



Submission: Public consultation on working document on the protection of human rights and dignity of persons with mental disorder with regard to involuntary placement and involuntary treatment DH-BIO/INF (2015) 7.

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The Hallmark Disability Research Initiative at the University of Melbourne, Australia, provides this written submission to the Committee on Bioethics (DH-BIO) of the Council of Europe regarding the Additional Protocol to the Convention on Human Rights and Biomedicine.

About the Hallmark Disability Research Initiative

The Hallmark Disability Research Initiative (DRI) at the University of Melbourne coordinates interdisciplinary projects with the involvement of community partners and those with lived experience of disability. Its brief is to develop high-quality applied research, policy and education programs. The aims of the DRI are to:

- enable the development of disability research in collaboration with the wider community;
- bring together people with disabilities and their representative organisations with academic researchers; and,
- foster a rich understanding of how to match research to the needs and desires of the community.

Summary of the Submission

The DRI provides this written submission to the Committee on Bioethics (DH-BIO) of the Council of Europe regarding the Additional Protocol to the Convention on Human Rights and Biomedicine (Additional Protocol). We welcome efforts to advance understandings of the Convention on Human Rights and Biomedicine particularly with regards to detention and involuntary treatment in the mental health context. At the same time, we wish to raise serious concerns about the content of the Additional Protocol, with regard to recent developments in international human rights law, particularly related to the UN Convention on the Rights of Persons with Disabilities (CRPD).

Our submission draws on international human rights law regarding persons with disabilities, particularly persons with psychosocial (mental health) disability. We consider how the human rights of persons with disabilities have been interpreted, monitored and implemented to date, including with regard to the CRPD, but also the Convention against Torture (CAT) and the International Covenant of Economic, Social and Cultural Rights (ICESCR). Interpretive guidance from UN treaty bodies and legal instruments will also be considered, including the Special Rapporteurs for Torture, the Rights of Persons with Disabilities and the Right to Health. We will also draw upon interpretations of the UN Committee on the Rights of Persons with disabilities

(CRPD Committee) and the Council of Europe (namely the Commissioner for Human Rights) and will have regard to scholarship in related fields.

On the basis of this material, we recommend that the Additional Protocol should be withdrawn, with a view to shifting the focus from restraining rights to liberty and consent to healthcare, and instead to a focus on facilitating access to support.

This submission is not meant as a critique of individual clinical mental health professionals, who are typically humanist, hard-working and compassionate. Instead the submission is meant as a contribution to the ongoing conversation about mental health law and policy, even as we hope to shift debate and practices in this area.

International context

To be maximally effective, general discussion about the human rights and dignity of persons with mental impairments¹ has to be positioned in a broader discussion of international human rights law related to persons with disabilities. As such, we welcome the aspiration to align the Protocol with the United Nations (UN) Convention on the Rights of Persons with Disabilities (CRPD) (lines 11-13). We also applaud efforts to elaborate on the implications of Article 1 of the Convention on Human Rights and Biomedicine to ‘protect the dignity and identity of all human beings and guarantee everyone, without discrimination, respect for their integrity and other rights and fundamental freedoms with regard to the application of biology and medicine’.

Nevertheless, we wish to raise the following concerns about the inconsistencies between the Additional Protocol and the CRPD. The following articles of the CRPD appear to be inconsistent with the general premise of the Additional Protocol.

Article 5, for example, prohibits disability-based discrimination (para. 2), and paragraph 1 directs States Parties to “recognize that all persons are equal before and under the law and are entitled without any discrimination to the equal protection

¹ Article 1, CRPD.

and equal benefit of the law”. Laws that discriminate on the basis of disability also may contradict the fundamental principles in Article 3 of the CRPD, particularly with regards to paragraphs (a) (“[r]espect for inherent dignity, individual autonomy including the freedom to make one’s own choices, and independence of persons”); (b) (“non-discrimination”); and (e) (“equality of opportunity”).

