27 October 2022

Subject: Comments to the outlines of the CD-BIO draft recommendations promoting the use of voluntary measures in mental healthcare services

The European Disability Forum (EDF), Mental Health Europe (MHE), Inclusion Europe, European Network of (Ex-)Users and Survivors of Psychiatry (ENUSP) Validity, Autism-Europe and the European Association of Service providers for Persons with Disabilities (EASPD) welcome the decision of the Committee of Ministers to suspend the decision on transmission for opinion to the Parliamentary Assembly of the draft additional protocol to the Oviedo Convention until completion of several deliverables at the end of 2024.

We naturally welcome a future declaration of the Committee of Ministers affirming the commitment of the Council of Europe to improving the protection and the autonomy of persons in mental health care services, to be finalised after the examination of these completed deliverables.

We particularly welcome the request of the Committee of Ministers addressed to the Council of Europe's Steering Committee for Human Rights in the fields of Biomedicine and Health (CD-BIO) to complete a draft recommendation promoting the use of voluntary measures in mental health care services by 31 December 2024.

As we have stated for several years, we believe that such a recommendation is necessary to reform our mental health systems in line with the obligations undertaken by 45 of the 46 Member States of the Council of Europe under the United Nations Convention on the Rights of Persons with Disabilities (UN CRPD).

However, such recommendation must be fully aligned with the UN CRPD and focus on principles and measures needed to not only decrease coercion in mental health care services, but with the objective to completely eliminate such human rights violations.

Therefore, in particular, we call on CD-BIO to:

- Recognise the significance of the UN CRPD as international law in lieu of the ECHR and Oviedo Convention;

- Remove all mention of the draft additional protocol to the Oviedo Convention, which has not been adopted by the Council of Europe;
- While acknowledging the need to eliminate involuntary measures, remove all mention of involuntary measures as a last resort;
- Extend the scope of the recommendation from exclusively healthcare institutions (e.g. psychiatric hospitals) to mental health and social service providers who work with persons with mental health problems in residential settings and in the community;
- Stress the ultimate objective to eliminate coercion in mental health care and social services and improve States' compliance with international human rights standards and current international recommendations and practices.

Attached to this letter you will find proposed modifications for the above purposes to the documents shared by the CD-BIO Secretariat prior to the meeting on the 2nd November 2022.

Sincerely,

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Kristijan Grđan, Vice-President, Mental Health Europe

Jyrki Pinomaa, President, Inclusion Europe

Olga Kalina, Chair, European Network of (Ex-)Users and Survivors of Psychiatry

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Maya Doneva, Secretary General, European Association of Service providers for Persons with Disabilities

Comments on the draft recommendation

The signatories of this letter recommend the following changes to the draft recommendation. These proposals are indicated in the text **in bold** and explained after each section and article.

Preamble
• Recalling **the UN CRPD**, the ECHR and the Convention on Human Rights and Biomedicine; • Recalling relevant international work including the ~~**UNCRPD**~~ **WHO QualityRights Guidance and Training**; • Having regard to the case-law of the European Court of Human Rights ~~**on the protection of persons with mental disorders**~~ **related to persons with psychosocial disabilities and mental health issues**; • Having regard to the work of the CPT; • Recalling Rec(2004)10 ~~**[and draft Additional Protocol with regard to involuntary placement and treatment within mental healthcare services]**~~; • Emphasising key relevant principles from the Convention on Human Rights and Biomedicine including: ● Non-discrimination ● Consent ● Professional standards ● Equitable access to healthcare ● **Primacy of the human being** • **Emphasising key relevant principles from the UN CRPD including:** ● **Equal recognition before the law** ● **Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons** ● **Liberty and security of the person** ● **Freedom from torture or cruel, inhuman or degrading treatment or punishment** ● **Living independently and being included in community** • **Stressing that the widespread use of involuntary measures in member states amounts to violations of human rights therefore** ~~**Stressing that the use of involuntary measures should always be a last resort and therefore**~~ • Recommending that governments of member states implement the guidelines in this Recommendation.
Explanatory note: Ad.1) The UN CRPD is the international human rights treaty adopted in 2006 and ratified by 45 Member States of the Council of Europe. As such, the UN CRPD must be recognized in the Preamble at the same level as the European treaties of the Council of Europe, such as the ECHR and the Convention on Human Rights and Biomedicine which are mentioned. Ad.2) Instead of referring to the UN CRPD as "relevant international work", in line with our proposal in Ad.1), other recent work of the UN should be recognized here, in particular the

WHO QualityRights Guidance & Training and recent Guidance on rights based and person-centred services (2021), along with the upcoming OHCHR and WHO Guidance on Mental Health, Human Rights and Legislation (expected in 2023).

