

**In the matter of the request for an advisory opinion by the Council of Europe Committee on Bioethics under Article 29 of the Oviedo Convention**

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**WRITTEN SUBMISSIONS ON BEHALF OF CENTER FOR THE HUMAN RIGHTS OF USERS AND SURVIVORS OF PSYCHIATRY**

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**Part I: Position of CRPD in international law and its relationship to Articles 7 and 27 of the Bioethics Convention**

CRPD as intentional modification of international norms

1. International human rights law is a body of interacting premises within a discourse framed by core principles such as non-discrimination. Core treaties of the United Nations, such as the Convention on the Rights of Persons with Disabilities (CRPD),<sup>1</sup> occupy a central place in such discourse, along with significant regional treaties and jurisprudence such as those of the European Convention on Human Rights and this Court. The CRPD is unique, not only as the binding instrument of global reach comprehensively setting out guarantees of full and equal human rights to all persons with disabilities, but as an instrument developed in a deliberative process that was unusually open and accountable to civil society organizations of the persons whose rights are directly affected. This imparts to the CRPD a role in shaping the evolution of general international law, by imparting a disability perspective – that is, a lens of theory and practice on human rights as lived, exercised and experienced by persons with disabilities.
2. The role of disabled people’s organizations in elaborating the CRPD was unprecedented; the Chair of the negotiating body famously observed that 80% of the Convention was written by civil society. This was due not only to the determination, organization and capability of those organizations, but also to the understanding of the negotiating parties, taken from principles of a human rights-based approach to development cooperation,<sup>2</sup> that participation of

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<sup>1</sup> U.N.T.S. vol. 2515, p. 3 (2006), entered into force 3 May 2008.

<sup>2</sup> Office of the High Commissioner for Human Rights, Frequently Asked Questions on a Human Rights-Based Approach to Development Cooperation, <https://www.ohchr.org/Documents/Publications/FAQen.pdf> (accessed 10 November 2020).

marginalized groups was essential to successful programming of any kind, including the elaboration of a human rights treaty. Civil society organizations selected by the disability community comprised almost a third of the drafting group, the remainder being state delegations and a representative of national human rights institutions.<sup>3</sup> Many states included experts with disabilities on their delegations in the drafting group and throughout the negotiations. The richness and diversity of this expertise shaped the substantive content of the treaty.

3. The CRPD takes a multi-dimensional and contextual approach that responds to the particular injustices faced by persons with diverse types of disabilities in the exercise or enjoyment of the right in question. It is the product of collaborative deliberation by states together with diverse organizations of persons with disabilities, including the World Network of Users and Survivors of Psychiatry (WNUSP) as a global organization of persons with actual and perceived psychosocial disabilities.
4. WNUSP contributed actively to the development of text in the CRPD that had the intention and effect of reversing the direction of international law with respect to involuntary hospitalization and treatment. The contrast between the CRPD and its antecedents was recognized by Special Rapporteur on Torture Manfred in a 2008 thematic report on torture and persons with disabilities. After describing key provisions of the CRPD, including the principle of respect for autonomy and provisions on legal capacity and free and informed consent in health care, he concluded:

Thus, in the case of earlier non-binding standards, such as the 1991 Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (resolution 46/119, annex), known as the MI Principles, the Special Rapporteur notes that the acceptance of involuntary treatment and involuntary confinement runs counter to the provisions of the Convention on the Rights of Persons with Disabilities.<sup>4</sup>

5. The details of the CRPD normative framework that separately and together require the abolition of involuntary hospitalization and treatment in mental health settings will be set out in Part II of this intervention. In this section, the premise that CRPD does in fact require the

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<sup>3</sup> See <https://www.un.org/esa/socdev/enable/rights/ahcwg.htm>. The author of this intervention was among the civil society representatives.

<sup>4</sup> U.N. Doc. A/63/175, paragraph 44.

abolition of that regime is taken as a given. It has been so interpreted by the treaty monitoring body, the Committee on the Rights of Persons with Disabilities, in its General Comments, Guidelines on Article 14, and numerous Concluding Observations to States Parties. The response of UN human rights mechanisms, international agencies and regional bodies, has predominantly been to follow the CRPD as a modification of international norms, as the examples below will demonstrate.

