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COMMITTEE ON BIOETHICS (DH-BIO)

Draft Explanatory Report to the Additional Protocol to the Convention on Human Rights and Biomedicine concerning the protection of human rights and dignity of persons with regard to involuntary placement and involuntary treatment within mental health care services

revised by the Secretariat in line with the revised version of
the draft Additional Protocol (DH-BIO(2019)20REV4)

Preamble

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

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

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

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

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

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

7. The Preamble emphasises that any form of discrimination on grounds of mental health problems must be prohibited.

8. The particular importance of ensuring both adequate initial qualification and continuous training of all staff working within mental health care services, as highlighted by the CPT, is also reflected in this Preamble.

9. The Preamble emphasises the need for persons to be supported in order to exercise their autonomy and the importance of involving them in decisions about their treatment and care. This is in line with the overall goal of the Council of Europe Disability Strategy 2017–2023 to achieve equality, dignity and equal opportunities for persons with disabilities through ensuring independence and freedom of choice.

10. The principle of free and informed consent to ~~healthcare~~ interventions is particularly important in the context of mental health care. The Preamble emphasises that involuntary treatment used on a person whose ability to decide on treatment is severely impaired must aim at enabling that person to regain such ability or, in case the person's ability to decide was already impaired before, to return that person to their previous level of functioning. Furthermore, even if a person is subject to an involuntary measure, attempts shall continue to be made to seek their consent to all aspects of their therapeutic programme.

11. The Preamble recognises that the use of involuntary placement and of involuntary treatment has the potential to endanger human dignity and fundamental rights and freedoms ~~and must therefore be minimised~~ and **that such measures are therefore** only **to** be used as a last resort. In order to minimise the use of involuntary measures, the primary importance of developing appropriate mental health care ~~measures/~~ services carried out with the consent of the person concerned is emphasised.

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

13. The Preamble finally emphasises the importance of monitoring the use of involuntary measures in ensuring compliance with relevant standards, including those set out in this Additional Protocol. Persons who have experienced mental health problems can make an important contribution to improvements in the quality of health **care** services and to monitoring processes. Advocacy services can also contribute to such improvements.

Chapter I – Object and scope

Article 1 – Object

14. The first paragraph sets out the aim of the Additional Protocol, which is to protect the dignity and identity of all persons and to guarantee respect for their autonomy, their identity and their other rights and fundamental freedoms with regard to the use of involuntary placement and involuntary treatment within mental health care services. The first paragraph further emphasises that this protection shall take place without discrimination. As spelled out in Art. 3 para.3, the existence of a mental disorder in itself shall**,** in no case**,** justify the use of involuntary measures.

15. The Protocol pursues its objective in three ways. Firstly, by promoting the use of voluntary treatment and care practices. Secondly, by providing safeguards to ensure that involuntary measures are only used as a last resort, and thirdly, by ensuring that if such measures are used, then the persons concerned receive appropriate protection and procedural safeguards that enable them to effectively exercise their rights.

16. The term "mental health care services" is to be seen in a broad sense and covers care or treatment administered within as well as outside a hospital setting (compare paragraph 18 below). As defined in Article 2 para. 4, second indent, any placement and/or treatment which is carried out without the concerned person's free and informed consent or against the will of that person is to be considered as "involuntary".

17. In line with Article 27 of the Convention on Human Rights and Biomedicine, ~~the second~~ paragraph **2** makes clear that States may apply rules of a more protective nature than those contained in the Additional Protocol.

[1] *Artico v. Italy*, judgment of 13 May 1980, Series A no. 37, § 33

Article 2 – Scope and definitions

18. The first paragraph of the Article specifies that the Additional Protocol applies to involuntary placement and to involuntary treatment of persons with mental disorder. For the definition of the term "mental disorder", compare the definition in Article 2 first indent and para. 21 below. The safeguards laid down in the following chapters of this Protocol apply to any involuntary placement and to any involuntary treatment, irrespective of where this takes place. This includes involuntary treatment administered in ambulatory care or outside a hospital setting. It should be noted that Article 2 only delimits the scope of the Additional Protocol; the criteria for the exceptional use of involuntary measures are specified in Article 11.

