



Report by Spain's Bioethics Committee assessing the Draft Additional Protocol to the Oviedo Convention concerning the protection of human rights and dignity of persons with mental disorder regarding involuntary placement and involuntary treatment

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Abbreviations:

DAPIPT: Draft Additional Protocol to the Oviedo Convention concerning the protection of human rights and dignity of persons with mental disorder regarding involuntary placement and involuntary treatment

CoE: Council of Europe

CRPD: Committee on the Rights of Persons with Disabilities

ECHR: European Convention on Human Rights and Biomedicine

CERMI: Spanish Committee of Representatives of People with Disabilities

(Spanish acronym)

CRPD: Convention on the Rights of Persons with Disabilities

DH-BIO: Council of Europe Bioethics Committee

LBAP: Basic Law on Patient Autonomy (Spanish acronym)

LEC: Code of Civil Procedure (Spanish acronym)

IOT: Involuntary outpatient treatment

TC: Constitutional Court (Spanish acronym)

ECHR: European Court of Human Rights

STC: Constitutional Court Judgment (Spanish acronym)

UN: United Nations Organization

1. Introduction

The Council of Europe (CoE) is a European intergovernmental organization that was specifically created to protect human rights. In 1950 it approved the European Convention on Human Rights greatly strengthening the rights of citizens of its Member States. Its scope is supranational. Since then, the CoE has become a benchmark in the protection of human rights at universal level and, in fact, in other regions of the world institutions have been created with analogous aims and procedures.

In order to achieve more effective and thorough protection of human rights, the CoE has approved a series of legally binding instruments on specific matters. In 1997 it approved the European Convention on Human Rights and Biomedicine (ECHRb), also known as the Oviedo Convention, with a view to strengthening the protection of human rights in the face of advances in biomedicine. At present, 29 of the Council of Europe's 47 member states, including Spain, have ratified it and are therefore bound to comply with it. It is the first (and to date the only) international convention that acknowledges and establishes protection mechanisms for human rights in the specific field of biomedicine. The Oviedo Convention and the four additional protocols approved so far, place the CoE at the forefront of Biolaw worldwide.

The Council of Europe Bioethics Committee (DH-BIO) is the body commissioned by the Council of Europe's Committee of Ministers to prepare legal texts or recommendations on human rights in the field of biomedicine. This body, which drafted the text of the Oviedo Convention and the additional protocols approved so far, is still responsible for drawing up new additional protocols adhering to the guidelines received from the Committee of Ministers.

In 2013, DH-BIO began work on a draft additional protocol to the Oviedo Convention on the human rights and dignity of persons with mental disorders, focusing on involuntary placement and treatment (DAPIPT). Since 2015 when this initiative was opened for public consultation, many stakeholders called for its withdrawal because they believed that it contradicted the Convention on the Rights of Persons with Disabilities (CRPD). Among them are expert committees of intergovernmental organizations, notably the Committee on the Rights of Persons with Disabilities of the United Nations Organization (CRPD); and non-governmental human rights organizations and representatives of persons with disabilities. This movement to reject the initiative was even taken up by some bodies of the CoE itself; important ones such as the Parliamentary Assembly or the Commissioner for Human Rights of the CoE. Some states such as Portugal, Bulgaria and the Republic of North Macedonia have already expressed their opposition to DAPIPT. DH-BIO remains committed to moving forward in the development of a legal instrument that protects the rights of people diagnosed with a mental health disorder who have been involuntarily institutionalized or treated.

In a letter dated 7 March 2019, the Secretary General for Health and Consumer Affairs called on Spain's Bioethics Committee "as the Government's highest advisory body concerning matters of Bioethics" to issue "a reasoned and qualified assessment of the Draft Additional Protocol to the Oviedo Convention." In response to this request, Spain's Bioethics Committee, as a collegiate and independent body with advisory responsibilities in the area of bioethics, and in the exercise of the duties attributed to it by virtue of Article 78 of the Biomedical Research Act, issued this report.

After providing a general overview of the DAPIPT, the report reflects the reactions to this initiative from both intergovernmental organizations devoted to human rights as well as the civil society through non-governmental organizations working in the field of human rights and of disability. We especially focus on the situation in Spain. Lastly, we offer our assessment of the DAPIPT.

2. Fundamental aspects of the DAPIPT

The aim of the DAPIPT is to implement the provisions of the ECHR on involuntary placement and treatment. We should therefore begin by referring to the provisions of this Convention that is binding on the 29 CoE States that have ratified it, including Spain.

The ECHR allows involuntary interventions on people with a psychosocial disability in two types of situations: when it has been determined that they do not have the capacity to consent and when they act against their own health.

First, the Convention recognizes that the capacity of a person with psychosocial disability to act may be reduced or non-existent. In those cases, their capacity is in the hands of a representative who makes decisions for them. The ECHR provides as follows:

"3. Where, according to law, an adult does not have the capacity to consent to an intervention because of a mental disability, a disease or for similar reasons, the intervention may only be carried out with the authorisation of his or her representative or an authority or a person or body provided for by law. The individual concerned shall as far as possible take part in the authorisation procedure" (Article 6).

This model of substitution in decision-making could be interpreted as contrary to the CRPD, whose Article 12 recognizes that "persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life." According to this provision, the fact of having a disability does not justify a lesser recognition of legal capacity (or capacity to act) and certainly does not annul it. People with intellectual or psychosocial disabilities have the same legal capacity as anyone else and what they need are the necessary support measures to effectively exercise that capacity.

Secondly, the ECHR allows the involuntary treatment and placement of a person with a mental disorder when his or her health is at risk:

“Subject to protective conditions prescribed by law, including supervisory, control and appeal procedures, a person who has a mental disorder of a serious nature may be subjected, without his or her consent, to an intervention aimed at treating his or her mental disorder only where, without such treatment, serious harm is likely to result to his or her health.” (Article 7).

According to this article, it is possible to intervene against the will of the person to treat his or her mental disorder but only in cases where not taking such action would pose a risk to that person’s health. Therefore, four conditions must be met: the person must suffer a mental disorder that diminishes his/her mental faculties; the intervention is needed to specifically treat that mental disorder; not providing treatment would damage the person’s health; and protective guarantees under national laws must be respected.

This provision could be considered to run counter to the CRPD, specifically the right not to be arbitrarily deprived of liberty (Article 14); to not be subjected to torture or other cruel, inhuman or degrading treatment or punishment (Article 15); and to receive health care based on free and informed consent (Article 25). The entire CRPD revolves around the principle that disability can never justify different treatment from that received by other people, although other circumstances are taken into consideration. Article 7 of the ECHR seems to go against that principle.

When the pathology that threatens the health of persons with a psychosocial disability is not mental but of some other type, one can intervene without having their consent, either when it is considered that they lack the capacity to consent (according to Article 6 of the ECHR), or in the case of an emergency (according to Article 8). Involuntary interventions on people with mental disorders, as well as on people with no such disorders, can be carried out insofar as they are necessary to protect the freedoms or rights of others (Article 26 of the ECHR).

Following the approval of the CRPD in 2006, and given that many States that had ratified the ECHR had also ratified the CRPD, DH-BIO raised the question of whether there could be some incompatibility between the two texts, specifically between CRPD Articles 14, 15 and 17 and ECHR Articles 7 and 26. In a brief statement adopted in 2011, the Convention stated that there was no incompatibility between the CRPD and the ECHR because “the existence of a disability may not in itself justify deprivation of liberty or involuntary treatment. Involuntary treatment or placement may only be justified in connection with a mental disorder of a serious nature if the absence of treatment or placement is likely to cause serious harm to the person's health or to a third party”¹.

The CoE has a long history of approving guidelines and rules on involuntary

¹ Steering Committee on Bioethics, *Statement on the United Nations Convention on the Rights of Persons with Disabilities*, CDBI/INF (2011) 10 November 2011, <https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=09000016804553b0>

placement and treatment that are respectful of human rights. In addition to the aforementioned articles of the ECHR, in 2004 a Recommendation was approved by the CoE's Committee of Ministers concerning the protection of the human rights and dignity of persons with mental disorders². This text already sets out the principles that, according to the CoE, should govern all decisions on the involuntary placement or treatment of people with a mental health diagnosis.

In 2013 the DH-BIO went to work on the DAPIPT. In 2015, it submitted it for public consultation with the commitment to take the comments into consideration when preparing its final version. The document containing those comments was made public and it bore witness to the reservations, and even open rejection, that the document caused³. In 2016 the CoE's Parliamentary Assembly adopted a very critical Recommendation concerning the DAPIPT which is referred to below, as it considered that it was incompatible with the CRPD. In November of the same year, the Committee of Ministers responded to the Parliamentary Assembly ensuring that the DAPIPT "would contribute to the prevention of abuse and promote the gradual transition towards a more uniform application by Member States of the voluntary measures in psychiatry in accordance with the spirit of the CRPD".

With the support of the Committee of Ministers, the DH-BIO resumed its work taking the comments received in the 2015 public consultation into consideration, and with the intention of involving disability rights organizations by inviting them to participate as observers in the sessions devoted to the DAPIPT. It was not long before these groups expressed their displeasure with the way they were permitted to participate and announced that they would stop attending the meetings. That being the case, in May 2018 a new version of the DAPIPT and its explanatory report was approved and distributed among the different CoE agencies calling for their opinion.

The current DAPIPT version consists of a Preamble and eight chapters: (I) Objective and scope, (II) Alternative measures, (III) General provisions, (IV) Criteria for involuntary placement and for involuntary treatment, (V) Procedures concerning involuntary placement and involuntary treatment, (VI) Specific situations, (VII) Information and communication, and (VIII) Record-keeping, complaints procedures and monitoring. We will now present a summary of the regulation proposed in the DAPIPT.