Ad.3) We propose that the wording “persons with mental disorders” be replaced with “persons with psychosocial disabilities and mental health issues” to reflect recent changes in terminology that are also in line with UN CRPD and WHO language and which significantly contribute to destigmatisation.

Ad.4) As put forward above as a general proposal, we are of the opinion that all reference to a draft Additional Protocol must be removed. This draft protocol has not been adopted and runs contrary to the spirit of a human-rights based recommendation on fully voluntary measures.

Ad.5) We propose that the principle from Article 2 of the Oviedo Convention - Primacy of the human being be added to the Preamble. Article 2 of the Oviedo Convention prescribes: “The interests and welfare of the human being shall prevail over the sole interest of society or science.” In this context, the member states should be reminded that rights of persons with psychosocial disabilities cannot be undermined by any prevailing social interest, especially in the context of allocating sufficient funding or resources.

Ad.6) In addition to the Oviedo Convention, we propose that the key relevant principles from the UN CRPD also be emphasized in the Preamble.

Ad.7) In line with our proposal to remove all mention of involuntary measures as a last resort, we propose removing this from the first part of the recital completely, and instead propose the following recital: “Stressing that the widespread use of involuntary measures in member states amounts to violations of human rights…” in recognition of the objective of this draft Recommendation.

Article 1 – Object

- to promote the use of voluntary measures in mental healthcare services**, as a way to decrease and with the ultimate objective to eliminate coercion**.

Explanatory note:

We recommend that this article refer to the objective of transforming our mental healthcare systems so that they are based on voluntary care and services, with the goal of completely eliminating coercion.

Article 2 – Scope and definitions

Scope – Making clear mental healthcare **and related social** services covers all environments in which persons receive mental healthcare **and support**.
Definitions – as required, **based on the UN CRPD, including the definition that voluntary measure means that informed consent shall be given by the person concerned. Substitute decision-makers, including guardians, must not provide consent on behalf of the person concerned.** ~~**based on definitions used in the draft Additional Protocol**~~.

Explanatory note:

Ad.1) We find it important to emphasize "related social services" and receiving "support", so that the scope includes the social welfare institutions and service providers (from residential institutions to community-based service providers) providing support and care to people with psychosocial disabilities and mental health problems, and not limited to healthcare institutions (e.g., psychiatric hospitals).

Ad.2) In line with our general proposal, we reiterate the necessity to delete the reference to a draft Protocol. The definition should be aligned with the UN CRPD, as an obligation of all members of the Council of Europe which have signed it and ratified it for 45 of them.

Ad.3) Similarly to the point above on the alignment to the UN CRPD, we believe that it is important to specify that consent given by a substitute decision-maker cannot be considered as a voluntary measure.

Article 3 – Commitment to the use of voluntary measures

- Member states should make an explicit commitment to promote the use of voluntary measures **in order to eliminate involuntary treatment and placement**;
- That commitment should be affirmed at all levels of responsibility for mental healthcare **and related social** services[1].

Explanatory note:

We strongly support this article and, as per the article above, we find it important to emphasize that the goal is to ultimately completely eliminate coercion and to explicitly mention "related social services" so that the scope includes the social welfare institutions and service providers.

Article 4 – Leadership

- Member states should demonstrate leadership in promoting the use of voluntary measures by ensuring national law and policy reflect this goal;
- Those responsible for mental healthcare services should ensure that practices within the service for which they are responsible reflect this goal.[2]

We strongly support this article.

Article 5 – Participation of persons with lived experience

- Member states should **ensure** ~~**promote**~~ the involvement of persons with lived experience of mental healthcare services or with ~~**relevant**~~ psychosocial disabilities in developing policies and practices that promote the use of voluntary measures.
- Member states should ensure that the involvement of persons with lived experience of mental healthcare services or of ~~**relevant**~~ psychosocial disabilities is appropriately resourced.

Explanatory note:

Ad.1) We insist that instead of "promoting", member states must "ensure" the involvement of persons with lived experience of mental healthcare services, to give additional strength to this important aspect of the recommendation and as provided for under the UN CRPD.

Ad.2) We propose that the word "relevant" in relation to persons with psychosocial disabilities be deleted, as this recommendation must specifically refer to all persons with psychosocial disabilities pursuant to the UN CRPD as all persons with disabilities enjoy equal protection, not only those deemed "relevant".

Article 6 – Promotion of early access to services [3]

- Member states should promote public understanding of prevention, recognition and treatment of **mental health problems** ~~**mental disorders**~~ and of the benefits of early access to mental health care services.

Explanatory note:

We fully support this article, however we propose a change in terminology to reflect the language adopted by the UN CRPD, as explained in the explanatory note of the preamble.

Article 7 – Appropriate mental healthcare

- Member states should~~**, taking into account available resources,**~~ ensure that equitable access is provided to a range of mental healthcare services of appropriate quality that promote the use of voluntary measures.