#### Reception of CRPD by global mechanisms and by the World Health Organization

6. The UN Basic Principles and Guidelines on Remedies and Procedures on the Right of Anyone Deprived of Their Liberty to Bring Proceedings Before a Court (2015) declare that involuntary committal based on an actual or perceived psychosocial disability is prohibited, that mental health services are to be provided based on the free and informed consent of the person concerned, and that perceived or actual deficits in mental capacity or decision-making skills of a person may not be used as a justification for denying legal capacity (legal standing and legal agency).<sup>5</sup>
7. The Human Rights Council's most recent Resolution on Human Rights and Mental Health calls upon States 'to abandon all practices and treatments that fail to respect the rights, autonomy, will and preferences of all persons on an equal basis with others.'<sup>6</sup> The same resolution calls on the High Commissioner for Human Rights to organize a consultation, and prepare a report, on 'the best ways to harmonize national laws, policies and practices relating to mental health with the norms of the Convention on the Rights of Persons with Disabilities.'<sup>7</sup>
8. The World Health Organization (WHO) has withdrawn its earlier Resource Book on Mental Health, Human Rights and Legislation, because it was drafted prior to the CRPD and did not comply with the latest norms.<sup>8</sup> WHO now provides training and guidance on 'how to implement a human rights and recovery approach in the area of mental health in line with the UN Convention on the Rights of Persons with Disabilities and other international human rights

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<sup>5</sup> U.N. Doc. A/HRC/30/37, paragraphs 103 and 106(b).

<sup>6</sup> U.N. Doc. A/HRC/43/L.19 (2020), paragraph 8.

<sup>7</sup> Id., paragraphs 18-21.

<sup>8</sup> [https://www.who.int/mental\\_health/policy/legislation/en/](https://www.who.int/mental_health/policy/legislation/en/) (accessed 10 November 2020).

standards.<sup>9</sup> The training module on Mental Health, Disability and Human Rights instructs learners that ‘Detention on the basis of a diagnosed or perceived disability is not allowed, even when additional reasons or criteria are given for the detention, such as “need for treatment”, “presumed dangerous” or “lack of insight”.’<sup>10</sup>

9. The Human Rights Committee and the Subcommittee on the Prevention of Torture are notable exceptions to the consensus that has emerged. The former cited the CRPD in an apparent error as to its text and interpretation, in support of a standard maintaining that the existence of a disability in itself cannot justify a deprivation of liberty, rather it must be necessary and proportionate ‘for the purpose of protecting the individual in question from serious harm or preventing injury to others.’<sup>11</sup> The Committee on the Rights of Persons with Disabilities clarified the following year that negotiating parties to the CRPD rejected proposals to modify the prohibition of disability-based deprivation of liberty by terms such as ‘solely’ or ‘exclusively’, ‘arguing that it could lead to misinterpretation and could allow deprivation of liberty on the basis of actual or perceived impairment in conjunction with other criteria, such as posing a danger to oneself or to others.’<sup>12</sup>
10. The Subcommittee on Prevention of Torture, in a 2016 document, takes the view that medical necessity can justify involuntary treatment, including mental health treatment, based on an approach to consent that was rejected by the CRPD Committee both in its General Comment No. 1 (2014) dealing with legal capacity and in its Guidelines on Article 14.<sup>13</sup> This view is an outlier in the global regime, and fails to appreciate that legal capacity is an integral component of the equality and non-discrimination guaranteed to all persons with disabilities under the CRPD.

#### Regional state practice by the Organization of American States and the African Union

11. Among regional bodies, the monitoring body for the Inter-American Convention on the Elimination of all Forms of Discrimination Against Persons with Disabilities was first to

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<sup>9</sup> <https://www.who.int/publications/i/item/who-qualityrights-guidance-and-training-tools> (accessed 10 November 2020).

<sup>10</sup> <https://apps.who.int/iris/bitstream/handle/10665/329546/9789241516709-eng.pdf> (accessed 10 November 2020).

<sup>11</sup> U.N. Doc. CCPR/C/GC/35 (2014), paragraph 19.

<sup>12</sup> Guidelines on the right to liberty and security of persons with disabilities, U.N. Doc. A/72/55, Annex (2015).