Article 14(1) refers to the right to liberty and states that, “the existence of a disability shall in no case justify a deprivation of liberty”. It is true that the words, “the existence of a disability shall in no case justify a deprivation of liberty” have been interpreted in two ways. According to the first reading, “the existence of a disability *alone*” cannot justify such laws. According to the second reading the use of disability as a criterion for the deprivation of liberty, even when used in conjunction with other criteria to justify detention (such as risk of harm to self or others), would violate Article 14. The CRPD Committee has decisively endorsed the latter view, in its General Comment 1, stating that:

legislation of several states party, including mental health laws, still provide instances in which persons may be detained on the grounds of their actual or perceived disability, provided there are other reasons for their detention, including that they are dangerous to themselves or to others. *This practice is incompatible with article 14 as interpreted by the jurisprudence of the CRPD committee.*²

Other articles of the CRPD appear to be violated by typical powers to detain and treat involuntarily. Article 17 states that “(e)very person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others.” With regard to the right to health, Article 25 (d) directs that States Parties shall “(r)equire health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent”. Finally, Article 12 directs that States Parties shall not place restrictions on legal capacity on the basis of a disability, which mental health legislation clearly does.

² Para. 1 (emphasis added).

The CRPD explicitly prohibits laws that discriminate on the basis of disability and recent statements by UN bodies, such as the CRPD Committee³ and the United Nations Office of the High Commissioner of Human Rights (OHCHR),⁴ advance the view that discriminatory mental health laws should be replaced.

United Nations treaty bodies have provided interpretive guidance on how mental health legislation can be understood in relation to the CRPD. The OHCHR, for example, has expressed the view that mental health legislation is unjustly discriminatory against people with psychosocial disability because it systematically uses mental illness as a criterion to limit legal capacity.⁵ In 2009, the OHCHR made the following statement:

Legislation authorizing the institutionalization of persons with disabilities on the grounds of their disability without their free and informed consent must be abolished. This must include the repeal of provisions authorizing institutionalization of persons with disabilities for their care and treatment without their free and informed consent, as well as provisions authorizing the preventive detention of persons with disabilities on grounds such as the likelihood of them posing a danger to themselves or others, in all cases in which such grounds of care, treatment and public security are linked in legislation to an apparent or diagnosed mental illness.⁶

The CRPD Committee echoed the view of the OHCHR (though not in such decisive terms). In its concluding observations on the compliance of China with the CRPD, the CRPD Committee recommended “the abolishment of the practice of involuntary civil commitment based on actual or perceived impairment”.⁷ The most recent concluding observations to Australia—in the strongest terms of a concluding

³ United Nations Committee on the Rights of Persons with Disabilities, ‘Equal Recognition Before the Law—Article 12; Liberty and Security of the Person—Article 14’ CRPD/C/CHN/CO/1 Distr.: General 27 September 2012. Available online: http://www.ohchr.org/Documents/HRBodies/CRPD/8thSession/CRPD-C-CHN-CO-1_en.doc (accessed on 8 October 2012).

⁴ United Nations General Assembly, OHCHR, Tenth session Agenda item 2. “Annual Report of the United Nations High Commissioner for Human Rights and Reports of the Office of the High Commissioner and the Secretary-General: Thematic Study by the Office of the United Nations High Commissioner for Human Rights on Enhancing Awareness and Understanding of the Convention on the Rights of Persons with Disabilities.” Distr. GENERAL A/HRC/10/48 26 January 2009. Available online: <http://www2.ohchr.org/english/bodies/hrcouncil/docs/10session/A.HRC.10.48.pdf> (Accessed 4 June 2015).

⁵ Ibid.

⁶ Ibid, para 49.

⁷ United Nations Committee on the Rights of Persons with Disabilities, ‘Equal Recognition Before the Law—Article 12; Liberty and Security of the Person—Article 14’ CRPD/C/CHN/CO/1 Distr.: General 27 September 2012. Available online: http://www.ohchr.org/Documents/HRBodies/CRPD/8thSession/CRPD-C-CHN-CO-1_en.doc (accessed on 8 October 2012).

observation yet—directed that Australia repeal “legal provisions that authorize commitment of individuals to detention in mental health services, or the imposition of compulsory treatment either in institutions or in the community via Community Treatment Orders (CTOs)”.⁸

The CRPD Committee elaborated further on the matter of repealing mental health law in its General Comment 1. Paragraph 42 of the Comment refers to Article 12 in conjunction with Articles 15, 16 and 17 of the CRPD, regarding respect for personal integrity and freedom from torture, violence, exploitation and abuse:

As has been stated by the Committee in several concluding observations, forced treatment by psychiatric and other health and medical professionals is a violation of the right to equal recognition before the law and an infringement of the rights to personal integrity (art. 17); freedom from torture (art. 15); and freedom from violence, exploitation and abuse (art. 16). This practice denies the legal capacity of a person to choose medical treatment and, is therefore, a violation of article 12 of the Convention. States parties must, instead, respect the legal capacity of persons with disabilities to make decisions at all times, including in crisis situations; must ensure that accurate and accessible information is provided about service options and that non-medical approaches are made available; and must provide access to independent support. States parties have an obligation to provide access to support for decisions regarding psychiatric and other medical treatment. Forced treatment is a particular problem for persons with psychosocial, intellectual and other cognitive disabilities. *States parties must abolish policies and legislative provisions that allow or perpetrate forced treatment, as it is an ongoing violation found in mental health laws across the globe, despite empirical evidence indicating its lack of effectiveness and the views of people using mental health systems who have experienced deep pain and trauma as a result of forced treatment.* The Committee recommends that States parties ensure that decisions relating to a person’s physical or mental integrity can only be taken with the free and informed consent of the person concerned.⁹

⁸ United Nations Committee on the Rights of Persons with Disabilities. “Committee on the Rights of Persons with Disabilities. ‘Concluding Observations of the Committee on the Rights of Persons with Disabilities (Australia) (Advance Unedited Version) CRPD/C/AUS/CO/1 10th sess.” 2–3 September 2013. Available online: http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD%2fC%2fAUS%2fCO%2f1andLang=en (accessed on 2 December 2013).

⁹ United Nations Committee on the Rights of Persons with Disabilities, General Comment No. 1—Article 12: Equal Recognition before the Law, UN Doc. No. CRPD/C/GC/1, adopted at the 11th Session (April 2014) Para. 42 [emphasis added]. Available online: <http://www.ohchr.org/EN/HRBodies/CRPD/Pages/GC.aspx> (accessed on 2 June 2015).

The CRPD Committee directs States Parties to replace mental health law with a 'supported decision-making regime'. Such a regime would involve providing new measures under the imperative to provide support to exercise legal capacity to persons with psychosocial disability, and seemingly to replace any functions of mental health law that are necessary to uphold other rights.

The views of UN treaty bodies on mental health law, and the implications of each of the various Articles noted previously have been discussed in detailed studies and do not warrant elaboration here.¹⁰ This brief summary is instead meant to elucidate the call under international human rights law to rethink mental health laws, and (potentially) to use mental capacity as a replacement for the diagnostic criteria.

As well as the generalized human rights concerns raised above, we also wish to comment on specific elements of the draft Additional Protocol.

Participation of People with Disabilities

The development of the Additional Protocol appears to have occurred without the significant input of persons with lived experience of mental health crises, psychosocial disability, mental illness, and so on. This is a matter of process, but relates also to compliance with substantive requirements of the CRPD. Art 4(3) CRPD states:

In the development and implementation of legislation and policies to implement the present Convention, and in other decision-making processes concerning issues relating to persons with disabilities, States Parties shall closely consult with and actively involve persons with disabilities, including children with disabilities, through their representative organizations.

Although laws that enable involuntary psychiatric intervention are ostensibly designed to safeguard the rights of those who are subject to involuntary treatment, it appears that this same cohort has been historically (and contemporaneously) excluded from the development of these law reform processes. This historical trend

¹⁰ A Nilsson, 'Objective and Reasonable? Scrutinising Compulsory Mental Health Interventions from a Non-discrimination Perspective' (2014) 14 *Human Rights Law Review* 459.

ought not be repeated at the international level in the development of instruments such as the Additional Protocol.

Recommendation: DH-BIO, in developing any materials related to psychosocial disability, particularly those with a focus on the CRPD, ought to actively consult disabled peoples organisations, particularly those representing people with psychosocial disability.

References to Risk to Others

In the working document it is stated that “that restrictions on the rights set out in the Convention on Human Rights and Biomedicine are permissible only if prescribed by law and are necessary in a democratic society in the interests of public safety, crime prevention, protection of public health or the protection of the 33 rights and freedoms of others” (lines 30-31). The various justifications for restricting rights in the above statement deserve careful consideration.