The Preamble of the DAPIPT affirms that the Additional Protocol is based on the

² Council of Europe, *Recommendation 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*, 22 September 2004, https://search.coe.int/cm/Pages/result_details.aspx?ObjectID=09000016805dc0c1

³ DH-BIO, *Additional Protocol on the protection of the human rights and dignity of persons with mental disorders with regard to involuntary placement and involuntary treatment. Compilation of comments received during the public consultation*, DH-BIO/INF (2015) 20, 9 December 2015, <https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=09000016805ab6fe>

European Convention on Human Rights (ECHR), the ECHR, and the CRPD, and expounds upon the provisions of the 2004 Recommendation (10). The aim is to protect the rights of people with mental disorders who are subjected to involuntary placement or treatment (Article 1). It does not include minors or those affected by these measures in the context of criminal proceedings (Article 2). It requires States to develop and use less restrictive and intrusive measures than involuntary placement and involuntary treatment (Article 3). Involuntary measures shall only be used in accordance with the principle of proportionality and necessity such that people shall be cared for in the least restrictive environment possible and with the least intrusive treatment taking into account their health needs and the need to protect other persons from harm (Article 5). Persons with mental disorder shall have the right to choose a person of trust and receive legal assistance (Article 6). Persons subject to involuntary measures shall receive care from competent and experienced staff in accordance with professional obligations and standards (Article 8) and in an appropriate environment (Article 9).

Involuntary measures will only apply when the following conditions are met: (1) the person's mental health condition represents a significant risk of serious harm to his or her health and his or her ability to decide on placement is severely impaired; or the person's mental health condition represents a significant risk of serious harm to others; (2) the involuntary placement has a therapeutic purpose; and (3) any voluntary measure is insufficient to address the risks (Articles 10 and 11).

The decision to apply Involuntary measures must be taken by a court or other competent body based on the report of a specialist physician and after having listened to the person affected, who will have the support of a person of his or her trust. Said decision must take the affected person's opinion into account as well as any wishes expressed previously and, where relevant, the person's representative must be consulted. Once placement has been decided, involuntary treatment can be decided by two physicians, as long as the opinions of the affected person, his or her person of trust and, where appropriate, his or her representative are considered. The decision to apply an involuntary measure must set a time limit and the law must specify the maximum period of validity of any decision to subject a person to an involuntary measure and the arrangements for periodic review (Article 12). In emergency situations, the decision to subject a person to an involuntary measure may be taken by a competent body on the basis of the relevant medical report and after having listened, to the extent possible, to the affected person, his or her person of trust and, where appropriate, his or her representative. These measures shall be applied for as brief a period as possible and shall never be extended beyond the legally established period. The duration of this period may only be extended where so decided subject to the procedure described in the previous article (Article 13).

The end of the involuntary measures shall be determined by the physician in charge of the person's care and the authority responsible for the measure (Article 15). The

person subject to the involuntary measure shall have the right to appeal the decision and request a review of the measure or its continuing application (Article 16).

Seclusion and restraint measures may only be used as a last resort and for the time strictly necessary (Article 17). In any case, the use of measures that produce irreversible physical effects is prohibited (Article 18).

Persons subject to the measure, persons providing them with legal assistant, their person of trust and their representative must be informed of their rights, the reasons for adopting the measure and its foreseeable evolution (Article 19). Persons subject to involuntary measures have the right to unrestricted communication with those providing legal assistance, their person of trust and their representative (Article 20). Lastly, States must ensure that compliance with these provisions is subject to independent monitoring and that the facilities at which placements are made have the required accreditation (Article 23).

According to DAPIPT, involuntary measures can only be applied where the mental health condition of the person poses a significant risk of serious harm to his or her health or to that of others, where it has a therapeutic purpose and where voluntary measures are insufficient to mitigate the risk. These measures are the last resort. Such measures may only be adopted through a judicial process in which the person has the right to a defence and must be heard. The measure may only be applied for as long as the risk that triggered it remains present. Only qualified people are authorised to care for these people. The DAPIPT and its explanatory report insist that these measures are not discriminatory insofar as their justification does not hinge on the existence of a mental disorder per se.

In view of the enormous controversy generated by the DAPIPT, in January 2019 the DH-BIO published a note explaining the need for its approval⁴. The DH-BIO points out that many CoE Member States regulate involuntary measures and that they report the implementation of the CRPD convention in their countries to the CRPD committee. Only three countries (Portugal, Bulgaria and North Macedonia) have expressed their commitment to the CRPD committee to eliminate involuntary measures over the short term. These same three countries have also publicly expressed their rejection of the DAPIPT.

It notes that States are increasingly being convicted for violation of Article 5 of the European Convention on Human Rights due to lack of procedural guarantees when implementing involuntary measures. It also recalls that when the degree of compliance with Recommendation 2004 (10) was examined, it was found that several Member States lacked adequate regulations when adopting involuntary

⁴ DH-BIO, *Draft Additional Protocol concerning the protection of human rights and dignity of persons with mental disorder regarding involuntary placement and involuntary treatment. Frequently asked questions*, DH-BIO/INF (2018) 10, 9 January 2019, <https://rm.coe.int/inf-2018-10-psy-frequent-questions-e/1680925d19>

measures. The approval of an Additional Protocol on this matter would help the States to incorporate the guarantees that effectively protect the rights of people with mental disorders into their regulations on involuntary measures. And they would do so by aligning themselves with case law of the European Court of Human Rights (ECHR) on this issue. The DH-BIO has stated that the DAPIPT does not promote the adoption of involuntary measures, as some have claimed. On the contrary, it will serve to prevent abuses, promote the use of alternative voluntary measures, ensure that involuntary measures are always used as a last resort and that they are applied in such a way that affected persons are able to exercise their rights.

Before presenting the opinions against the DAPIPT, it would be worthwhile to provide a brief review of ECHR case law on the conditions that must be met for involuntary placement.

Article 5 authorizes the deprivation of liberty of persons with mental disorders when there is a danger to the safety of third parties, or when the person's own interests may require such involuntary placement⁵. And while Article 5's scope is not limited to a mental disease in the strict sense of the term (other social conditions such as alcoholism or drug addiction could also suffice), this does not allow the detention of a person simply because his or her point of view or behaviour deviates from established social norms⁶.

The term mental disorder must have an autonomous meaning, without the Court necessarily being bound by the interpretation of the term established by a national law⁷, although this is not necessarily a requisite condition for a person whose criminal responsibility is limited or excluded national law⁸.

Court doctrine has called for three minimum requirements to be able to deprive a person with a mental disorder of his or her liberty⁹:

1. A mental disorder accredited by a medical professional. It must be reliably demonstrated that the person concerned is not of sound mind. In other words, a true mental disorder must be established before a competent authority based on objective medical evidence.

In relation to this minimum requirement, the Court has declared that no deprivation of liberty of a person with mental illness is in accordance with Article 5 if it has been ordered without the opinion of a medical expert¹⁰. When a personal examination by

⁵ Guzzardi v. Italy, § 98 in fine.

⁶ Rakevich v. Russia, § 26.

⁷ Petschulies v. Germany, 74-77.

⁸ Inseher v. Germany [GC], § 149.

⁹ Inseher v. Germany [GC], § 127; Stanev v. Bulgaria [GC], § 145; DD v. Lithuania, § 156; Kallweit v. Germany, § 45; Shtukaturv v. Russia, § 114; Varbanov v. Bulgaria, § 45; and Winterwerp v. the Netherlands, § 39.

¹⁰ Ruiz Rivera v. Switzerland, § 59; SR v. the Netherlands (Dec.), § 31.

a medical expert is not possible (for example if the person concerned does not give consent), the medical expert must have at least assessed the medical history of the subject¹¹.

In the case *X v. Finland*, the Court held that Article 5 of the Convention had been breached given that the deprivation of liberty was not based on an independent medical opinion since the doctors who supported prolonging the deprivation of liberty of the person in question provided their services in the same Hospital where that person was being detained.

2. Deprivation of liberty may be justified in the specific case where the measure is necessary.

It may be necessary to deprive persons with a mental disorder of their liberty not only when they need therapy, medication or other clinical treatment to cure or alleviate their condition, but also when they need control and supervision to keep them from causing harm to themselves or others¹². And while Article 5 authorizes the confinement of a person with mental disorders even when no medical treatment is provided, such a measure must be duly justified by the seriousness of the person's state of health and the need to protect the person in question or other persons¹³.

The person's disease or disorder must be of some seriousness to be considered a 'true' mental disorder¹⁴. To be classified as a true mental disorder for the purposes of sub paragraph (e) of Article 5(1), the mental disorder in question must be so severe as to require treatment in an appropriate institution for mental health patients¹⁵.

3. The mental disorder persists throughout the period of the deprivation of liberty. Reports by medical experts on which the authorities have based their decision must be sufficiently recent¹⁶.

Moreover, the Court has established that for deprivation of liberty to meet Convention standards it must have been adopted in the context of a fair and proper proceeding that offers the person in question adequate protection against arbitrary deprivation of liberty¹⁷. Here, special attention must be paid to the vulnerability of the individuals suffering from mental disorders and the need to give very important reasons justifying any restriction of their rights¹⁸. Therefore, it is essential for the person concerned to have access to a court and the opportunity to be heard

¹¹ *Constancia v. Netherlands*, § 26.

¹² *Ilmseher v. Germany* [GC], § 133; *Hutchison Reid v. United Kingdom*, § 52.

¹³ *N. v. Romania*, § 151.

¹⁴ *Glien v. Germany*, § 85.

¹⁵ *Ilmseher v. Germany* [GC], § 129; *Petschulies v. Germany*, § 76.

¹⁶ *Kadusic v. Switzerland*, §§ 44 and 55.

¹⁷ *VK v. Russia*, § 33; *X. v. Finland*, § 148.

¹⁸ *MS v Croatia (no. 2)*, § 147.

personally or, where necessary, through some type of representation. This implies that a person confined in a psychiatric institution should, unless there are special circumstances, receive legal assistance in proceedings related to the continuation, suspension or termination of their confinement¹⁹.

3. Dissenting voices against the DAPIPT in the Council of Europe itself

To date, two CoE bodies have issued an opinion on the DAPIPT: the Parliamentary Assembly and the Commissioner for Human Rights. Both have done so by repeatedly rejecting the initiative.