19. For the purpose of this Additional Protocol, a "minor" is a person who has not reached the age of majority as defined by national law. Paragraph 2 excludes minors from the scope of the Additional Protocol because minors find themselves in a different legal context than adults. Similarly, according to paragraph 3, this protocol does not apply to placement and/or treatment for mental disorder imposed in the context of a criminal law procedure, as additional considerations apply in such contexts that are not relevant in the civil context.

20. Another group which would not fall within the scope of this Additional Protocol would be persons with advanced dementia, who do not express any will regarding a placement or treatment proposed to them, as the measure would not be carried out against their will. However, member states are not prevented from choosing to apply part or all of the provisions of the Additional Protocol to any of the groups mentioned above. Member States may also choose to provide alternative mechanisms to protect these persons' human rights and fundamental freedoms, taking into account the specific legal context and their vulnerability.

21. Paragraph 4 of the Article defines certain key terms used in the Additional Protocol. "Mental disorder" is defined in accordance with internationally accepted medical standards. This method of defining mental disorder aims to prevent idiosyncratic approaches to diagnosis. An example of an internationally accepted medical standard is that provided by Chapter V of the World Health Organization's International Statistical Classification of Diseases and Related Health Problems, which concerns mental and behavioural disorders. However, this classification is very broad and includes many categories for which involuntary measures would never be **acceptable** ~~appropriate~~, such as gender incongruence, sleep disorders and sexual dysfunctions.

22. In line with the relevant case-law of the European Court of Human Rights[2], a failure to adapt to society's moral, social, political, religious or other values may not be regarded as a mental disorder.

23. When a person comes into contact with mental health care services for the first time, it is not always possible or appropriate to make a final diagnosis immediately. If necessary, a provisional diagnosis is made which can then be reviewed in the light of further observation. A provisional diagnosis made in accordance with internationally accepted medical standards is included within the term "mental disorder".

24. The definition of *"*involuntary measure*"* in the Additional Protocol covers the use of involuntary placement, involuntary treatment or both. "Placement*"* refers to the action of being placed in a specific facility for a particular purpose or purposes. *"*Treatment" refers to physical and psychological interventions in relation to the person's mental disorder, irrespective of

[2] Compare, for example, *Winterwerp v. the Netherlands*, 24 October 1979, § 37, Series A no. 33: "... Article 5.1e [of the European Convention on Human Rights] obviously cannot be taken as permitting the detention of a person simply because his views or behaviour deviate from the norms prevailing in a particular society."

where this intervention takes place and whether or not the person is also subject to an involuntary placement.

25. The notion of "involuntary **measure**" covers two distinct situations: In the first case, if the person concerned is able to give consent, any measures which is taken without that person's free and informed consent (Art. 5 of the Convention on Human Rights and Biomedicine) is considered to be "involuntary" within the meaning of this Additional Protocol. In the second case, if the person is not able to give free and informed consent, any measure taken against the will of that person falls under the definition of "involuntary measure". This applies irrespective of whether that person has a legal representative who is prepared to authorise the measure.

26. Involuntary measures should not be equated with forced measures. Although a person may comply with a measure, that does not necessarily mean that he or she is voluntarily accepting it. The reference to the person's "will" means that it is the person's current attitude to the measure that is to be assessed. The fact that a person has, for example, accepted or refused a proposed treatment some time ago does not mean that it should be assumed that he or she would accept or refuse a renewed offer of the same treatment. Similarly, if a person has been admitted to a facility on a voluntary basis and later on wishes to leave but is not allowed to, the person should receive the protections applicable to involuntary placement. The reference to "placement and/or treatment" makes clear that the person's attitudes to placement and to treatment are separate questions. A person might object to a proposed placement, but agree to the proposed treatment, or *vice-versa*.

27. The definition of "therapeutic purpose" sets out appropriate aims of treatment **which are contributing to the ultimate objective of recovery of the person concerned.** As specified in Article 11 paragraph 1 ii, any involuntary placement and any involuntary treatment must have a therapeutic purpose in relation to a mental disorder. Health problems unrelated to a mental disorder are to be addressed in accordance with Articles 5, 6 or 8 of the Convention on Human Rights and Biomedicine.

