deprived of their rights to legal assistance in these proceedings on grounds of inability to pay; however, the second paragraph leaves it to national law to determine how legal assistance should be funded. Thus, this paragraph does not exclude persons having to pay for legal assistance if they have the financial resources to do so.

50. 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 has the right to obtain legal assistance, this Article does not provide a right to have any proceedings to subject a person to an involuntary measure delayed in order that the person concerned can obtain such assistance. That might involve unacceptable risk to the person or to others. In contrast, appeals and reviews of involuntary measures take place in a planned manner and therefore it shall always be made possible to obtain legal assistance, should the person so wish.

Article 8 – Professional standards

51. 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. Article 11 of Rec (2004) 10 *concerning the protection of the human rights and dignity of persons suffering from mental disorder* sets 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, including continuing professional development, to enable them to fulfil their role. It is important that sufficient staff resources in terms of numbers, categories of staff, and experience and training, are allocated to enable the requirements of this Article to be fulfilled.

52. In paragraphs 42 to 46 of its 8th General Report (document CPT/Inf (98)12), the CPT emphasises the importance of establishing a therapeutic relationship between health-care staff and patients. The different categories of staff working in a psychiatric unit (such as psychiatrists, general practitioners, nurses, psychologists and social workers) should form a team under the authority of a senior doctor and meet regularly, in order to allow day-to-day problems to be identified and discussed and guidance to be given. 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.

53. The principle of equitable access to health care recalled in the Preamble is relevant to the physical health care needs of persons with mental disorder. Such needs should receive appropriate attention, including the use of relevant health screening. A person subject to involuntary placement should always be offered an appropriate physical examination and adequate follow-up, where necessary.

Article 9 – Appropriate environment

54. 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 and patients must always be treated with respect and dignity.

55. A range of facilities are necessary in order that persons can be placed in an environment which is appropriate to their health needs and the need to protect the safety of others according to their progress during their treatment. 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

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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.

56. Particular attention should be paid to paragraphs 34 to 36 of the CPT's 8th General Report (document CPT/Inf (98)12), in which the Committee indicates a number of criteria which should be met to create a positive therapeutic environment for persons placed on an involuntary basis in a psychiatric facility. 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.

57. According to Article 23 paragraph 2, facilities designed for the involuntary placement of persons with mental disorder shall 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.

58. As laid down in Article 8 of the Additional Protocol, any treatment shall be delivered in accordance with professional obligations and standards. This is particularly important if it is delivered outside a medical facility, for example in a nursing home or in the patient's own home. Any necessary medical monitoring or other support required for the administration of the treatment must be available. An appropriate environment in which to deliver treatment is one in which the treatment can be delivered in a way that is safe for the recipient, for the person delivering the treatment, and for any other persons in the vicinity. Administration of involuntary treatment to a person who actively resists it is not recommended outside a medical facility.

59. The principle of equitable access to services recalled in the Preamble means that consideration has to be given to the accessibility of services providing involuntary placement or treatment to those with physical disabilities.

Chapter IV – Criteria for involuntary placement and for involuntary treatment

60. The Preamble emphasises that the existence of a mental disorder in itself shall in no case justify an involuntary measure and that involuntary measures must only be used as a last resort. In line with this, the provisions of this Chapter lay down the criteria to ensure that involuntary measures are only used in a manner that is proportionate and necessary in relation to the risk posed by a person's mental health condition.

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61. As involuntary measures must only be used as a last resort, efforts must be made to address an identified risk by less intrusive means (such as recourse to alternative measures as set out in Article 3), before implementing involuntary measures. The principle of least restriction set out in Article 5 implies that use of involuntary measures shall be minimised as far as possible. Similarly, even if an involuntary measure has been applied, continuing efforts should be made to apply the measure on a voluntary basis. Persons subject to involuntary measures should be reviewed frequently to check that their legal status remains justified and that they are benefitting from an appropriate therapeutic programme.

Article 10 – Criteria for involuntary placement

62. This Article stipulates that a person with a mental disorder may be subject to involuntary placement only under certain criteria: the person's mental health condition represents a significant risk of serious harm to himself/herself or to a third party, the placement has a therapeutic purpose, and no voluntary measures are sufficient to address the risk. Involuntary placement is in general only considered relevant with regard to conditions arising from certain types of severe mental disorder, for example psychoses.