In 2016, the Parliamentary Assembly of the Council of Europe adopted recommendation 2091 (2016) on “The case against a Council of Europe legal instrument on involuntary measures in psychiatry”²⁰. In it the following recommendations are made to the CoE’s Committee of Ministers to instruct the DH-BIO. First, it proposes doing away with the DAPIPT and instead working on promoting alternatives to involuntary measures and devising measures that increase the involvement of people with psychosocial disabilities in decisions that affect their health. In the event that the Committee of Ministers concludes that it is worthwhile to continue working on the DAPIPT, the Parliamentary Assembly recommends that the DH-BIO involve organizations advocating for the rights of persons with disabilities in the drafting process, in accordance with Parliamentary Assembly Resolution 2039 (2015) which requires that all policies and measures adopted that relate to persons with disabilities be carried out in close participation with the organizations that represent them.

The Parliamentary Assembly holds this position for the following reasons. It recalls that the CRPD (which was adopted in 2006, came into force in 2008, and is currently ratified by 177 States, including 46 of the 47 member States of the Council of Europe) is the benchmark against which all regulations concerning the rights of persons with disabilities adopted at national and international level must be evaluated. The CRPD does not expressly refer to the involuntary placement or treatment of persons with psychosocial disabilities. However, Article 14 on liberty and security of persons prohibits the deprivation of liberty based on the existence of a disability.

The Parliamentary Assembly recalls that the CRPD interpreted that Article 14 prohibits deprivation of liberty based on the existence of a disability, although additional circumstances are alleged to justify such measures, such as danger to oneself or to others. In its view, mental health laws that allow or regulate these measures are discriminatory and pose arbitrary deprivation of liberty. It takes this view because other people who could be considered dangerous to themselves or others are not subject to such restrictions of their rights. It also holds that

¹⁹ Ibid., §§ 152 and 153; N. v. Romania, § 196.

²⁰ <http://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-en.asp?fileid=22757&lang=en>

involuntary treatment violates the right to equal recognition before the law and the right to personal integrity. The Parliamentary Assembly concludes that the DAPIPT establishes a link between involuntary measures and disability that is discriminatory and runs counter to the CRPD.

The Committee of Ministers, in turn, responded to the Recommendation of the Parliamentary Assembly²¹. It does not directly address the issue of whether the DAPIPT and the CRPD are compatible or not. However, it does recall that the European Court of Human Rights (ECHR) has admitted that these measures may be lawful under certain conditions²². Bearing in mind that there is a wide array of rules on involuntary measures in the various Member States of the CoE, and that the ECHR has received many complaints related to the adoption of involuntary measures, the Committee of Ministers takes the view that the adoption of this instrument will serve to establish common standards that guarantee the protection of the human rights of people with psychosocial disabilities who are subjected to involuntary measures. Therefore, it supports the work of the DH-BIO while urging it to involve organizations fighting for the rights of persons with disabilities in the preparation of the DAPIPT.

In May 2018, the DH-BIO decided to circulate a new version of the DAPIPT to various bodies of the CoE calling on them to send comments. It also agreed to declassify the document thus making it available to the general public. The new version met with the same rejection as the previous one as it does not modify any of the essential aspects that had sparked the initial rejection.

The DH-BIO maintains its work agenda on the DAPIPT for the following reasons. First, the DAPIPT implements some provisions of the CRPD, limiting its scope to establishing the specific guarantees that must be provided so that the involuntary measures allowed by the CRPD can be adopted. Secondly, it believes that all the States that have ratified the CRPD have laws on their books that permit involuntary measures affecting people with psychosocial disabilities. If all these laws truly were, in principle, contrary to the CRPD, States would not have ratified said convention. But precisely because the greatest number of violations of the rights of persons with disabilities occurs when adopting involuntary measures, as accredited by ECHR case law, the DH-BIO believes that it is advisable to approve basic guarantees on the way to proceed in those cases. This will increase the protection of the rights of people

²¹ Reply of the Committee of Ministers, “The case against a Council of Europe legal instrument on involuntary measures in psychiatry” Parliamentary Assembly Recommendation 2091 (2016), CM/AS(2016)Rec2091-final, 9 November 2016; https://search.coe.int/cm/Pages/result_details.aspx?ObjectId=09000016806b8195

²² The ECHR says that “a mental disorder may be considered as being of a degree warranting compulsory confinement if it is found that the confinement of the person concerned is necessary as the person needs therapy, medication or other clinical treatment to cure or alleviate his/her condition, but also where the person needs control and supervision to prevent him/her from, for example, causing harm to him/herself or other persons”; *Bergmann v. Germany*, No. 23279/14, judgment of 7 January 2016, § 97.

with disabilities.

The premise that the violation of human rights in relation to involuntary measures lies in the lack of guarantees and not in the substantive approach, however, falls apart if it is found that these guarantees are frequently violated. That is the complaint made by the CoE's Commissioner for Human Rights, Nils Muižnieks: the safeguards of the rights of people with psychosocial disabilities are not upheld when involuntary placements or treatments are adopted²³.

In October 2018 the Committee for Social Affairs, Health and Sustainable Development of the CoE's Parliamentary Assembly prepared a report on the situation facing the DAPIPT. The report insists that the best way to protect the rights of people with disabilities against involuntary measures in psychiatry is, first, to try to eliminate them and replace them with support services that allow these people to live independently, be part of the community and exercise their autonomy. The aim is to gradually eliminate involuntary measures that fail to respect their rights, will and preferences. Instead of adopting a legally binding instrument that runs the risk of perpetuating the current state of affairs, the CoE should consider what to do to motivate States to direct their policies towards the achievement of those objectives. That is the real challenge that must be faced and that will take time to tackle as it involves combating stereotypes and changing the mind of our societies where deep-seated beliefs that psychiatric patients are dangerous still exist. Many States and some medical groups resist this paradigm change.

The Human Rights Commissioner has twice spoken publicly about the DAPIPT. The first time was in 2017 in the aforementioned comment by Commissioner Nils Muižnieks and that had a very eloquent title: "Respecting the human rights of persons with psychosocial disabilities: an obligation not yet fully understood". According to the Commissioner, the DAPIPT's objective of adopting proper safeguards ensuring that involuntary measures applicable to people with psychosocial disabilities always respect their rights is sterile. Practice in the field confirms that these regulations do not serve that purpose, but rather only give the appearance of legitimacy to real violations of these people's rights. Therefore, while rejecting the initiative, he invites the Member States' mental health assistance systems to implement reforms based on good practices already in operation in different parts of the world, with the aim of drastically reducing coercive interventions in psychiatry until they are eventually eliminated. Involuntary placement should be limited to vital emergencies and should always be based on objective and non-discriminatory criteria that do not specifically target people with disabilities.

Dunja Mijatović replaced Nils Muižnieks as the CoE's Human Rights Commissioner

²³ Nils Muižnieks, *Comment: Respecting the human rights of persons with psychosocial and intellectual disabilities: an obligation not yet fully understood*, 28 August 2017, <https://www.coe.int/en/web/commissioner/-/respecting-the-human-rights-of-persons-with-psychosocial-and-intellectual-disabilities-an-obligation-not-yet-fully-understood>

and, like him, spoke out against continuing work to approve the DAPIPT and encouraged the DH-BIO to focus its efforts on proposing ways to reduce involuntary measures in psychiatry. The Commissioner pointed out that, going against the wishes and views of the people we are seeking to protect, and questioning the international standards reached following monumental efforts (in particular, the CRPD), will only serve to weaken the protection of the rights of persons with psychosocial disabilities and undermine the prestige of the CoE by exposing it to the serious risk of a conflict between international norms²⁴.

4. The CRPD Committee and the reactions of the CRPD and other UN bodies to the DAPIPT

The CRPD does not refer to involuntary measures but does contain provisions that directly affect their adoption in the case of persons with psychosocial disabilities. First, there is Article 12 which states:

“2. States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.

3. States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.”

This provision, which was one of the most controversial of the CRPD, nonetheless constitutes one of its fundamental pillars and enshrines the principle that the legal capacity of the person can never be modified based on his or her disability. No one disputed this principle in the case of sensory or physical disability. However, it caused doubts in cases of intellectual or psychosocial disability. It is generally agreed that health care should be provided in accordance with the principle of free and informed consent. The discrepancy lies in the fact that some argue that there may be certain circumstances that exceptionally justify the adoption of involuntary measures in cases of people with psychosocial disabilities, while others take the view that you can never deny or replace a person’s legal capacity based on his or her disability. That is the crux of the CRPD. What we need, then, are suitable support measures enabling people with psychosocial disabilities to understand what is being proposed to them so that they can freely take their decisions. In short, the CRPD discarded the paradigm of substitution in decision-making and embraced the paradigm of support in decision-making.

The CRPD specifies this principle of equal capacity in the field of health care by requiring health-care professionals to provide people with disabilities with the same quality of care as other people based on free and informed consent (Article 25). Based on the premise that people with disabilities have the same capacity as others, their health care can only be administered with their free and informed consent.

²⁴ Commissioner for Human Rights, Council of Europe, *2nd Quarterly Activity Report 2018*, pp. 10-11; <https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=09000016808d7ea2>

Regarding involuntary placement, the CRPD prohibits illegal or arbitrary deprivation of liberty and stresses that under no circumstances may disability be used as the grounds for depriving a person of his or her liberty. Therefore, the involuntary placement of a person can only be allowed when the law so authorizes, and the law may never justify such a measure based on the existence of a disability.

It is safe to say that the CRPD rules out involuntary measures applied to people with disabilities by proclaiming that “Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others” (Article 17). Furthermore, the CRPD obliges States to adopt “all effective legislative, administrative, judicial or other measures to prevent persons with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhuman or degrading treatment or punishment.” (Article 15(2)).