It is true that domestic and regional law may prescribe intervention. However, even *if* human rights concerns are set aside, the justifications identified at lines 30-31 of the Additional Protocol are not well supported by the evidence base. For example, the claim that detention and involuntary treatment in the mental health context is necessary to prevent risk to others rests on views that are scientifically unfounded. Typically, violence against others in the mental health context is associated with those diagnosed with schizophrenia. Yet there is limited evidence to justify this claim. In what is perhaps the largest study to date on the correlation between schizophrenia and rates of violent crime, 8003 people diagnosed with schizophrenia in the USA were compared with general population controls (n = 80 025) in terms of criminal convictions for violent crimes.¹¹ For the vast majority of those with the diagnosis who had committed a violent crime, the acts were attributed to drug

¹¹ S Fazel, N Långström, A Hjern, M Grann and P Lichtenstein, ‘Schizophrenia, Substance Abuse, and Violent Crime’ (2009) 301(19) *JAMA* 2016.

use.¹² Where other factors were controlled, those diagnosed with schizophrenia who had not abused drugs were only 1.2 times more likely to have committed at least one violent crime than the control group.¹³ However, when unaffected siblings were used as controls compared to their siblings, even where drug use had been a contributing factor, 'substance abuse comorbidity was significantly less pronounced... suggesting significant familial (genetic or early environmental) confounding of the association between schizophrenia and violence.'¹⁴ Despite this limited evidence for a causative relationship between mental impairment and violent crime,¹⁵ the notion of 'risk-of-harm to others' has remained a strong focus in justifications for detention and involuntary treatment in the mental health context. This skewed focus has arguably contributed to prejudice and discrimination towards people with psychosocial disability. This institutional discrimination is compounded given that other groups (such as young men drinking alcohol or known domestic abuse perpetrators, whose propensity to violence compared to others is empirically established) do not face similar restrictions on rights to liberty and consent to healthcare.

As such, we conclude that there is sufficient evidence to echo calls to abandon the risk criteria in mental health legislation.¹⁶ Risk assessment tests used in mental health laws are prejudicial, as they only apply to people with psychosocial disability. Such tests are misguided, given that a diagnosis of mental illness per se is marginally significant in indicating the likelihood of violence, and – in any case – they are ineffective. On this latter point: even *if* sufficient evidence exists to establish a causative link between mental illness and violence, there remains little evidence showing that risk assessment under mental health law reduces violent crimes and other risks to the public.¹⁷ Douglas Mossman has undertaken a meta-analysis of

¹² Ibid.

¹³ Ibid.

¹⁴ Ibid.

¹⁵ See A Nilsson, 'Objective and Reasonable? Scrutinising Compulsory Mental Health Interventions from a Non-discrimination Perspective' (2014) 14 *Human Rights Law Review* 459.

¹⁶ See for example, C Ryan, 'Capacity as a Determinant of Non-consensual Treatment of the Mentally Ill in Australia' (2011) 18(2) *Psychiatry, Psychology and Law* 248; C Ryan and S Callaghan, 'Rising to the human rights challenge in compulsory treatment – new approaches to mental health law in Australia' (2012) 46(7) *Aust N Z J Psychiatry* 611.

¹⁷ See, eg, D Mossman, 'The imperfection of protection through detection and intervention. Lessons from three decades of research on the psychiatric assessment of violence risk' (2009) 30 *Journal of Legal Medicine* 109, 139-140; P Appelbaum, 'Violence and Mental Disorders: Data and Public Policy' (2006) 163 *American Journal of Psychiatry* 1319.

studies that look retrospectively at risk-categorisation criteria in the lead up to violent acts and argues that no satisfactory balance between specificity and sensitivity in identifying risk could be found.¹⁸ ‘Hindsight,’ Mossman concludes, ‘makes “warning signs” clear, but before violent tragedies occur we cannot efficiently distinguish the signs that point to violence from those that will turn out to be false positive signals.’¹⁹ Indeed, it remains an open question in the literature on psychiatric coercion and violence, whether the range of civil commitment and legal involuntary treatment measures – including as applied by mental health courts, terms of sentencing, and inpatient and outpatient commitment orders – are effective in reducing the risk of violence.²⁰

Given the concerns outlined in this section, we recommend that the Additional Protocol does not include content which would support scientifically unfounded claims about the capacity for involuntary psychiatric intervention to increase “public safety, crime prevention, protection of public health or the protection of the 33 rights and freedoms of others.” Such claims have the potential to reinforce longstanding and destructive stereotypes, which promote the view that restraints and rights limitation are the natural course in responding to mental health crises.