Explanatory note:

We propose that the wording "taking into account available resources" be deleted as the issue here is "equitable access". Indeed, Article 12(1) of the International Covenant on Economic, Social and Cultural Rights (ICESCR) prescribes: "The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." The word "attainable" does not imply "available", therefore we are of the opinion that this Recommendation should not limit the activities of member states to available resources, but rather encourage member states to

allocate more resources to ensure that equitable access is provided to a range of mental healthcare services.

Article 8 – Complementary services

- Mental health care services should have appropriate links with other services that can contribute to **the reduction and ultimate elimination** ~~**a reduction in use**~~ of involuntary measures.[4]

Explanatory note:

In line with our proposal that the objective of the recommendation should be the elimination of coercion, we propose that the wording “ultimate elimination” be added.

Article 9 – Research

- Member states should promote research **on** ~~**to increase the use of**~~ voluntary measures in mental healthcare **corresponding to recognised good practices** and should ensure that such research is appropriately resourced.[5]

Explanatory note:

In our opinion, there is no need to refer to “increasing” the use of voluntary measures, implying that involuntary measures are applied as a rule considering the objective of this recommendation. We also recommend a reference here to good practices and the Compendium.

Article 10 – Appropriate environment

- The physical and social environment of mental health facilities should be reviewed and~~**, taking into account available resources,**~~ if necessary adapted to **ensure that there is no need** ~~**minimise the potential need**~~ for involuntary measures.
- **Member States should ensure that community based services are available to people with psychosocial disabilities.**

Explanatory note:

Ad.1) Again, we recommend deleting the words “taking into account available resources” for the reasons mentioned above.

Ad.2) In line with our proposal that the objective of the Recommendation should be the elimination of coercion, we propose this change as many inadequate environments lead to coercion and unlawful practices.
Ad.3) We propose that an additional paragraph be added so that the member states are asked to ensure that community-based services are available to people with psychosocial disabilities in line with Article 19 of the UN CRPD.

Article 11 – Public understanding

- Member states should promote public understanding of the importance of **eliminating ~~decreasing~~** the use of involuntary measures as a matter of human rights [6].

Explanatory note:

In line with our proposal that the objective of the recommendation should be the elimination of coercion, the public must be made aware of this ultimate goal as enshrined in international human rights law and promoted by the Council of Europe and European stakeholders.

Article 12 – Education and training

- All staff [7] involved in mental healthcare **and related social** services should have sufficient training to understand the importance of **respecting ~~promoting~~** autonomy and **eliminating ~~avoiding~~** the use of involuntary measures as a matter of human rights.
- Healthcare professionals in mental healthcare services should receive appropriate training in practices **respecting ~~promoting~~** autonomy.
- Primary care healthcare professionals should receive appropriate training in early identification of mental health problems and initiation of appropriate care that **respects ~~promotes~~** autonomy**.**
- **Front-line emergency workers (fire brigades, hospital emergency services, crisis centres) should receive appropriate training in practices respecting autonomy.**
- **Respect for autonomy and eliminating the use of involuntary measures as a matter of human rights should be integrated in training provided to students and professionals in all relevant fields (education, public policy, etc.).**

Explanatory note:

Ad.1) As in Article 2, it is important to integrate related services.

Ad.2) While voluntary measures may be promoted, the autonomy of a person can be only respected. Autonomy is a personal attribute and it must be respected by the staff in every single case.

Ad.3) In line with our proposal that the objective of the recommendation should be the elimination of coercion, we propose that the word “eliminating” be used rather than “avoiding”.

Ad.4) The same as for Ad.1)

Ad.5) Again, this opportunity to integrate other services is essential to a full-fledged approach.

Article 13 – Delivery of care

- ~~**Mental healthcare services should be delivered in a manner that minimises the use of involuntary measures.**~~
- **Mental healthcare services should be delivered in a voluntary manner.**
- Subject to the confidentiality of the person concerned, the potential benefits of involving the person's social network in his or her care should be considered.[8]
- ~~**Where appropriate,**~~ **P**ersons receiving mental health care services should be encouraged to express their preferences and wishes for care in advance of a future crisis or deterioration in mental health.

Explanatory note:

Ad.1) In line with our proposal to remove all mention of involuntary measures, we propose that this sentence simply remind member states of the objective of the Recommendation as regards mental healthcare services delivered.

Ad.2) We propose that the wording "where appropriate" be removed from the sentence, so that it is understood that persons receiving mental health care services should always be encouraged to express their preferences and wishes for care in advance of future crisis or deterioration in mental health, in line with Article 12 of the CRPD and General Comment no 1 to the CRPD.