While the foregoing interpretation would appear to be the most plausible, it is true that the text of the CRPD does necessarily exclude other types of interpretation. It is worth remembering, however, that in 2012 the CRPD adopted General Comment 1 to the CRPD which focused on Article 12 on equal recognition before the law. There we find the following paragraph on involuntary treatments of people with disabilities:

“38. 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 have an obligation to provide access to support for decisions regarding psychiatric and other medical treatment. Forced treatment is a 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.”

And just in case there were any doubts, in September 2015 the CRPD approved guidelines on Article 14 of the CRPD, which reaffirms the prohibition, without exception, of the placement of people by reason of their disability. It also considers involuntary institutionalization based on the alleged need for care or treatment to be contrary to the right to liberty. Despite being at odds with Article 14, it admits that many States allow the placement of these persons in the case of other circumstances such as presumed danger to themselves or to others.

These guidelines identify the prejudice that needs to be contended with, i.e. that of considering that when people with intellectual or psychosocial disabilities do not consent to or resist medical or therapeutic treatment, they automatically become a danger to themselves or to others. This creates a vicious circle for those with a disability: as they do not consent to a given treatment, they are considered a danger to themselves or others and therefore must be subjected to involuntary measures. The truth is that disability does not make people dangerous and, consequently, no special legislation such as mental health laws should target them specifically. Therefore, these laws which tend to erode their human rights protection standards, are incompatible with Article 14 of the CRPD and should be abolished. The solution is to apply the general laws that exist in all States where rule of law prevails, to deal with people when they endanger themselves or others.

This same document asserts that the freedom to make one's own decisions, recognized under Article 3 of the CRPD, includes the freedom to take risks and to make mistakes, under the same conditions as people without disabilities. Furthermore, General Comment 1 proclaimed that decisions regarding medical or psychiatric treatment should be taken in accordance with the autonomy, will and preferences of the person with the disability.

With all this background, it is not surprising that the CRPD approved and made public in 2018 a declaration asking the States parties to the CRPD to oppose the DAPIPT. This declaration considers that the DAPIPT is at odds with articles 5, 12, 14, 15, 17 and 25 of the CRPD. It argues that if the DAPIPT were to be approved, it would perpetuate mental health laws which are based on the erroneous belief that people with disabilities should be treated differently and would sanction lower levels of human rights protection.

The declaration goes on to assert that, despite the joint letter sent in 2017 to the Secretary-General of the Council of Europe by the Working Group on Arbitrary Detentions, the Chair of the Committee on the Rights of Persons with Disabilities, the Special Rapporteur on the Rights of Persons with Disabilities and the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, the DH-BIO has not envisaged any alternatives to the DAPIPT. It concludes by calling on the States Parties to the CRPD which are also members of the CoE to reject this draft as Bulgaria, Portugal and the Republic of North Macedonia have done.

Only two months later, on 9 October 2018, Catalina Devandas-Aguilar, UN Special Rapporteur on the rights of persons with disabilities, spoke before the Parliamentary Assembly of the Council of Europe about “Protection of the rights of people with psychosocial disabilities in relation to involuntary measures in psychiatry”.

The Special Rapporteur based her speech on a point around which there is general consensus: saving lives and helping people in crisis. The question is how to achieve this in a way that respects the dignity of the person, their physical and mental

integrity, their will and their preferences, i.e. in a way that respects their human rights.

In the opinion of the Rapporteur, the DAPIPT does not offer this solution and should be rejected insofar as it is based on an anachronistic conception of disability that runs counter to human rights. According to this conception, people with psychosocial disabilities are seen as patients, people with mental disorders who need to be ‘cured’ or ‘controlled’. The CRPD distances itself from this medical and paternalistic idea of disability. Instead, she asserted that every person with a disability should enjoy all human rights under the same conditions as everyone else. Therefore, exceptions to this enjoyment of rights based on a mental health problem, such as those proposed in the DAPIPT, stand in contrast to the spirit and letter of the CRPD, and specifically to the right to equality and non-discrimination.

From this concept of disability, what alternatives are there to save the lives of people with disabilities or the lives of third parties, and to properly meet their needs when they suffer a serious crisis? The alternative is the support model²⁵ enshrined in the CRPD. Wherever this model has been thoughtfully implemented, good results have been achieved in terms of protecting life and health and avoiding coercive measures and rights violations. These strategies include reducing coercion in hospitals, intervention initiatives in homes, peer-run initiatives and early intervention planning.

The biomedical and coercive intervention model fails to improve the mental health of patients because it does not reduce the risk of self-harm nor facilitate access to treatment. Quite the opposite; studies show that these interventions generate an alarming increase in stigmatization and discrimination, inequality, torture and mistreatment.

In her intervention, the Rapporteur recalled that 46 of the 47 member countries of the Council of Europe had ratified the CRPD. Specifically, the 29 countries that have so far ratified the ECHR have also ratified the CRPD. The European Union is party to the CRPD. In fact, it is the first time in its history that it has agreed to be a party to a human rights treaty. All these countries, and the European Union itself, are committed to protecting the rights of people with disabilities. To the extent that the CRPD committee covers all the issues raised in the DAPIPT, this latter text should be

²⁵ “The Convention advocates people with disabilities having legal capacity and personal autonomy, but with the necessary support to prevent abuses arising from their vulnerability. These supports could perfectly well include, for example, the guarantee of consent or assent of the support provider to engage in legal acts. In accordance with the Convention and getting past the insufficient medical model of disability, the aim is also to assume a social and rights and capacities-based perspective, addressing disability as a complex set of conditions, many of which are caused or aggravated by the social environment itself. Given all of this, the adoption of measures that eliminate personal autonomy, such as substitution in decision-making, is incompatible with the Convention”; Bioethics Committee of Spain, *Report on the need to adapt Spanish legislation to the Convention on the Rights of Persons with Disabilities*, 20 December 2017, http://assets.comitedebioetica.es/files/documentacion/es/informe_final_CRPD.pdf

consistent with the provisions of the former.

For all these reasons, the Rapporteur urgently calls for a change in the topic of conversation: instead of focusing on involuntary treatments, we should be speaking about human rights-based responses.

But not only the CRPD and the UN Special Rapporteur on the rights of persons with disabilities have spoken out on the DAPIPT. Others such as the UN High Commissioner for Human Rights, the UN Human Rights Council, and even the World Health Organization have done so directly or indirectly.

On 29 September 2017 the United Nations High Commissioner for Human Rights²⁶ sent a letter to the Secretary General of the Council of Europe regarding the DAPIPT. In it he contends that “the matters addressed by the draft Additional Protocol are within the scope of the Convention on the Rights of Persons with Disabilities, which is the most authoritative legal instrument to guide the formulation of standards, laws or guidelines related to the rights of people with disabilities”. The letter expresses great concern over the fact that “the proposed texts may be, prima facie, below the standards of human rights established by the Convention”.

Based on Article 12 of the CRPD, “States Parties are obliged not to deprive persons with disabilities of the right to make and carry out their own decisions, or to advocate substitute decision-makers to give consent on their behalf. On the contrary, States must provide persons with disabilities with access to different means of support that enable them to exercise their legal capacity, including the provision of consent.” For this and other arguments analogous to those expressed by other intergovernmental bodies which we have been referring to, the signatories of the letter show their willingness to collaborate so that the initiative undertaken by the DH-BIO ends up conforming to the standards of the CRPD.

It is interesting to note how the Report of the UN High Commissioner for Human Rights on mental health and human rights changed between 2017 and 2018. The final conclusion of the 2017 report marked a guideline in broad terms that allowed various interpretations. It proposed:

“policy shifts that recognize exclusion and marginalization as the causes and consequences of poor mental health and take seriously the commitment in the 2030 Agenda for Sustainable Development to leave no one behind and reach first those who are furthest behind. Consequently, in meeting their obligation to achieve the full realization of the rights of persons with mental health conditions, users of mental health services and persons with psychosocial disabilities, States should align the policy and legal framework with human rights norms, develop and implement rights-based strategies and plans, and share technical expertise and other resources, such as

²⁶ This letter is a mandate signed by the following agents: Mandates of the Working Group on Arbitrary Detention; the Chair of the Committee on the Rights of Persons with Disabilities; the Special Rapporteur on the rights of persons with disabilities and the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

good practice norms.”²⁷

However, in the 2018 Report²⁸ the High Commissioner goes further in defining his proposals. He goes beyond requesting that States adapt their mental health rules to human rights and develop good practices in the care of persons with psychosocial disabilities. He introduces a battery of concrete and demanding recommendations, among which we believe three are of the utmost importance: abandon, once and for all, the biomedical approach to mental health²⁹; repeal legal provisions that permit involuntary measures³⁰; states parties to the CRPD not to promote draft regulations that are contrary to it³¹.

In 2017, the Human Rights Council adopted a resolution on mental health and human rights³² in which, although it does not expressly reject involuntary placement and treatment,

²⁷ UN High Commissioner for Human Rights, *Report on Mental Health and Human Rights*, 2017; <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G17/021/37/PDF/G1702137.pdf?OpenElement>

²⁸ UN High Commissioner for Human Rights, *Report on Mental Health and Human Rights*, 2018; <https://undocs.org/A/HRC/39/36>

²⁹ “45. States should re-examine the biomedical approach to mental health, which maintains the imbalance of power between practitioners and users of mental health services, through a collective process that includes all stakeholders. Users of mental health services, persons with mental health conditions and persons with psychosocial disabilities should play a leading role in developing the conceptual framework that determines mental health services, and in their design, delivery and evaluation.”

³⁰ “46. States should ensure that all health care and services, including all mental health care and services, are based on the free and informed consent of the individual concerned, and that legal provisions and policies permitting the use of coercion and forced interventions, including involuntary hospitalization and institutionalization, the use of restraints, psychosurgery, forced medication, and other forced measures aimed at correcting or fixing an actual or perceived impairment, including those allowing for consent or authorization by a third party, are repealed. States should reframe and recognize these practices as constituting torture or other cruel, inhuman or degrading treatment or punishment and as amounting to discrimination against users of mental health services, persons with mental health conditions and persons with psychosocial disabilities. States should ensure their enjoyment and exercise of legal capacity on an equal basis with others by repealing laws that provided for substituted decision-making, and should provide:

a) a range of voluntary supported decision-making mechanisms, including peer support, respectful of their individual autonomy, will and preferences; b) safeguards against abuse and undue influence within support arrangements; and c) the allocation of resources to enable and ensure the availability of support.”