Recommendation – Remove any reference to ‘risk of harm to others’ criteria in justifying detention and involuntary treatment in the mental health context. Alternatively, a statement could be made which highlights the limited scientific evidence to support the view that risk assessment and subsequent detention and involuntary treatment can prevent harm to others.

“Involuntary Placement”

¹⁸ Mossman, ‘The imperfection of protection through detection and intervention. Lessons from three decades of research on the psychiatric assessment of violence risk.’

¹⁹ Ibid 139-140.

²⁰ P Appelbaum, ‘Violence and Mental Disorders: Data and Public Policy’ (2006) 163 *American Journal of Psychiatry* 1319.

The term “involuntary placement”, which is used throughout the Additional Protocol, is not a commonly understood term and has the potential to obfuscate the seriousness of involuntary psychiatric interventions which result in a deprivation of liberty. In contrast, the word ‘detention’ is simple, direct, and has been used in longstanding legal instruments that ensure procedural safeguards for those deprived of their liberty. These instruments include the European Convention on Human Rights²¹ and the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment.

Recommendation: Replace ‘involuntary placement’ with the term ‘detention’ in all DH-BIO references to deprivations of liberty in mental health settings under the powers of mental health legislation.

Conclusion

The use of involuntary treatment and detention in the mental health context remains the subject of wide ranging critique, with some commentators charging that such powers create more problems than they solve. Mental health law – and the powers to detain and treat involuntarily – has been variously described as anti-therapeutic, ineffective on its own terms, and discriminatory.²² Perhaps most importantly, detention and involuntary treatment under mental health laws have struggled to provide substantive rights to persons with mental impairments—that is *access to support and healthcare*. Indeed, there is even some evidence showing that the introduction of human rights advocacy within mental health law has led to an *increase* in detention and involuntary treatment.²³ The partial recognition of human rights in mental health legislation and policy is yet to achieve the type of deep

²¹ The European Convention on Human Rights and Fundamental Freedoms, (ECHR), 1950, Art 5.

²² A Nilsson, ‘Objective and Reasonable? Scrutinising Compulsory Mental Health Interventions from a Non-discrimination Perspective’ (2014) 14 *Human Rights Law Review* 459; A Dhanda, ‘Legal Capacity in the Disability Rights Convention: Stranglehold of the Past or Lodestar for the Future?’ (2007) 34 *Syracuse Journal of International Law and Commerce* 429; T Minkowitz, ‘The United Nations Convention on The Rights Of Persons With Disabilities and The Right To Be Free From Non-consensual Psychiatric Interventions’ (2007) 34(2) *Syracuse Journal of International Law and Commerce* 405; SJ Morse, ‘Crazy Behavior, Morals, and Science: An Analysis of Mental Health Law,’ (1997) 51 *Southern California Law Review* 653; T Campbell, ‘Mental Health Law: Institutionalised Discrimination’ (1994) 28 *Australian and New Zealand Journal of Psychiatry* 554, 556.

²³ See D Nahon, I Pugachova, R Yoffe, and Itzhak Levav, ‘The Impact of Human Rights Advocacy, Mental Health Legislation and Psychiatric Reform on the Epidemiology of Involuntary Psychiatric Hospitalizations’ (2006) 25 *Med. & L.* 283–96.

integration of human rights – in theory, everyday practice, and the law – to which this submission is aimed.

Therefore, we recommend that the DH-BIO withdraw the current additional protocol, with a view to shifting the focus from restraining rights to liberty and consent to healthcare, and instead to a focus on facilitating access to support. The DH-BIO is in a unique position to promote a legal and ethical framework for the delivery of these emerging systems of support.



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