28. The term "controlling symptoms" covers a wide range of interventions, for example those aimed at maintaining and facilitating autonomy as far as possible. Some mental disorders are not curable at the present time. However, it may be possible to slow down the rate of deterioration. "Rehabilitation" refers to interventions that aim to limit the impact of deficits in functioning as a result of a chronic mental health condition on a person's life. ~~The reference to "recovery" relates to the "recovery model" in mental health care, which puts an emphasis on the personal process involving the promotion of a feeling of security and sense of self, by fostering supportive relationships, empowerment, social inclusion, and the person's ability to cope with the situation and its subjective and personal meaning.~~ **As spelled out in Article 3 paragraph 4, all mental healthcare should ultimately aim towards the person's recovery. The term "recovery" refers to a unique and personal process of changing attitudes, values, goals and roles, in such a way that it allows the person concerned, as the main actor, to develop his or her own life project. At present, a large number of countries are taking practical steps to base the operation of their mental health care services on the recovery model.**

29. The definitions of "seclusion" and "restraint" are based on the work of the CPT[3]. For the purposes of the Additional Protocol, whether or not the door to the room in which a patient is secluded is locked is not relevant; the definition makes clear that what matters is that the person is kept alone, against his or her will, in an area which he or she cannot leave. The term "restraint" covers various measures aimed at immobilising a person, in particular manual control (*i.e.* holding a person by using physical force), mechanical restraint (*i.e.* applying

[3] as consolidated in the CPT standards on means of restraint in psychiatric establishments for adults, CPT/Inf(2017)6

instruments of restraint, such as straps) and chemical restraint (*i.e.* involuntary administration of medication for the purpose of controlling a person's behaviour).

30. A "representative" is a person provided for by law or appointed through a legal process to represent the interests of, and take decisions on behalf of, a person who does not have, according to national law, the capacity to consent. In line with the approach adopted by the Convention on Human Rights and Biomedicine, the Additional Protocol leaves it to the domestic law in each country to determine whether or not persons have capacity to consent.

31. Different states may have different names for the person fulfilling the role of a "person of trust". Unlike a representative, a "person of trust" cannot take decisions on behalf of the person concerned, but has the role to support and assist that person in making decisions him or herself. The definition of "person of trust" contains three elements: firstly, the choice of the person receiving mental health care; secondly, the designation of the person of trust. As specified in Article 7 of this Protocol, the designation of the person of trust is carried out in accordance with the national law. The third element is the chosen person's willingness to accept that role.

32. The characteristics of a "court" must be interpreted in line with the case law of the European Court of Human Rights[4]. This means that it must be a judicial body which satisfies the following conditions:

a. is established by law and meets the requirements of independence and impartiality;
b. can determine all aspects of the relevant dispute and hence give a binding decision on the matter before it;
c. is accessible to the individual concerned.

33. For the purposes of this Protocol "competent body" refers to the person or body provided for by law which can take a decision on an involuntary measure. The further specification of the "competent body" is left to the national law; this could be, for example, a person or body attached to the health ministry.

34. References to "responsible authority" in the Additional Protocol refer to the authority responsible for the facility in which the **person** ~~patient~~ is placed. Where the person is receiving treatment outside a facility, "responsible authority" refers to the authority with administrative responsibility for the physicians supervising the person's medical care. References to a physician in the Additional Protocol and in this Report mean a person with a medical qualification.

Chapter II – General Rule~~/Consent~~

Article 3 – General Rule

35. As emphasised in the preamble of this Additional Protocol, any use of involuntary placement and any use of involuntary treatment in the context of mental health care interferes with the human rights of the person**s** concerned and has the potential to violate their dignity. In line with the objective of this Additional Protocol, which is to protect the dignity and identity of all persons and to safeguard their human rights, **and with Article 5 of the Convention on Human Rights and Biomedicine,** Article 3 paragraph 1~~,~~ lays down the fundamental requirement that care or treatment administered in mental health care shall, as a rule, only be carried out with the free and informed consent of the person concerned (**compare paragraph 61 below for further details).** Where, according to national law, the person does

[4] compare, *inter* alia, Khlaifia and Others v. Italy [GC], no. 16483/12, §§ 128-130 and *Weeks v. United Kingdom*, no. 9787/82, § 61.

not have the capacity to consent, such care and treatment shall be carried out respecting the wishes of the person concerned.