³¹ “53. Given that, throughout the consultation, participants expressed their concern about the ongoing process within the Council of Europe to draft an additional protocol to the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine (the Oviedo Convention), indicating that the draft additional protocol on “the protection of human rights and dignity of persons with mental disorder with regard to involuntary placement and treatment” contradicted the Convention on the Rights of Persons with Disabilities, member States of the Council of Europe should evaluate the potential impact of the adoption of this instrument vis-à-vis their international obligations under the Convention on the Rights of Persons with Disabilities and other human rights law, specifically regarding the individual’s right to free and informed consent to treatment within mental health services. All States parties to the Convention on the Rights of Persons with Disabilities should undertake a review of their obligations before adopting legislation or instruments that may contradict their obligations to uphold the rights of persons with disabilities.”

³² <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G17/295/03/PDF/G1729503.pdf?OpenElement>

“Urges States to actively adopt measures to fully incorporate a human rights perspective in mental health and social services, and to adopt, implement, update, strengthen or monitor, as appropriate, all laws, policies and existing practices, in order to eradicate all forms of discrimination, stigma, prejudice, violence, abuse, social exclusion and segregation in that context, to promote the right of people with mental health or psychosocial disabilities to full inclusion and effective participation in society, on equal terms with others” (5).

Lastly, the World Health Organization’s Mental Health Action Plan 2013-2020 establishes, as one of its goals, States’ adoption of a national mental health policy or plan in accordance with international human rights instruments. In stating this goal, it warns that many policies and plans dating back more than 10 years may not reflect the most recent developments in international human rights law and evidence-based practice³³. It is obviously referring to the fact that States typically have laws on the books regarding coercive measures applicable to people with psychosocial disabilities while the CRPD, ratified by most countries around the world, does not allow such measures insofar as they imply discriminatory treatment.

5. Stance taken by affected groups

The first civil society declaration on the DAPIPT was made by the two most representative organizations in the field of mental health: the European Network of (Ex-)Users and Survivors of Psychiatry (ENUSP) and Mental Health Europe (MHE).

Their declaration constitutes an outright rejection of the DAPIPT³⁴. They stress the radical difference between care and coercion and argue that defending involuntary placement or treatment based on some presumed benefit for the person in question is an approach that contradicts current scientific evidence. Coercive measures cause more psychological harm, exclusion and isolation, increasing the risk of new problems. These measures are harmful and discriminatory practices, which produce severe pain and suffering, as well as fear and trauma in their victims. In some cases, they can amount to ill-treatment or even torture.

The European Disability Forum is a non-profit international organization that brings together all national organizations of people with disabilities within the framework of the European Union, as well as the most relevant organizations of people with disabilities throughout the rest of Europe. The Spanish representative in this organization is called CERMI (Spanish Committee of Representatives of People with Disabilities). On 14 May 2018 the European Disability Forum sent a letter to the CoE and its DH-BIO calling for the withdrawal of the DAPIPT for being contrary to the spirit and letter of the CRPD³⁵. The tone of the letter is harsh and conveys to the CoE

³³ World Health Organisation, *Comprehensive Mental Health Action Plan 2013-2020*, Geneva, 2013, https://apps.who.int/iris/bitstream/handle/10665/97488/9789243506029_spa.pdf;jsessionid=E0F64229C1A5C4111363B5A3FD7A5D9F?sequence=1

³⁴ <https://mhe-sme.org/statement-of-enusp-and-mental-health-europe-on-additional-protocol/>

³⁵ <https://www.inclusion-europe.eu/letter-to-the-council-of-europe-withdraw-the-draft-additional-protocol-to-the-oviedo-convention/>

the members' "deepest concern and opposition to the adoption of this protocol".

The Forum believes that this draft protocol goes against the Council of Europe's strategy on the rights of persons with disabilities (2017-2023) which includes among its priorities putting an end to violence, exploitation and abuse in this field; and the legal reforms that some member states have already undertaken to conform to the CRPD. If it were to be approved, they argue, it would create enormous confusion as there would be two legal instruments on the same subject but with conflicting approaches. The letter states that they will not continue participating in the DH-BIO meetings because they believe that the proposals they have been making so far have been systematically ignored and that transparency has been lacking in the process. They emphasize that it was a grave mistake to move forward in this process without having engaged in serious consultation with groups of disabled persons as required under Article 4(3) of the CRPD ("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"). That is precisely the motto of the European Disability Forum ('Nothing about us without us'). The letter was also signed by the most important European organizations of groups of people with intellectual and psychosocial disabilities: European Network of (Ex)-Users and Survivors of Psychiatry (ENUSP), Mental Health Europe, Inclusion Europe, Autism-Europe, International Disability Alliance, and others.

The European Network of National Human Rights Institutions (ENNHRI) groups together the Ombudsmen and the national human rights organizations of the EU Member States. This important organization in the field of human rights defence also published a statement which featured serious reservations about the DAPIPT and made three requests: to the DH-BIO to withdraw the DAPIPT in its present form owing to general rejection on the part of the groups affected and the CRPD; to the Member States urging them to request its withdrawal; and again "to the DH-BIO requesting that any text related to the deprivation of liberty of persons with disabilities include the necessary procedural guarantees and be subjected to consultation and dialogue with stakeholders, including national human rights institutions, organizations of persons with disabilities and civil society as a whole"³⁶.

Human Rights Watch, a very important human rights NGO, also spoke out against the DAPIPT, going as far as to call it a "threat to the rights of persons with disabilities."³⁷

6. The situation in Spain

³⁶ <http://ennhri.org/ENNHRI-Statement-on-the-Draft-Additional-Protocol-to-the-Oviedo-Convention>

³⁷ <https://www.hrw.org/news/2018/11/21/council-europe-threat-rights-people-disabilities>

Spain has a specific regulation on the involuntary placement of people with a psychosocial disability and has established procedural guarantees like those provided for in the DAPIPT. Specifically, Article 763 of the Code of Civil Procedure provides:

“1. Confinement based on the psychic disorder of persons who are not in a position to decide on their own shall require judicial authorization issued by the court of the city or town where the person affected by the placement proceeding resides, even if they are subject to parental authority or guardianship. Authorization must be issued prior to such placement unless an emergency calls for the immediate adoption of the measure. In this latter case, the director of the institution in which the person was placed must report the situation to the competent court as soon as possible and, in any case, within a period of twenty-four hours, in order to proceed to the mandatory ratification of said measure, which must be carried out within a maximum period of seventy-two hours after the placement is brought to the attention of the court.

In cases of urgent placement, ratification must be issued by the court of the city or town where the institution in question is located. That court shall act, as the case may be, in accordance with the provisions of section 3 Article 757 of this Law.

2. Confinement of minors must always be in an age-appropriate mental health establishment and be duly informed by the child assistance services.

3. Before granting authorization or ratifying a placement that has already been made, the court must hear the person affected by the decision, the public prosecutor and any other person whose appearance it deems appropriate or is requested by the person who is affected by the measure. Moreover, and without prejudice to any other evidence that may be considered relevant to the case, the court must itself examine the person subject to confinement and hear the opinion of a physician designated by him or her. In all actions, the person subjected to the confinement measure is entitled to representation and defence under the terms set forth in Article 758 of this Law.

In any case, the confinement decision adopted by the court is subject to appeal.

4. In the same resolution ordering confinement, the physicians responsible for the care of the person subject to confinement must be informed of their obligation to report periodically to the court on the need to keep the confinement measure in place, without prejudice to other reports that the court may require where deemed appropriate.

The periodic reports must be issued every six months unless the court stipulates a shorter period owing to the nature of the disorder that led to confinement.

Once the aforementioned reports have been received the court, having taken any other action deemed relevant, will take a decision regarding whether to extend confinement or not.

Notwithstanding the provisions of the preceding paragraphs, should the physicians caring for the confined person come to believe that such confinement is no longer

necessary, they must discharge the patient and immediately inform the competent court”.

It should be recalled that this provision was the subject of a constitutional query in which the Court considered whether it was constitutional for an ordinary law to regulate non-voluntary confinement based on a mental disorder as such a measure entails deprivation of liberty. The issue was resolved in STC 132/2010. Here we will refer to the ruling and the reasons on which it is based, but also to the arguments put forward by the Counsel for the State in defence of the constitutionality of the norm. Both clearly illustrate the conceptualization of disability that is usually at the core of those norms and that of society that approves and enforces them.

The Counsel for the State argued that placing someone in an institution against their will for reasons of citizen security (which is what happens when a person is arrested to investigate his or her participation in a crime) is not the same as institutionalizing someone for his or her own good (which is what happens with the placement of a person with a mental disorder). While detentions made for reasons of citizen security should be considered as a deprivation of liberty and, as such, must be regulated by means of an organic law, the involuntary placement of persons with psychosocial disabilities should not be assessed in the same way. Consequently, the fact that these measures are regulated by ordinary law should not be considered unconstitutional.

Delving deeper into this line of reasoning, the Counsel for the State argues that involuntary placements are in fulfilment of the constitutional mandate established in Article 49 of the Constitution whose aim is the “care, treatment, rehabilitation and integration of the physically, sensorially and mentally handicapped”. According to the Government representative, the aforementioned constitutional precept authorizes such placements, “as the best enforcement and guarantee of the right to freedom”. In short, in the view of the Counsel for the State involuntary placements do not limit the rights of people with disabilities. Quite the contrary; they are a guarantee that reinforces the right to freedom for these people and, therefore, can be regulated under ordinary law.

This argument made by the Counsel for the State illustrates the sort of prejudice that people with disabilities have faced historically and which, since the entry into force of the CRPD, should be forever abolished: the prejudice to maintain that the best guarantee of the rights of persons with psychosocial disabilities could consist in limiting their freedom by imposing placement and treatment.