<sup>13</sup> U.N. Doc. CRPD/C/GC/1, paragraphs 13-15, 18, 21 and 42; in the Guidelines on Article 14, see especially paragraphs 10-16 and 22.

acknowledge the impact of CRPD in reversing the direction of international human rights norms. The Committee on the Elimination of all Forms of Discrimination Against Persons with Disabilities, composed of state party representatives and known as CEDDIS, issued a General Observation in 2011 'on the need to interpret Article I.2(b) *in fine* of the Inter-American Convention on the Elimination of All Forms of Discrimination against Persons with Disabilities in the context of Article 12 of the United Nations Convention on the Rights of Persons with Disabilities.' CEDDIS regarded as 'obsolete' the provision of the regional treaty providing that 'declaration of a person as legally incompetent does not constitute discrimination', and observed that 'what the United Nations Convention demands is that support be based on trust, provided with respect, and never against the will of the person with disabilities.' They resolved to urge states parties to adopt measures to recognize universal legal capacity, including that of persons with disabilities, and to replace practices such as guardianship and declaration of legal incompetence 'with a practice based on decision-making support'.<sup>14</sup>

12. Although the right to legal capacity is not directly at issue in the matter before the Court, it is part of the same shift in international norms and provides partial legal and conceptual grounding for the prohibition of involuntary hospitalization and treatment, as will be shown in Part II. The Organization of American States followed the CRPD approach to legal capacity and on free and informed consent to any treatment, in negotiating the Inter-American Convention on the Rights of Older Persons.<sup>15</sup>
13. The African Union's Protocol on the Rights of Persons with Disabilities repeated and built upon the CRPD guarantee of universal legal capacity and its prohibition of disability-based detention. The Protocol adds protection against interference with the person's legal capacity, prohibition of forcible confinement by any person or institution, and protection against medical or scientific intervention (as well as experimentation) without free, prior and

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<sup>14</sup> General Observation of the Committee for the Elimination of All Forms of Discrimination against Persons with Disabilities on the need to interpret Article I.2(b) *in fine* of the Inter-American Convention on the Elimination of All Forms of Discrimination against Persons with Disabilities in the context of Article 12 of the United Nations Convention on the Rights of Persons with Disabilities, OEA/ Ser.L/XXIV.3.1, CEDDIS/doc.12(I-E/11) rev.1 (28 April 2011).

<sup>15</sup> A-70 (2015), entered into force 11 January 2017.

informed consent.<sup>16</sup> Although the Protocol has not yet entered into force, it has been signed by eight countries, progressing though not rapidly since its adoption in 2018.

#### Implications for the Council of Europe Convention on Human Rights and Biomedicine

14. The examples of regional state practice in the Americas and Africa affirming the modifications made to international law by the CRPD are instructive for Council of Europe institutions.
15. The Convention on Human Rights and Biomedicine, adopted in 1997, contains provisions that are outdated in light of the CRPD. Not only does Article 6 maintain the figure of incapacity to consent based on disability, Article 7 authorizes nonconsensual treatment against persons with psychosocial disabilities in particular in relation to their disability, which is viewed as a health condition requiring treatment. This is simple discrimination that is impossible to reconcile with the CRPD.
16. The Bioethics Convention itself supplies a pathway to resolution through Article 27, which allows states parties to apply a wider measure of protection. Articles 1 and 5 of that Convention, read in conjunction with the CRPD, require states to refrain from discriminating based on disability with regard to the right to free and informed consent, to interpret Article 6 within a CRPD-compliant framework and to deny effect to Article 7.

#### **Part II: Content of CRPD Norm on Abolition of Involuntary Hospitalization and Treatment**

17. As a comprehensive human rights treaty, the CRPD can be read to shed light on any theme of concern to persons with disabilities. With respect to involuntary hospitalization and treatment, the most relevant are Articles 1 and 3 on purpose and principles to guide interpretation, and Articles 12, 14, 19 and 25 which supply the substantive guarantees regarding legal capacity, liberty and security of the person, living independently in the community and free and informed consent in health care.
18. Article 1 establishes the purpose of the Convention to 'promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with

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<sup>16</sup> Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa, adopted 29 January 2018, <https://au.int/en/treaties/protocol-african-charter-human-and-peoples-rights-rights-persons-disabilities-africa> (accessed 10 November 2020).

disabilities.’ The Convention is comprehensive in scope and leaves no one behind; no subset of persons with disabilities can be entitled to anything less than full and equal enjoyment of their rights and freedoms.