63. Indent i. 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 is not possible. Structured clinical assessment methods for assessing risk may help.

64. Risk of serious harm may arise in various ways. There may be direct risk of physical harm to others or to the person him or herself (for example a risk that the person intends to end their life). The person may behave in a way that poses a significant risk of serious physical harm to others (for example, because of their seriously uncontrolled behaviour and apparent lack of awareness of the potential impact of this on others). A person who repeatedly threatens or stalks another person can pose a serious risk to that person's mental health. Other actions may present indirect risks of serious harm to persons, such as setting fires. In some States, these examples would be covered by a provision concerning public safety or public order. Nevertheless, the underlying principle is that of risk to persons and hence such risks are covered by indent i.b.

65. The concept of health has to 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 a mental health condition 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.

66. Indent i. makes a distinction between those who only pose risks to themselves (a) and those who present risk to others (b), 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 condition. 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.

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67. If a person's ability to decide is not severely impaired, and the risk is to the person alone, there is no justification for restricting their rights to autonomy. 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 right 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 if this is necessary in a democratic society and the exception is set out in national law.

68. Factors other than a mental health condition can also impair an individual's ability to decide, or to express a decision: these include communication difficulties, physical health problems, and the effects of medication, fear and exhaustion. Those conducting assessments should be aware of such issues and ensure that they are minimised to the extent possible.

69. Indent ii. requires that a placement has a therapeutic purpose. Provisions concerning involuntary placement of persons with mental disorder shall not be used solely to ensure a person is confined in a safe setting. The existence of a therapeutic purpose does not require that complete cure is envisaged as this may not be possible. As specified in the definitions in Article 2, therapeutic purpose includes controlling symptoms of the disorder and rehabilitation.

70. Further, a "therapeutic purpose" should not be equated with invasive medical treatment. In paragraph 37 of its 8th General Report (document CPT/Inf (98)12), the CPT highlights that, in the context of involuntary placement, psychiatric treatment should always be based on an individualised approach. In addition to pharmacotherapy, individual treatment plans should contain a wide range of rehabilitative and therapeutic activities (such as occupational therapy, group therapy, individual psychotherapy). 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.

71. Indent iii. derives from the principles of proportionality and least restriction spelled out in Article 5 of this Additional Protocol. The reasons why voluntary measures are insufficient to address the risk of serious harm to the person's own health or to others should be recorded in a manner that enables the use of involuntary measures to be monitored, having particular regard to Parties' responsibility under Article 3 of this Additional Protocol to ensure the development and use of alternatives to involuntary placement and treatment. The importance of monitoring is emphasised in Article 23 of this Additional Protocol.

Article 11 – Criteria for involuntary treatment

72. This Article parallels Article 10 and paragraphs 63 - 71 above are therefore also relevant to this Article.

Chapter V – Procedures concerning involuntary placement and involuntary treatment

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

73. 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. Considering both types of measure at the same time is, however, 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

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legal bases are required and the possibility of appeal shall be provided regarding each measure individually.

74. Paragraph 1 requires the person concerned to be examined by at least one physician in accordance with applicable professional obligations and standards. The provision reflects the case law of the European Court of Human Rights, which requires any decision on involuntary placement to be based on objective medical expertise. The physician(s) shall have the necessary competencies (for example, expertise in assessing risk to the person concerned or to others if an involuntary measure is not used) and experience to perform the task. The European Court of Human Rights generally considers that national authorities are best placed to assess what qualifications the medical expertise requires. However, it has stressed that, in certain cases, and particularly where the person subject to the involuntary measure did not have a history of mental disorder, it is essential that the evaluation be conducted by a psychiatric expert[6]. In some cases, for example where a person has a developmental disorder and is also thought to have developed a mental illness, a multidisciplinary assessment may be appropriate. The task has to be approached objectively. Thus, it is not appropriate for physicians who are closely related to the patient to undertake this examination. The provision does not exclude the relevant physician(s) receiving information from other health care professionals who have personally examined the patient. In addition, the evaluation shall be sufficiently recent to allow the competent authorities to assess the clinical condition of the person concerned at the time when the lawfulness of the placement is examined. For example, the European Court of Human Rights considered that a psychiatric report dating back one and a half years was not sufficient in itself to justify deprivation of liberty[7].