In response to this reasoning, the Constitutional Court reaffirmed that any deprivation of liberty must be regulated by an organic law, a ruling previously handed down in STC 119/1999:

“As a measure amounting to deprivation of liberty, it is obvious that a decision entailing forced placement can only be taken by the courts and that, turning to the important matter under discussion here, the precept that makes it possible can only

be an organic law because, as a norm that establishes one of the cases in which a person can be deprived of his or her liberty, it involves a fundamental right guaranteed under Article 17(1)" (STC 132/2010, FJ 2).

On that basis, the Court declared the article 763 LEC unconstitutional, but failed to declare it null and void due to the problems that could be caused by such a legal vacuum resulting from eliminating such a provision until another organic regulation was passed. In any case, this claim of unconstitutionality was legally repaired through Organic Law 8/2015 of 22 July 2015 amending the system protecting children and adolescents, Article 2(3) of which provides the organic law status needed for the controversial article 763.

The Constitutional Court ruled that that provision, which allows the involuntary placement of people suffering from a psychic disorder by means of judicial authorization, is constitutional. In emergency situations, this measure can be adopted even without prior judicial authorization if it is followed by an ex post judicial ratification. The Constitutional Court did not investigate the issue of whether the Constitution should be interpreted in a manner consistent with the provisions of the CRPD, which was already a binding norm for Spain at the time the judgment was published.

In STC 141/2012 of 2 July 2012, which resolved an appeal for legal protection in a case of emergency involuntary placement, the Court indirectly validated the guarantees established under Article 763 LEC by admitting the appeal for protection based on four main arguments. First of all, the Court held the view that the period of time that the Judge has to decide a posteriori on the constitutionality of the measure cannot exceed, in any case, 72 hours from the moment he learns of its adoption, a backlog of work not being considered a valid reason for failing to comply with that deadline. Moreover, this inability to extend the deadline cannot be remedied by handing down a late decision ratifying placement. Secondly, evidence of the need for the measure was not furnished and the alternative of applying a much less harmful treatment such as outpatient care, which is the usual treatment for these disorders, was not clearly ruled out. The mere existence of a psychiatric illness does not justify internment or the emergency adoption of such a measure. Moreover, the requirement of necessity must be met. Thus, the Constitutional Court confirmed the constitutional requirement to prove the necessity of the placement measure and, therefore, the impossibility of resorting to another measure less restrictive of the right. Thirdly, the Constitutional Court rebuked the first instance Judge for not having informed the person subjected to placement of his right to legal counsel in this proceeding and his right to adduce evidence, the presumption that the subject was aware of this rule not coming into play. Lastly, the Constitutional Court condemned the indiscriminate use of simple forms filled out as evidence of meeting the medical-legal requirements of placement. Based on these forms it cannot be deduced that a specific and detailed assessment of this specific case was performed, thus failing to justify the court's unverified assumption.

Furthermore, there is a lacuna in the Spanish legal system regarding involuntary outpatient treatment (IOT). Such treatment is administered when the person affected by a mental health problem abandons the prescribed treatment and it is feared that this could have a serious negative impact on his or her health and/or on the lives of others. In this connection, the application of IOT is not without controversy. Advocates consider that this is a way to complete therapy and help patients to improve while opponents believe that measures such as this are a violation of the fundamental rights of the person and serve to increase coercion and heighten the stigma suffered by psychiatric patients. The situation in Spain can be summarized as follows: In October 2004, at the request of FEALES (Spanish Confederation of Groups of Relatives and Mentally Ill persons), a proposal was submitted to the Congress of Deputies (Spanish Parliament) to amend Article 763 of the Code of Civil Procedure to regulate the non-voluntary treatment of people with psychic disorders thus opening the door to the possibility of legally compelling a certain type of patient to receive outpatient treatment. In plenary session Congress agreed to consider the introduction of a fifth point in that article which would allow the court to authorize IOT subject to a reasoned proposal made by the physician, a hearing of the interested party, and a report from the forensic doctor and the prosecutor. The draft bill included that the judicial decision should include a treatment plan, control mechanism, a responsible community health mechanism, periodic information on the evolution of the measure to the judge, and the maximum period of application of the measure. The intention of the FEALES proposal was to implement a measure that would give family members and professionals the assurance that therapy would be completed in the case of seriously ill mental patients with a high risk of relapse if they left treatment. Its purpose was also to prevent more radical interventions such as placement in hospital and civil incapacitation.

As in many other countries, controversy surrounds the suitability of measures like this which have their advocates and detractors. For instance, the Spanish Association of Psychiatry and the Spanish Association of Legal Psychiatry have spoken out in favour of legislative reform. On the other side is the Spanish Association of Neuropsychiatry which has come out against by giving greater weight to potential drawbacks and defending the need to develop intensive community monitoring programmes and complete the implementation of the General Health Act. This draft legislation was withdrawn from parliament due to the lack of consensus.

A new draft bill was presented in October 2006. The government tabled a bill on Voluntary Jurisdiction, Chapter IX of which covers “judicial authorization of non-voluntary treatment of people with mental disorders”. Unlike the 2004 bill in which the judicial measure was always based on a physician’s examination, this new bill envisaged going directly to the court without the prior reasoned proposal of the specialist. Finally, after its debate in Parliament, the set of articles on the regulation

of “non-voluntary treatment” was once again deleted and the bill removed from Parliament. It is worth mentioning that the final version of the CRPD saw the light of day on 13 November 2006 in New York.

In practice IOT in Spain is a reality: treatments are secretly administered in patients' food and long-term injectable treatments are administered without properly informing them. Despite patients' open reluctance to receive such treatment, court authorisation to force patients to submit to involuntary treatment is not requested. The impact of these measures is not known since the initial assumptions do not allow for a rigorous or ethical investigation.

Fortunately, the frequency of these practices is decreasing due to the greater awareness of Spanish society in general and of health professionals in particular of the importance of respecting the rights of patients (based on the principle of autonomy and its application through informed consent). Thus, pursuant to the basic law on patient autonomy, any action taken in the area of healthcare requires prior patient consent and every patient has the right to refuse treatment.

In recent years, the civil courts of some Spanish cities (San Sebastian, Barcelona, Alicante, Valencia) have been authorizing IOT with the aim of keeping people with severe mental illness in treatment with a view to preventing more extreme situations of hospital admission or civil incapacity. Although in general terms this may be a beneficial alternative for some patients, the scientific community warns that further study is needed on this subject and considers that a large proportion of these patients could respond to intensive monitoring programmes such as assertive community treatment without the need for judicial intervention. It is likely that the lack or scarcity of such assistance resources results in increased IOT by professionals devoted to caring for patients with psychosocial disabilities. IOT is not a treatment in itself but rather the way in which the prescribed treatment is administered, and the question is whether IOT addresses the stigma, the difficulties that people with mental health problems have in finding employment and accessing social and health resources in general in their recovery process and in developing their life project.

It is also worth mentioning that IOTs cannot be assessed without considering how they affect not only people with a serious mental health diagnosis, but also all the people involved in their treatment such as family members, caregivers, and people of trust, who are on the front line providing support for them.

The CRPD provides (Article 35) that States Parties must submit to the CRPD a comprehensive report on measures taken to effectively comply with their obligations under the Convention within two years of its entry into force. Exactly two years after the CRPD entered into force, Spain submitted the requisite report. The CRPD evaluated that report and published its Concluding Observations in 2011. Among them, we find two that are directly related to the regulation of involuntary placement in Spain and that, consequently, are relevant for the DAPIPT:

“35. The Committee takes note of the legal regime allowing the institutionalization of persons with disabilities, including persons with intellectual and psychosocial disabilities (“mental illness”). It is concerned at the reported trend of resorting to urgent measures of institutionalization which contain only ex post facto safeguards for the affected individuals. It is equally concerned at the reported abuse of persons with disabilities who are institutionalized in residential centres or psychiatric hospitals.

36. The Committee recommends that the State party: review its laws that allow for the deprivation of liberty on the basis of disability, including mental, psychosocial or intellectual disabilities; repeal provisions that authorize involuntary internment linked to an apparent or diagnosed disability; and adopt measures to ensure that health-care services, including all mental-health-care services, are based on the informed consent of the person concerned.”³⁸

The CRPD expresses its concern about two types of actions: abuse in the adoption of urgent internment measures which only contain ex post facto safeguards, and ill-treatment suffered by people with psychosocial disabilities in the centres where they are interned. These are bad practices, or even real violations of rights, which are not protected under Spanish law because urgent measures can only be adopted on an exceptional basis and because ill treatment not only lacks legal protection but must be prosecuted (to a greater degree than what is currently being done).

But, while Concluding Observation 35 draws attention to certain bad practices that must be combated, 36 expressly recommends regulatory amendment, i.e. the repeal of provisions that authorize the involuntary internment of persons with psychosocial disabilities.

7. Spain’s reaction to the DAPIPT

As the European Disability Forum that preceded it, in 2018 CERMI and Mental Health Spain sent a letter to the Ministers of Foreign Affairs and Health, urging the Spanish Government oppose the DAPIPT. In addition to making similar arguments as other bodies, the letter noted that the DAPIPT

“Confuses coercion and care, authorizes the deprivation of liberty of people with mental health problems based on the presumption of risk, fails to support or promote the creation of alternative resources that respect people's will and preferences and ignores the warnings of the most relevant human rights organizations”³⁹.

Two of Spain’s Autonomous Communities (regions) have taken a stance on the DAPIPT. In May 2018, the Bioethics Committee of Catalonia expressed its opinion at

³⁸ Concluding observations of the Committee on the Rights of Persons with Disabilities in the framework of the Review of reports submitted by Spain under Article 35 of the Convention (September 2011), CRPD/C/ESP/CO/1.

³⁹ <http://semanal.cermi.es/noticia/CERMI-SALUD-MENTAL-ESPAnA-exigen-Gobierno-oponga-Protocolo-Adicional-Convenio-Oviedo-contrario-derechos-humanos.aspx>

the request of user groups in that region⁴⁰. Its position deviates from the general trend of rejecting the DAPIPT as a matter of principle. Even so, it advocates rejecting it as inappropriate, unnecessary and insufficient.