19. Article 3 contains the Convention’s principles, which include ‘respect for inherent dignity, individual autonomy including the freedom to make one’s own choices, and independence of persons,’ ‘non-discrimination,’ ‘full and effective participation and inclusion in society,’ and ‘respect for difference and acceptance of persons with disabilities as part of human diversity and humanity.’<sup>17</sup> The principles inform us about the values motivating the treaty, and serve as parameters to ensure fidelity of an interpretation to the treaty’s object and purpose.
  
20. Article 12 obligates states to ‘recognize that persons with disabilities enjoy legal capacity on an equal basis as others in all aspects of life.’ They must also ‘provide persons with disabilities with access to the support they may require in exercising their legal capacity’ and ‘ensure that all measures that relate to the exercise of legal capacity provide for ... safeguards to prevent abuse’; the safeguards are to ensure that such measures ‘respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person’s circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body.’<sup>18</sup>
  
21. Legal capacity has the ordinary meaning it does elsewhere in the international human rights regime, with particular reference to Article 15 of the Convention on Elimination of All Forms of Discrimination Against Women, which is consistently interpreted by its treaty body as encompassing both legal standing and legal agency.<sup>19</sup> The enjoyment of legal capacity on an equal basis in all aspects of life therefore operationalizes the principle of respect for individual autonomy, assuring to persons with disabilities the legal status of subjects whose autonomous decision-making is protected.
  
22. The enjoyment of legal capacity applies in the context of health care decision-making and, read in conjunction with Article 25, requires that health services, including mental health

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<sup>17</sup> The premises cited are set forth in paragraphs (a), (b), (c) and (d) respectively. See also Preamble paragraphs (n) and (h).

<sup>18</sup> The quotes are from paragraphs 2, 3 and 4 of Article 12 respectively.

<sup>19</sup> See CEDAW General Recommendation No. 21 (1994), paragraphs 7-9.

services, be provided only on the basis of the free and informed consent of the person concerned. The CRPD Committee has linked this standard to Article 14 as well as Article 12, bringing it under the right to security of the person where it is accompanied by the obligation to repeal legislative provisions that authorize the detention of persons with psychosocial or intellectual disabilities. In the Guidelines on Article 14, the Committee clarified explicitly that ‘involuntary commitment in mental health facilities carries with it the denial of legal capacity to decide about care, treatment and admission to a hospital or institution, and therefore violates article 12 in conjunction with article 14.’<sup>20</sup>

23. The relation between the three core components of Article 12: enjoyment of legal capacity, support, and safeguards, has been explained normatively in General Comment No. 1 and is being further developed through adaptation by states parties.<sup>21</sup> Substitute decision-making must be entirely replaced by support measures that respect the person’s autonomy, will and preferences. Mental capacity assessments cannot be invoked to restrict a person’s exercise of legal capacity, nor can they be used to determine the types of support a person may need. The use of support cannot be required as a condition for the person’s exercise of legal capacity; all persons have the right to refuse support and to change or terminate a support relationship at any time. Legal capacity must be respected at all times, including in crisis situations. Safeguards have as their primary purpose to ensure respect of the person’s rights, will and preferences and must themselves respect rights, will and preferences, including the right to take risks and make mistakes. As a matter of last resort, and only after significant efforts have failed to determine the person’s will and preferences, a ‘best interpretation’ must be made; the ‘best interests’ principle cannot be applied in relation to adults.<sup>22</sup> Peruvian notary Rosalía Mejía Rosasco applies the same standard to persons with disabilities as to others in determining whether the individual has manifested their will with respect to a particular legal act; the Peruvian reform includes systematic transformation of provisions

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<sup>20</sup> Guidelines on Article 14, paragraph 10; see also General Comment No. 1, paragraph 42.

<sup>21</sup> See Antonio Martínez-Pujalte, Legal Capacity and Supported Decision-Making: Lessons from Some Recent Legal Reforms, *Laws* 2019, 8(1), 4; <https://doi.org/10.3390/laws8010004>.