75. As a matter of professional obligations and standards, the physician should consider the person's opinion concerning the use of placement or treatment. 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. Considering whether the person's assessment of the situation is realistic is also helpful in assessing the extent to which, if at all, the person's ability to decide on placement is impaired. Because many serious mental disorders are recurrent, when the person's mental health condition allows it, it may be possible to discuss their preferences for placement and treatment in the event of a future relapse. Paragraph 2 indent iv. clarifies that such wishes shall be taken into account as well as any current views of the person concerned.

76. Similarly, the person's opinion on the different therapeutic alternatives in respect of treatment is important in finding an optimal balance between respecting self-determination and the duty to protect the person and/or others. This does not imply that the patient's opinion must always be followed.

77. Paragraph 2 requires the decision on placement or treatment to be taken by a court or another competent body. (For the definition of the latter terms see Article 2 paragraph 4 of this Additional Protocol and paragraphs 33 and 34 above.) The underlying principle is that the decision is taken by a body that is independent of the person or body proposing the measure. The body that takes the decision shall act on the basis of the medical examination (i) and shall be satisfied that the criteria in Articles 10 and/or 11, respectively, are met (ii). A decision taken by a court or competent body that the person should be subject to involuntary treatment does not mean the court or other competent body has to approve, for example, each dose of medication to be given.

78. Paragraph 2 indent iii) emphasises that the court or competent body shall act in accordance with procedures provided by law. These must comply with the guarantees of the

[6] Kadusic v. Switzerland, no. 43977/13, § 43, judgment of 9 January 2018
[7] Herz v Germany. 44672/98, § 50, judgment of 12 June 2003

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European Convention on Human Rights and shall be based on the principle that the person concerned shall be heard in person**.** Where necessary, an interpreter or other communication aids shall be provided to ensure that the person can communicate as effectively as possible. Some persons may struggle to express themselves orally, for example some persons suffering from learning difficulties. They have the same right as others to be engaged as fully as possible in decisions and therefore extra time, support and a range of communication media may be needed to establish their views and preferences as accurately as possible in the context of the use of involuntary measures. In some circumstances, the person's condition would not permit any communication or interaction, but this is subject to thorough assessment. Consultation of the person concerned enables the court or other competent body to form an independent view of the situation. This contact 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.

79. The person concerned shall be entitled, in principle, to be supported by his or her person of trust during the consultation. Reasonable efforts should be made to contact the person of trust. However, if the person of trust is not contactable or not available, the procedure can lawfully proceed in his or her absence.

80. Indent iv) lays down that the opinion of the person concerned shall be taken into account, and any previously expressed wishes made by that person. 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.

81. The intention of paragraph 2, indent v) is that if it is known that the person concerned has a representative, 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.

82. Paragraph 3 of this Article provides, if permitted by national law, an alternative means of taking a decision on the use of involuntary treatment for persons who are subject to involuntary placement. In that case, the physician responsible for the care of a person subject to involuntary placement together with at least one other physician who is not involved in the person's care may be entitled under domestic law to take the decision. This second physician must also examine the patient and take into account his or her opinion. The requirement for at least two physicians to participate in the decision is intended to provide an additional safeguard. This means that each physician must be able to make an independent decision without undue influence by the other. Physicians who are related to each other or in a dependent relationship (for example, where one of the physicians is the academic supervisor of the other) would not have a sufficient degree of independence to provide this safeguard. The physicians shall act in accordance with the requirements laid out in paragraph 2, indents ii) to v) (see paragraphs 77 to 81 above).

83. Paragraph 4 provides that a decision to subject a person to an involuntary placement shall specify the period of its validity and shall be documented. This time limit shall comply with the maximum period of validity laid down in national law, as provided in paragraph 5. Thus, open-ended or unlimited placements would never be lawful. In addition, Article 19 paragraph 2 foresees that the person concerned, any representative and any person providing them with legal assistance, and, subject to national law, the person of trust, shall be informed regularly and appropriately of the reasons for the measure and of its potential extension or termination.

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84. Although a decision will have a maximum duration, this does not mean that the involuntary measure will last that long in practice. Paragraph 5 requires the law to lay down arrangements for periodic review. Article 15 regulates the termination of involuntary measures and makes clear that the person shall be regularly examined in order to ensure that the criteria for the application of the relevant measure or measures are still satisfied.

Article 13 – Procedures for taking decisions in emergency situations

85. 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 appropriate examination from a physician with the qualifications laid down in Article 12 paragraph 1. In these situations, paragraph 1 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 placement[8].