It argues that several points need to be improved. Specifically, it points out that involuntary placement does not, in and of itself, justify involuntary treatment meaning that informed consent must be sought for such treatment. And involuntary placement is even less of a justification for the adoption of more intrusive measures such as isolation, lack of communication with the outside world or physical restraint. It also believes that the DH-BIO should provide arguments in favour of the compatibility between the CRPD and DAPIPT in view of the apparent contradiction between the two instruments, particularly as regards legal capacity. It goes without saying that the reasons why DH-BIO sees no contradiction between the DAPIPT and the CRPD regarding equal legal capacity of persons with disabilities should not appear in the DAPIPT text. But these reasons should be developed in the Explanatory Report on the DAPIPT, something that has yet to be done.

The Catalan Committee contends that

“the concept of disability, which to a greater or lesser extent may or may not be associated with a serious mental disorder, should not be confused with the corresponding clinical and behavioural manifestation.

Disability is, of course, basically a psychosocial issue and requires, as proposed by the CRPD, a rights-based legislative and social framework. In contrast, an episode of depression or a psychotic crisis is, first of all, a clinical issue and should therefore be approached from a medical perspective within a bio-psycho-social framework”.

Without rejecting the initiative outright, the Bioethics Committee of Catalonia qualifies it as inappropriate because “it may contradict at least the currently dominant interpretations of the Convention on the rights of persons with disabilities”; as unnecessary because there is enough European regulation in this regard; and as insufficient because “the regulation of restrictive measures should always be considered within a much more proactive and participatory model of care, in which decisions can be shared between patients and professional caregivers, the former having more choices in accordance with their values and way of coping with life”.

Months later, the Directorate for Bioethics Strategy of Andalusia, the Directorate for the Integrated Mental Health Plan of Andalusia and the Public Health School of Andalusia, attached to the Department of Health of the Regional Government of Andalusia, published a joint position on the DAPIPT. Their position echoes the

⁴⁰ Posicionament del Comitè de Bioètica de Catalunya respecte del “Protocolo Adicional al Conveni d’Oviedo sobre Drets Humans i Biomedicina sobre la protecció dels drets humans i la dignitat de les persones amb trastorns mentals respecte a ingressos i tractaments involuntaris” que proposa el Comitè de Bioètica del Consell d’Europa, http://canalsalut.gencat.cat/web/.content/_Sistema_de_salut/CBC/recursos/documents_tematica/protocol_cbc_consell_Europa.pdf

rejection expressed by the most prestigious international institutions responsible for ensuring human rights and that of the mental health and disability sector of European civil society in general. Their rejection is “based on the risk that it could be counter-productive with respect to the purpose that it presumably seeks, i.e. to better protect the rights of people with mental health problems when they find themselves in situations of greater vulnerability”.

The document highlights that the eventual approval of the DAPIPT, rather than being an instrument that facilitates the implementation of initiatives and alternatives to improve the care received today by people with mental disorders in situations of greater vulnerability, will maintain the status quo and/or legitimize practices that unfortunately still today can be considered human rights abuses and violations.

What the DAPIPT presents as measures that supposedly benefit the people to whom they are applied, are actually coercive practices. The alleged benefits of involuntary placement and treatment for the good of patients are outdated arguments. There is growing evidence that the use of coercive measures causes even more psychosocial damage, exclusion and isolation than the person already suffers from their mental disorder and increases the risk of suffering additional problems. Moreover, many other practices have been proven to have real benefits when they have the consent of the person. That is why the declaration insists that the DAPIPT, instead of allowing involuntary placement and treatment, should support and promote alternatives that “respect the will and preferences of the people concerned and are based on their free and informed consent”.

Our Spanish Bioethics Committee has not specifically addressed the DAPIPT, but in December 2017 it did approve a report on the need to adapt Spanish law to the Convention on the Rights of Persons with Disabilities in which it takes a stand on involuntary internment measures envisaged under Spanish law⁴¹.

That Report states as follows with respect to involuntary internment:

“Forced internment for reasons of psychic disorders contemplated in Article 763 of the Code of Civil Procedure (LEC) can also be considered as another violation of the CRPD, specifically of the provisions of Article 14. Indeed, Article 14(1) obliges States to ensure that “persons with disabilities, on an equal basis with others, enjoy the right to liberty” (sub-paragraph a) and that “the existence of a disability shall in no case justify a deprivation of liberty” (sub-paragraph b). Likewise, Article 25(d) requires that health care for persons with disabilities be provided “on the basis of free and informed consent”. The Constitutional Court specifically confirmed that forced internment as regulated under Article 763 LEC constitutes deprivation of personal liberty which is why it ordered that it be regulated by means of an Organic Law (STC 132/2010, FJ 2^o). It is also obvious that the reason for this deprivation of

⁴¹ Bioethics Committee of Spain, *Report on the need to adapt Spanish legislation to the Convention on the Rights of Persons with Disabilities*, 20 December 2017, http://assets.comitedebioetica.es/files/documentacion/es/informe_final_CRPD.pdf

liberty is the existence of a disability since the only requirements listed in the provision are the existence of a 'psychic disorder' (...) and that the person is not in a position to make a decision on his or her own internment. Therefore, we have a measure that is clearly within the scope of the prohibition described under Article 14(1)(b) of the CRPD (...). This explains why this violation was also denounced by the UN Committee on the Rights of Persons with Disabilities in the Concluding Observations Report on Spain (...).

Therefore, in order to resolve this other friction between the CRPD and Spanish law, Article 763 of the LEC must be repealed, leaving treatment of this situation to general health legislation. In this connection, Law 41/2002 of 14 November 2002 providing basic regulation for patient autonomy (LBAP), establishing as a general rule the requirement of patient consent for any action in the health field (Article 8(1)), foresees the possibility of performing essential clinical interventions without the consent of the affected person "when a serious and immediate risk is posed to the physical or mental integrity of the patient and it is not possible to obtain authorization.

When circumstances allow, the person's relatives or those who are de facto linked to him or her shall be consulted" (Article 9(2)(b)). The law also envisages the possibility of consent by representation "when the patient is not able to make decisions, at the discretion of the physician responsible for providing care, or his physical or mental condition does not allow him to take charge of his situation" (Article 9(3)(b)). However, in relation to consent by representation, paragraphs 6 and 7 of the provision add that "the decision must be adopted always taking into account the greatest benefit for the patient's life or health" and that "consent by representation shall be adapted to the circumstances and proportionate to the needs that must be met (...). To the extent possible, the patient shall participate in decision making throughout the health-care process. If the patient is a person with a disability, the relevant support measures must be offered, including information in appropriate formats, adhering to the rules set by the design-for-all principle, in a way that is accessible and understandable for people with disabilities, to make it easier for the patient to personally give consent."

In the light of this regulation, it is clear that there are clinical interventions for which patients do not have to give their consent, which may include internment, either because they are essential in preventing an immediate serious risk to the physical or mental integrity of the patient, or because at that moment the patient is not able to make decisions or his physical or mental condition does not allow him to take charge of his situation, and the consent is then given by representation (by his legal representative or persons linked to him based on family or de facto ties). This same discipline should also apply to mental health situations. If Article 763 LEC is repealed, to prevent such an amendment from leading to a loss of guarantees, Article 9 of the LBAP should also be amended (which should have the rank of an Organic Law) to incorporate the guarantees that the involuntary internment measure has today: specifically the requirement of judicial authorization, at least for internments that exceed a certain period of time, or whose purpose is more than a simple intervention or one-off treatment requiring only a short internment period (...). Another possibility would be to incorporate into the LEC, a new procedure for

the judicial authorization of any non-voluntary internment for health reasons of the patient or a third party which would cover other cases such as, for example, the compulsory internment of patients with infectious-contagious diseases when these pose a threat to public health”⁴².

On a previous occasion Spain’s Bioethics Committee addressed a question partially related to this one in its 7 June 2016 Report on Ethical Considerations in the Use of Mechanical and Pharmacological Restraints in the social and health areas⁴³. In that Report we advocated a paradigm shift in the handling of patients, those with and without confirmed mental illness, one of the aims being humanization:

“We must be demanding when it comes to humanization as the provision of care entails more than the application of a set of protocols and keeping medical records. In accordance with universally established ethical principles and recognizing the rights of users, it is imperative that health care be administered with humanity and compassion, terms that are no longer in vogue but that in the end call on us to humanize treatment. The ethics of caregiving are based on the relationship with the other and must take emotions into account. Empathy and active listening are essential if we are to take the step from the theoretical to the real world with a view to flexibly responding to individual needs. One must be able to understand the concept of otherness in all its facets, be able to listen, respect other ways of thinking even where differences are apparent and, above all, we must be willing to make the effort to understand how others feel. Despite all of this, there are exceptional situations in which restraint is justified and, in those cases, basic ethical principles must be respected”.

In short, that Report promoted a paradigm shift that we were unable to deduce from the DAPIPT, even though the goals pursued support respect for the rights of individuals. The problem does not lie in the aims of the DAPIPT, which no one would doubt are laudable, but rather in the fact that the model on which it is based should have been cast aside some time ago, especially after the approval of the CRPD.

8. Evaluation of the DAPIPT by Spain’s Bioethics Committee and proposals for the future

Although the problem that has arisen around the assessment of the DAPIPT has an ethical dimension, it is our view that legal and political dimensions interact inseparably with the ethical and thus take on greater relevance. All the agents that have participated so far in the debate on the DAPIPT accept the principles and rights enshrined in the CRPD. The CoE has never called the legitimacy of this Convention into question and, at the same time, all those who oppose the DAPIPT do so because they claim that it collides with the CRPD.

It goes without saying that the ensuing problem is eminently ethical and is of a clear

⁴² Ibid, pp. 15-16.