<sup>22</sup> The premises cited in this paragraph are found in General Comment No. 1, paragraphs 26-28 (see also Corrigendum CRPD/C/GC/1/Corr.1); 14-15 and 29(i); 19 and 29(g); 18 and 42; 20 and 22; and 21, respectively.

regarding the manifestation of will in order to eliminate barriers and include persons with disabilities.<sup>23</sup>

24. The General Comment calls for the abolition of ‘policies and legislative provisions that allow or perpetrate forced treatment,’ and sets out the obligation of states parties to ‘instead, respect the legal capacity of persons with disabilities to make decisions at all times, including in crisis situations; ... ensure that accurate and accessible information is provided about service options and that non-medical approaches are made available; and ... provide access to independent support.’ In addition to violating the right to legal capacity, forced psychiatric or medical treatment infringes the rights to personal integrity, freedom from torture, and freedom from exploitation, violence and abuse.<sup>24</sup>

25. Article 14 on liberty and security of the person, directs states parties to ‘ensure that the existence of a disability shall in no case justify a deprivation of liberty.’ This provision has two dimensions, addressing both individual cases and regimes of detention that are based on the existence of a disability. All instances of involuntary hospitalization or institutionalization in mental health facilities that are authorized under domestic law are based on the existence of a disability, as they can only be applied once a person has been diagnosed with a mental illness or disorder. It is not sufficient to apply the prohibition through review of individual cases; the laws that maintain a discriminatory regime of detention must be repealed or nullified. As the Committee on the Rights of Persons with Disabilities has explained in the Guidelines on Article 14, neither a crisis situation nor the appeal to motivations such as public safety or protection of the person herself can justify a deprivation of liberty that is based on the existence of a disability.<sup>25</sup> Persons with psychosocial disabilities are entitled to exercise their own judgment about their needs, and cannot be subjected to a regime of preventive detention either as involuntary protection or as a discriminatory regime to protect the public safety. As members of the public, they are bound by mutual duties just as other members of society and are entitled to the same guarantees of a fair trial if accused of criminal conduct.<sup>26</sup>

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<sup>23</sup> La Implementación de la Convención de las Personas con Discapacidad en la Función Notarial (2019), pp. 56 et seq.

<sup>24</sup> General Comment No. 1, paragraphs 7 and 42. Paragraph 12 of the Guidelines on Article 14 affirms that forced treatment not only infringes, but violates, Article 15 on the freedom from torture and other ill-treatment.

<sup>25</sup> Paragraphs 7, 13-15 and 22.

<sup>26</sup> CRPD Preamble paragraph (w); Guidelines on Article 14, paragraphs 16-18, 20 and 21.

26. Article 19 sets out the right of persons with disabilities to ‘choose where and with whom to live on an equal basis with others,’ to have access to ‘support services ... necessary to support living and inclusion in the community, and to prevent isolation,’ and that ‘services for the general population are available on an equal basis to persons with disabilities and are responsive to their needs.’<sup>27</sup> As explained in the CRPD Committee’s General Comment No. 5, this entails an obligation of meaningful deinstitutionalization, ensuring that persons with psychosocial disabilities can choose to live on their own and are not compelled to accept institutional living arrangements or unwanted services either as a matter of law or policy or due to the lack of options that respect their will and preferences. Article 19 has additional implications that remain largely unexplored,<sup>28</sup> for the development of crisis-related support based in the right to independent living, as services needed to maintain one’s life in community during those periods of difficulty.

27. The CRPD offers a coherent alternative to prior mental health law that is based in full respect for persons with psychosocial disabilities as legal subjects and as collaborators in the development of international norms. The Court should support the modifications to human rights law introduced by the CRPD and avoid taking any steps that would hinder their further development.

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<sup>27</sup> The premises cited are set forth in paragraphs (a), (b) and (c) respectively.

<sup>28</sup> But see Guidelines on Article 14, paragraph 9; General Comment No. 5, U.N. Doc. CRPD/C/GC/5, paragraph 48; Minkowitz, Positive Policy to Replace Forced Psychiatry Based on the CRPD, [https://www.academia.edu/39229717/Positive\\_policy\\_to\\_replace\\_forced\\_psychiatry\\_based\\_on\\_CRPD](https://www.academia.edu/39229717/Positive_policy_to_replace_forced_psychiatry_based_on_CRPD) (accessed 12 November 2020).