86. 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 physician. This combination of expertise would meet the requirement for a medical examination in these circumstances.

87. 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.[9]

88. Paragraph 2 requires that the maximum period for which an emergency measure may be applied is specified by the national law. Time-limits of 72 hours provided in some national laws may be considered as good practice.

89. Paragraph 3 emphasises that the duration of an emergency measure shall be as short as possible. Determining when the emergency situation has ended may be difficult and should be done by the physician responsible for the patient's care in accordance with professional obligations and standards. Paragraph 3 provides that the measure may be continued if the procedures set out in Article 12 have been initiated. In order to keep the duration of an emergency measure as short as possible, steps should be taken to initiate those procedures without delay, once the emergency measure is in force. In order to avoid undue prolongation of the emergency measure, the procedure under Article 12 should be completed promptly.

90. As noted in paragraph 85 above, the person may have not been seen by a physician with the appropriate qualifications as referred to in Article 12 paragraph 1 prior to the use of the emergency measure. Once the measure is in force the person must receive a specialist assessment as soon as possible.

91. As specified by Article 15 paragraph 1, if any of the criteria for a measure are no longer met the measure shall be terminated. It is thus possible for a measure to be terminated before the court or another competent body could have taken a decision in accordance with Article 12.

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[8] *X v United Kingdom, judgment of 5 November 1981, Application number 00007215/75*
[9] *Summarised in MH v United Kingdom, judgment of 22 October 2013, Application number 11577/06*

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

640 **Article 14 – Extension of involuntary measures**

641 93. When a decision is made according to Article 12 to subject a person to involuntary
642 placement and/or involuntary treatment, this will be for a defined period. In many cases, the
643 person's mental health will improve during that period and the measure will be terminated. In
644 other cases as the period of the measure comes towards its end it may be evident that the
645 measure cannot be safely terminated.

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

650 **Article 15 – Termination of involuntary measures**

651 95. The case law of the European Court of Human Rights makes clear that involuntary
652 placement must cease as soon as it is no longer required by the patient's mental health
653 condition[10]. This Article follows that principle, which has also been emphasised by the CPT.
654 Thus, it is important that the patient's mental condition is assessed frequently, particularly
655 during times when it is changing rapidly.

656 96. The term "responsible authority" is defined in Article 2 § 4, last indent (see paragraph
657 34 above). Under Article 15 paragraph 3, this authority shall ensure that there are
658 procedures in place to guarantee that the conformity of involuntary measures with the legal
659 requirements are reviewed regularly, independently of a request by the person concerned, at
660 a frequency reasonable in relation to the potential for changes to a person's mental condition
661 that would have implications for the fulfilment of the criteria for the relevant involuntary
662 measure. Such review is particularly important in protecting the rights of patients who may
663 not be able to act for themselves and to ensure they are not disadvantaged if they do not, for
664 example, have a representative who could prompt a review by the court.

665 97. It is important that the person, with the support of his/her person of trust, if any,
666 participates as fully as possible in the process. In the context of people with communication
667 problems, approaches to maximising the person's participation might include:

668 - Establishing a time of day when the person functions best and approaching them at
669 that time;

670 - establishing the environment in which the person functions best and approaching
671 them in that environment;

672 - establishing the people with whom the person communicates best and involving them
673 in the communication process.

674 **Article 16 – Appeals and reviews concerning the lawfulness of involuntary measures**

675 98. An appeal is a challenge against the decision to apply a measure. A review is an
676 examination of the continuing legality of the measure, for example on the grounds that the
677 applicant's mental condition has improved. For persons to be able to exercise their right to
678 reviews and appeals, they must first understand that they have such rights. The right to

[10] *Winterwerp v The Netherlands, judgment of 24 October 1979, Application number 6301/73*

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information (Article 19) is therefore fundamental in enabling a person to exercise his or her rights under Article 16.

99. The case law of the European Court of Human Rights makes clear that a person has the right to appeal against decisions concerning involuntary placement or involuntary treatment (or, if applicable, both) and to have involuntary measures reviewed at reasonable intervals[11]. It also makes clear that appeal and review procedures must be undertaken by a specialist body that has the characteristics of a court (see paragraph 33 above), and is able to decide on the lawfulness of the measure and order its termination if necessary[12].