Article 14 – Review

- ~~**The use of any**~~ **Any** involuntary measure should be reviewed locally, on the basis of appropriate documentation **and personal testimonies**, to **enact** ~~**consider the need for**~~ changes to practice in order to prevent such a measure **occurring** ~~**being required**~~ in the future.[9]

Explanatory note:

Ad.1) This word order modification stresses the importance of "any" occurrence.

Ad.2) We propose that the words "and personal testimonies" be added so that any inquiry may be done on the basis of testimonies of persons who received mental health services and suffered involuntary measures. In many instances, mental health service provision documentation is inadequate and non-existent to prove that the violation occurred. This addition also corresponds to the requirement in Article 5 of this draft Recommendation regarding the involvement of persons with psychosocial disabilities.

Ad.3) We stress that “consider the need for changes to practice” is insufficient and that changes must be made in the event involuntary measures “occur” and that in any case, they should not be considered “required”.

Article 15 – Complaints

- Mental healthcare services should have a complaints procedure **and ensure that the complaints are responded to appropriately**.[10] **Patients must be informed of their rights to file complaints.** Information from such complaints that could contribute to **eliminating involuntary measures** ~~**increasing the use of voluntary measures**~~ should be made available.

Explanatory note:

Ad.1) We propose that the wording “and ensure that the complaints are responded to appropriately” and that patients be informed of this right be added to the first sentences. This is fully in line with Article 37(1)(v) of Rec(2004)10: “Monitoring compliance with standards should include … ensuring that complaints procedures are provided and complaints responded to appropriately”. The existence of a formal complaints procedure does not guarantee that the outcome would be effective or that the victims of potential abuse would be remedied, therefore we propose that the full sentence of Article 7(1)(v) of the Rec(2004)10 mentioned above be repeated in the first sentence of Article 14 of the draft Recommendation.

Ad.2) We propose that the wording in the sentence “increasing the use of voluntary measures” be replaced by the very objective of the Recommendation as otherwise it implies that the use of involuntary measures is the rule in mental health settings, i.e., “eliminating involuntary measures”.

Article 16 – Monitoring

- Documentation concerning complaints and the use of involuntary measures should be made available to bodies responsible for quality assurance and monitoring [11];
- Such bodies should be encouraged to produce reports that can contribute to the goal of **eliminating the use of involuntary measures** ~~**increasing the use of voluntary measures**~~.

Explanatory note:

We recommend that the wording “increasing the use of voluntary measures” be replaced by “eliminating the use of involuntary measures” again as it implies that involuntary measures are applied as a rule.

Article 17- Accountability and reporting

- Those at all levels of responsibility for mental healthcare **policy and** services should be accountable for progress towards **eliminating the use of involuntary measures** ~~**increasing the use of voluntary measures**~~;
- Reports on progress should be provided at appropriate intervals and made widely available.

Explanatory note:

Ad.1) We propose adding the policy level in order to hold political bodies of the member states accountable for progress towards eliminating the use of involuntary measures.

Ad.2) Again we propose that the wording “increasing the use of voluntary measures” be replaced by “eliminating the use of involuntary measures” in order to correspond to the objective of this Recommendation.

~~**[Seclusion and restraint**~~

~~**CDBIO may wish to consider whether this topic should be explicitly covered. It is covered extensively in the draft Protocol. In this draft Recommendation, one could consider provisions on training on decreasing the use of seclusion and restraint, on review of all instances of the use of restraint and seclusion, and on learning from such reviews and from complaints as particularly relevant. An alternative would be to refer to seclusion and restraint in the EM to the general articles on those topics.]**~~

Explanatory note:

Our proposal to not refer in this Recommendation to a draft Additional Protocol that has led to controversy since its inception is a condition for our support for this Recommendation. In our opinion, there is no place in a Recommendation on voluntary measures for provisions on “seclusion” or “restraint”.

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[1] National government, regional, local etc
[2] The EM should explain that this Article is about achieving cultural change.
[3] The earlier someone presents to a service for treatment, the more likely it is that an involuntary measure can be avoided.
[4] The EM would explain these include services connected to providing appropriate housing, assistance with employment and social security benefits, and activities promoting social engagement of service users in the community.
[5] The EM can explain that more understanding is needed of demographic variation in the use of involuntary measures and of how to translate successful services into areas with different characteristics.
[6] EM reference to Article 28 of the Biomedicine Convention
[7] i.e. not just health and social care professionals, but administrative and other staff too.
[8] The EM can explain that such involvement may contribute to decreasing the need for involuntary measures.
[9] The EM could also highlight the benefit of having comparative statistics, so that different local teams can compare their performance on reducing the use of involuntary measures and learn from each other if appropriate.
[10] Rec(2004)10, Article 37.1.v
[11] Chapter VII of Rec(2004)10