⁴³ Bioethics Committee of Spain, *Ethical and legal considerations in the use of mechanical and pharmacological restraint in the social and health areas*, 7 June 2016; <http://assets.comitedebioetica.es/files/documentacion/Informe%20Contenciones-CBE.pdf>

legal and political nature. From a legal perspective, the question is whether the DAPIPT can be considered compatible with the CRPD. The CRPD takes the view that it is not and that, as it is a legal instrument with universal scope and is binding on the member states of the CoE for having ratified it, a regulation that contradicts it should not be approved. From a political perspective, and even if the two norms were deemed compatible, the question is whether it would be wise to support an initiative that seeks to protect the rights of persons with disabilities but, for the time being, is doing so with the opposition of those same people. We do not act as a legal or political consultant. Consequently, we have treated both problems from an ethical perspective, taking their legal and political dimensions into account only to the extent that they constitute the factual elements on which we must base our reflection and assessment.

We can summarize our position in the following points:

1. The CoE is an intergovernmental body recognized worldwide for its protection of human rights. One of the many achievements in this field was the approval of the ECHR, also known as the Oviedo Convention, and the four additional protocols approved thus far. It is the only international binding legal instrument that exists in the world specifically devoted to the protection of human rights in the area of biomedicine.
2. The ECHR accepts that involuntary placement and treatment is a possibility within the framework of the European Convention on Human Rights, provided that they comply with certain guarantees. In recent years, the number of convictions handed down by the ECHR to CoE Member States for the involuntary placement and treatment of people with mental disorders has risen. However, these convictions were not because the measures themselves were contrary to the European Convention on Human Rights. The convictions were based on insufficient safeguards. In other words, the rights of those subjected to these measures were not adequately guaranteed.
3. The DH-BIO, aware that many member states of the CoE have regulations on involuntary placements and treatments that do not comply with the standards of the European Convention on Human Rights and leave the rights of those who suffer these measures unprotected, has been promoting measures for more than fifteen years aimed at better protecting the human rights of people with psychosocial disabilities in the face of involuntary placement and treatment. Recommendation (2004) 10 of the Committee of Ministers of the CoE on the protection of human rights and the dignity of people with mental disorder was an important step in that direction. Since 2013, DH-BIO has been developing a binding legal instrument focused on involuntary placement and treatment. The objective is to approve an additional protocol that implements the provisions of Article 7 of the ECHR in accordance with the criteria already approved in Recommendation (2004) 10. The intention is for all CoE member states to comply by providing guarantees that

sufficiently protect the human rights of persons subjected to involuntary measures because of their psychosocial disability. The DH-BIO has always defended that the ECHR is compatible with the CRPD and with future regulation of involuntary measures.

4. In 2015 the DH-BIO presented the first version of the DAPIPT in order to receive comments from interested agents. The vast majority were extraordinarily critical and advocated its withdrawal. In 2017 a new version was presented which attempted to reflect the suggestions received. However, the substance of the previous version remained unchanged, i.e. people with psychosocial disabilities could still be subjected to involuntary placement and treatment. As expected, the reaction to this new version of the DAPIPT was equally negative.

5. Both the civil society and intergovernmental bodies in the field of human rights rejected the DAPIPT. The most important associations in Europe representing people with disabilities grouped together in the European Disability Forum consider it a step backwards in the fight for their rights. Among the intergovernmental organizations we would draw attention to the reaction of the UN High Commissioner for Human Rights who expressed misgivings about the DAPIPT. The position adopted by the CRPD Committee, the body in charge of monitoring compliance with the CRPD and offering official interpretation, merits special consideration. It rejected it outright.

6. It is odd, to say the least, that voices at the very heart of the CoE have been critical of the DAPIPT. The Parliamentary Assembly, no less, has requested the withdrawal of the DAPIPT and, in the case that the initiative continues forward, calls for the effective participation of associations representing people with disabilities. The Commissioner for Human Rights of the CoE has also repeatedly expressed her rejection.

7. The current climate does not favour the agreement. The Committee of Ministers is in favour of going forward with the work. The Parliamentary Assembly is more in favour of discontinuing it. The associations of people with disabilities and the DH-BIO do not have the type of fluid relationship that allows for collaboration and agreement. Three member states of the CoE, Bulgaria, Portugal and the Republic of North Macedonia have already taken a stance against the DAPIPT. The CRPD remains convinced that the DAPIPT would generate a conflict between norms of international human rights law.

8. Spain has a guarantee-based regulation regarding involuntary internment. Even though Spain's Constitutional Court declared it unconstitutional in 2010 on the grounds that an organic law should regulate matters such as this that affect human rights, it did not issue any reproach regarding the content of that regulation. In the appeals for legal protection regarding involuntary internment, the Constitutional Court has ruled by interpreting Article 763 LEC from a constitutional perspective, without issuing any constitutional reservation regarding that law. It is our view that

this doctrine, recently reiterated by the Constitutional Court itself, has made it unnecessary to heighten guarantees in favour of people susceptible to involuntary internment as such guarantees are already sufficiently explicit in the legal system. It does, however, demand effective compliance in practice. The exquisite control exercised by the Constitutional Court, especially since 2010, enables us to confidently assert that the current situation is better than it was decades ago. This is not to say, however, that there is no room for improvement in terms of caring for and treating people with a mental health diagnosis.

9. Spain ratified the CRPD and, since its entry into force in 2010, it has been under obligation to comply. Since then, the Government and Parliament have been adapting Spain's legal system to the requirements of this new norm. In 2011, the CRPD published some General Comments on the degree of compliance with the CRPD in Spain. It expressly called on Spain "to repeal provisions that authorize involuntary internment linked to an apparent or diagnosed disability; and adopt measures to ensure that health-care services, including all mental-health-care services, are based on the informed consent of the person concerned" (36).

10. At the request of the Ministry of Health and Consumer Affairs, the Bioethics Committee of Spain approved a report on the need to adapt Spanish law to the CRPD. In that report it was suggested that the regulation on involuntary internment be amended, either by repealing Article 763 LEC and generally applying the regulation contained in the LBAP (and introducing a jurisdictional guarantee when it comes to authorizing internments); or by eliminating the discriminatory bias contained in Article 763 LEC, and converting it into a norm of general application to all persons under certain circumstances.

11. Spain urgently needs to define its position on this matter which affects the rights of people with psychosocial disabilities. In our view it has two options. First, to conclude that the current regulation is not only in accordance with the Constitution and the ECHR but can also be interpreted without contradicting the CRPD. In that case, it would make sense to keep things as they are. But upholding this option would mean providing rigorous and sufficiently consistent reasons to contradict the recommendations that the CRPD Committee, the official body charged with interpreting the CRPD, has made to Spain on two occasions regarding this aspect. In both 2011 and 2019 the CRPD Committee recommended that Spain repeal or amend Article 763 LEC which allows involuntary placement and treatment of people with psychosocial disabilities, and that it commit to promoting a socio-health policy that contributes to reducing recourse to involuntary measures to completely exceptional cases. Based on what we have indicated throughout this report, this position would be difficult to sustain.

12. The second option would be to admit that involuntary placement and treatment measures for people with psychosocial disabilities are indeed contrary to the CRPD. In this case, the government would need to do three things. First, repeal the norm

that allows these measures and, where appropriate, adopt another that regulates involuntary measures based on respect for human rights. As concerns the topic under discussion, this requirement would mean eliminating discrimination based on psychosocial disability. Second, it should promote a general health policy, specifically mental health, in which people truly have the necessary support to give their free and informed consent to receive health care and ensure that medical or psychiatric treatments are consistent with their autonomy, will and preferences. Third, it should defend the inadmissibility of DAPIPT in its discussions with the DH-BIO.

13. This Committee reaffirms what it asserted in its December 2017 report: any norm that authorizes the adoption of involuntary measures based on a person's psychosocial disability should be repealed as soon as possible. These norms conflict with the CRPD because they are discriminatory, unduly deprive people of their liberty, violate their physical and moral integrity and can lead to abuse. We will therefore urge our government not to support the work of the DH-BIO aimed at approving the DAPIPT.

14. The CoE is recognized worldwide for its work in protecting human rights in the face of advances in biomedicine. In an attempt to get all of its member states to comply with minimum standards such as those required by the ECHR in terms of the involuntary placement and treatment of persons with psychosocial disabilities, the DH-BIO has been promoting the approval of an additional protocol to the Oviedo Convention. We are concerned that if this measure were finally approved, these standards would not be raised and instead methods that run counter to the CRPD would be legitimized, as the CRPD Committee has repeatedly stated.

15. For all the foregoing, we urge the Government:

- To encourage legislative reform that includes repealing norms that permit the involuntary placement of people with disabilities. Such an exceptional limitation of personal dignity and freedom should be circumscribed to a general regime that does not consider whether a person has a disability. In term of taking decisions on involuntary placement and treatment for health reasons, the subject's disability cannot be used as a criterion and can never by itself justify deprivation of liberty. Specifically, as we proposed in our 2017 Report, we need to either repeal Article 763 LEC and amend, where appropriate, Article 9 LBAP to incorporate the guarantees contained in the former but without linking its application to the concurrence of a psychic disorder or disability; or draft a new Article 763 LEC, eliminating the mention of psychic disorder as a criterion to determine internment. Both solutions require changing the status of the norm to that of organic law in compliance with the provisions of the Constitution as indicated by the Constitutional Court itself in 2010.
- To promote a health policy, specifically a mental health policy, focused on the person and on providing people with the support they need so that they can

freely consent to their health care and become fully integrated into the community. Special attention should be paid to their families and the people who comprise their trusted environments.

- To defend, at DH-BIO meetings, the need to refocus efforts aimed at protecting the rights of people with psychosocial disabilities. The problem is not that some States do not have sufficient guarantees when taking involuntary measures. The problem is that these measures violate many rights of people with psychosocial disabilities because of their discriminatory nature.

These measures should be adopted with the participation of CERMI and, in general, of associations of people with disabilities. In this matter so directly related to human rights, it would be ideal if, as far as possible, there were broad consensus regarding the policies and norms approved, so that they are not at the mercy of the political majorities of the moment.