100. The person has the right of access to the court at reasonable intervals. The European Court of Human Rights has recognised that States may need to place restrictions on access to court in terms of frequency of review to ensure that courts are not over-burdened with "excessive and manifestly ill-founded applications"[13]. 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 time passed since the last review. 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 review application 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.

101. It is good practice to inform the physician responsible for the person's care of the relevant proceedings (i.e. the holding of the review or appeal) and of the physician's right to participate in them.

102. The court must, 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.

103. The person shall always be entitled to be supported by his or her person of trust (if he or she has one). Although the case law of the European Court of Human Rights emphasises the importance of the individual's right to be heard in person, it also acknowledges that if necessary the person may be heard through his or her representative. This might occur, for example, if the person's mental state was too disturbed to be able to participate in proceedings.

104. Paragraph 3 follows the general principle that the person concerned and any person providing legal assistance in the court proceedings shall have access to all materials before the court. By way of exception, paragraph 3 refers to the possibility that national law may provide that certain information be withheld on grounds of the confidentiality and safety of others. In particular, this is designed to ensure that those close to the person concerned can give information to the clinical team about the person's condition (for example after 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 he/she is not as well (and hence not as suitable for discharge) as he or she would like to appear.

105. The individual concerned continues to have the right to respect for private life with respect to his or her health information, as set out in Article 10 of the Convention on Human Rights and Biomedicine. Therefore the person can decide to what extent his or her health information is shared with his/her person of trust. This is reflected in Article 16 paragraph 3,

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[11] *Stanev v Bulgaria, judgment of 17 January 2012, Application number 36760/06*
[12] *Winterwerp v The Netherlands, judgment of 24 October 1979, Application number 00006301/73*
[13] *Stanev v Bulgaria, judgment of 17 January 2012, Application number 36760/06 at paragraph 242*

where a distinction is made between the extent to which materials before a court (which will include personal health information) shall be shared with the person's representative and the person providing legal assistance on the one hand, and with their person of trust on the other.

Chapter VI – Specific situations

Article 17 – Seclusion and restraint

106. This Article is based on the relevant standards of the CPT (set out in document CPT/Inf (2017) 6). The terms "seclusion" and "restraint" are defined in Article 2 paragraph 4 of this Additional Protocol (see paragraph 30 above). Seclusion and restraint may only be used if necessary and proportionate in order to prevent serious imminent harm to the person concerned or to others. Seclusion and restraint must never be used as a punishment, for the mere convenience of staff, because of staff shortages or to replace proper care or treatment. The CPT emphasises the importance of training of staff, for example in de-escalation techniques, in order to minimise the use of seclusion and restraint.

107. Seclusion and restraint shall only take place in an appropriate environment, which is one in which the intervention can take place in a manner that is safe for the person concerned, for the staff carrying out the intervention and for others in the immediate vicinity. As it is not possible to monitor someone in seclusion at home, the situation is not safe for the person concerned and therefore such an intervention is prohibited.

108. Paragraph 2 is based on the CPT Standards, which prescribe that every instance of seclusion and restraint (including chemical restraint) is recorded in the patient's medical file as well as specifically registered. This can also be done in the form of a data bank from which all pertinent information of the medical files can be extracted. Such records fall within the scope of Article 21 of the Additional Protocol. The person concerned will have rights to access this information according to Article 10 of the Convention on Human Rights and Biomedicine. The entry shall include the nature of the resort to seclusion or restraint, the times when it began and ended, the circumstances of the case, the reasons for resorting to the seclusion or restraint, the name of the physician who ordered or approved it, and an account of any injuries sustained by patients or staff.

109. The CPT emphasises the importance of such registers as they enable the responsible authority to have an oversight of the extent of the use of seclusion and restraint and, where appropriate, to take measures to reduce their incidence. Each State shall ensure that the responsibility for establishing and maintaining the register is clear. In practice, it is likely that such registers will be held in the relevant facilities. The register will contain sensitive personal data and as noted in paragraph 127 below must be protected accordingly. Information on the use of seclusion and restraint within an institution is also important as part of the monitoring process required by Article 23. Sensitive personal data must be appropriately protected in such a process.

110. Seclusion and restraint may pose particular risks to patients, and thus patients subject to their use shall receive continuous monitoring. These procedures should only be used in an appropriate environment (see paragraph 107 above). Seclusion can cause disorientation and anxiety. Restraint must be applied with skill and care in order not to endanger the health of the patient or cause pain. It is particularly important that vital functions such as respiration and communication are not hampered. Video surveillance cannot replace continuous staff presence. In the case of seclusion, the staff member may be outside the room, provided that the patient can fully see the staff member and the latter can continuously observe and hear the patient. Continuous monitoring also ensures that the

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measure can be used for the minimum necessary time only, as required by paragraph 1 of this Article.

111. The CPT emphasises that every psychiatric facility should have a comprehensive restraint policy, which should cover staff training. Staff conducting monitoring according to paragraph 3 should fully understand the policy and have received appropriate training in ethically acceptable use of restraint and seclusion, including recognition of signs that the process is having detrimental effects on the patient and the need for prompt and appropriate action to address this.

112. The use of seclusion or restraint is not subject to the provisions of Article 16, which concerns appeals and reviews of the lawfulness of involuntary placement or involuntary treatment. However, paragraph 4 of this Article makes clear that any use of seclusion or restraint may be subject to the complaints procedures set out in Article 22. Under the principle of wider protection as laid down in Article 1 paragraph 2 of this Additional Protocol, Parties may also chose to make use of seclusion and restraint subject to appeal to a court.

113. Access to appropriate support, for example from the person of trust, may be particularly important when a person has been subject to seclusion or restraint and their right to communication under Article 20 of this Additional Protocol may be particularly important in this context. Such support may also help the person to use the complaints system effectively. Accordingly, Article 19 paragraph 3 foresees that the person providing legal assistance, the representative and the person of trust shall be informed promptly of any use of seclusion and restraint.

114. The use of seclusion or restraint on persons with mental health problems who are not subject to involuntary measures, for example persons who committed themselves voluntarily to a facility, would not fall within the scope of this Additional Protocol as laid down in its Article 2 paragraph 1. If such measures are considered as a matter of necessity, then consideration should be given to protecting the person's human rights by the formal use of an involuntary measure which would bring that person within the scope of this Additional Protocol. Under the principle of wider protection (compare Article 1 paragraph 2), a State could also choose to apply the provisions of Article 17 to uses of seclusion and restraint on persons who do not fall within the scope of this Protocol.

Article 18 –Treatment with the aim of producing irreversible effects

115. Article 18 addresses recourse to treatment that aims to produce irreversible physical effects. An example of such a treatment is a psychosurgical operation aimed at producing a small lesion at a specific site in the brain. Such treatments shall only be undertaken with the informed consent of the person concerned. The difficulty of ensuring that consent is truly voluntary when a person is subject to involuntary measures means that it is ruled out to use such treatments in the context of involuntary placement and/or treatment.

116. This Article does not cover treatments that may, as an unintended side-effect, have irreversible physical effects. For example, certain drugs used to treat psychosis may produce the potentially irreversible condition tardive dyskinesia in a proportion of patients after long-term use. However, these effects are not the aim of administering the drug.

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812 **Chapter VII – Information and communication**

813 **Article 19 – Right to information**

814 117. When a person is either placed or treated for mental disorder on an involuntary basis,
815 he or she shall be informed of his or her rights in a way that enables him or her to, as far as
816 possible, understand and use that information.

817 118. When a person is subject to an involuntary measure it is good practice to give
818 him/her information about their rights both verbally and in written form. It is important that
819 any language barriers are addressed, for example by providing interpretation in the person's
820 native language. However, written information should not be regarded as a substitute for
821 information given face-to-face, but as a supplement to such information. Written information
822 should be in accessible formats, including easy to read text, where needed. This information
823 must include information on their rights to reviews and to appeal against the measure
824 concerned according to Article 16 of this Additional Protocol. Some patients may be illiterate
825 and it is important to ensure that they are not disadvantaged in exercising their rights for this
826 reason. In accordance with the case law of the European Court on Human Rights, a person
827 subject to involuntary placement shall also be promptly informed about the reasons for the
828 involuntary placement[14].

829 119. At the time the person is subjected to an involuntary measure their mental health
830 condition may make it difficult for them to understand information about their rights. The
831 person should be provided with as much information as their mental health condition
832 permits, and the information may need to be repeated (perhaps more than once) as the
833 person's mental health condition improves. Similarly, people with memory problems may
834 need to receive written information to remind them of what has been said, and prompts to
835 periodically reconsider the information if appropriate. It is important that the person
836 understands their rights in respect of involuntary measures as soon as possible, and the
837 person of trust may be able to help them to do this.

838 120. Paragraph 2 acknowledges that, in addition to the person concerned, any person
839 providing legal assistance and representative require information about the reasons for the
840 decision in order to be able to, where appropriate, challenge it effectively. The information
841 may also be given to the person's person of trust, if any, depending on whether and in what
842 manner national law permits this. Because information on the reasons for a decision will
843 include personal health information, as discussed in paragraph 105 above, such information
844 sharing must take into account the right to private life of the person concerned. The person
845 may choose to share the information with his or her person of trust.

846 121. As discussed in paragraph 113 above, persons subject to seclusion or restraint may
847 be in particular need of support; to address this, paragraph 3 introduces a specific obligation
848 to inform promptly the person providing legal assistance, the representative and the person
849 of trust about any use of seclusion or restraint.

850 **Article 20 – Right to communication**

851 122. Communication is a broad term. It covers written expression, such as writing or
852 receiving a letter or an email; verbal expression, such as talking on a telephone, and
853 communication face to face with another individual. Restrictions on communication may
854 therefore be partial, for example where a person is able to use the facility's telephone, which
855 may or may not be monitored, but not able to use their own mobile phone; or is able to meet

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

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with people from outside the facility, but only in the presence of a member of the facility's staff.

123. The 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. Communication is important in ensuring that the persons can maintain, if possible, social and family ties that are important to them.

124. It is not envisaged that it would ever be appropriate to restrict communication with the persons or bodies listed in paragraph 1. Official bodies include those charged with monitoring compliance with the provisions of this Additional Protocol according to Article 22 and international bodies such as the European Court of Human Rights, the CPT, the United Nations Subcommittee on Prevention of Torture and National Preventive Mechanisms established under the Optional Protocol to the United Nations Convention against Torture.

125. The right to communicate with other persons or bodies may only be restricted to the extent that is necessary to protect the health and personal security of the person concerned or of others. An example would be clear evidence of contact with a specific person leading to severe deterioration in the person's mental health. This does not mean that a facility cannot, for example, have "house rules" regarding visiting times, but such rules should be available for independent scrutiny. Such "house rules" should only consist of rules of everyday life that are normally set for living in any given housing.

Chapter VIII – Record-keeping, complaints procedures and monitoring

Article 21 – Record-keeping

126. Comprehensive medical records are always important, and administrative records are also required when a person is subject to an involuntary measure. When persons 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.

127. Under the principles of the data protection instruments of the Council of Europe in force, such as the Convention for the Protection of Individuals with regard to Automatic Processing of Personal Data (ETS 108, 1981), data concerning a person's mental disorder or condition or concerning a person's treatment for that disorder or condition are forms of sensitive data and are granted a high level of protection, wherever they are recorded.

128. The conditions governing access to this information shall be clearly specified by law, in accordance with the relevant principles of access to health-related data of the instruments noted in paragraph 127 above. Similarly, the period of storage shall be specified by law.

Article 22 – Complaints procedures

129. The existence of effective complaints systems provide an important protection for the human rights and dignity of people subject to involuntary measures. This Article follows the recommendations of the CPT. "Responsible authority" is defined in Article 2 (see paragraph 34 above). Article 16 of the Additional Protocol enables a person to challenge the lawfulness of an involuntary measure. However, a person may also wish to complain about issues such as living conditions, restrictions on communication or use of seclusion or restraint (compare Article 17 paragraph 4 for the latter).

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Article 23 – Monitoring

130. Monitoring is important in ensuring the protection of the human rights and dignity of persons with mental disorders and in ensuring compliance with national legal standards, including those set by this Additional Protocol. The value, and importance, of involving persons who have or have had mental disorders, those close to them, and organisations representing them, in developing policy and procedures in the context of mental health care is increasingly recognised. Thus, the involvement of such persons and organisations in the monitoring process is encouraged.

131. In paragraph 55 of its 8th General Report (document CPT/Inf (98)12), the CPT attaches considerable importance to psychiatric establishments being visited on a regular basis by an independent outside body which is responsible for the inspection of patients' care. This body should be authorised, in particular, to talk in private to patients and make any necessary recommendations to the responsible authority.

132. 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 persons receive dignified, human and professional treatment in which they are protected from abuse and that their human rights are fully respected.

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