36. In order to ensure that involuntary placement and involuntary treatment are only used exceptionally and as a last resort, paragraph 2 obliges the competent body to consider and assess all available options respecting the wishes of the person concerned before resorting to involuntary placement or involuntary treatment. This corresponds with the provision laid down in Article 11 indent iii, according to which involuntary measures may only be used if any voluntary measure is insufficient to address the risk entailed.

37. In line with the principle of non-discrimination, paragraph 3 makes clear that the existence of a mental disorder in itself shall, in no case, justify involuntary placement or involuntary treatment.

38. In line with the overall objective of putting persons in a position where they can exercise their autonomy, paragraph 4 requires that in all cases and to the extent possible, the person shall be involved in the planning of his or her mental health care and be treated where he or she lives, with a view to his or her recovery (**for explanation of the term "recovery", see paragraph 28 above).** This means, for example, that preference shall be given to administering treatment in the person's own home, where appropriate, or in a community centre in the person's neighbourhood.

Article 4 – Access to appropriate mental health care

39. Article 4 specifies State parties' obligation under Article 3 of the Convention on Human Rights and Biomedicine to provide equitable access to health care of appropriate quality by obliging State parties to ensure that a range of services of appropriate quality respecting the general rule laid down in Article 3 of this Additional Protocol is provided.

40. Such services may include, but are not limited to, the provision of home treatment and crisis intervention services. Given that many serious mental health conditions are recurrent, minimising the risk of relapse, for example by addressing a person's need for appropriate housing and social support as well as their general healthcare needs, also contributes to the minimisation of the use of involuntary measures.

Chapter III – General Provisions

Article 5 – Legality

41. Under the principle of legality, an involuntary measure can only be justified if it is carried out in in accordance with the conditions set out in the national law. Under the case-law of the European Court of Human Rights, this requires that the measure has a basis in national law; it also refers to the quality of the law in question, requiring that it has to be accessible, and that its consequences have to be foreseeable.[5] Furthermore, the law has to provide adequate safeguards against arbitrary application of a measure.[6] In line with this, Article 5 further requires that the measure be carried out in accordance with the safeguards established in this Additional Protocol.

[5] X v. Finland, no. 34806/04, § 215.
[6] X v. Finland, § 220.

Article 6 – Proportionality and necessity

42. In legal terms, necessity is included within the concept of proportionality. However, the term is included within the Additional Protocol to emphasise that the use of involuntary measures must be a last resort. The principles of proportionality and necessity have important implications for the use of seclusion and restraint in mental health care. This is developed further in Article 17 of the Additional Protocol (see paragraph ~~98~~ **96** below).

43. The principle of least restriction, which derived from the principle of proportionality, is a fundamental principle that **is** recognised internationally in the context of mental health care ~~for many years~~. It implies that when several appropriate options are possible that could contain a risk posed by a person's mental health condition, or that may provide effective treatment for the person, the least restrictive and/or intrusive must be used first; for example ambulatory treatment as an outpatient rather than inpatient treatment.

Article 7 – Person of trust

44. In the context of a procedure concerning an involuntary measure, the person concerned shall have the right to choose a person of trust who would be expressly designated in accordance with domestic law. The role of the person of trust as defined in Article 2 paragraph 4, **seventh** indent ~~7~~, of this Protocol (see paragraph 31 above) is to assist and support the person receiving mental health care, for example in his or her interactions with professionals, or by bearing witness to the person's wishes when the person is not able to do so him or herself. The notion of "choice" implies that it would not be appropriate for another person, including the representative, to select a person to fulfil this role. However, domestic law may provide for the person of trust being formally appointed by a competent body, as long as the right of the person to choose is respected.

45. Under this Additional Protocol, the right to choose a person of trust is guaranteed from the moment one of the proceedings listed in chapter 5 of this Additional Protocol is instigated. However, under Article 1 paragraph 2 of this Additional Protocol, state parties are not prevented from granting a wider measure of protection, for example by providing the right to choose a person of trust by national law to all persons receiving mental health care.

46. The person of trust can be someone close to the person concerned, such as a family member or friend, or a person provided by an advocacy service or voluntary body who has been trained to take up this role and that the person trusts. If a person is unable to find a person of trust him or herself, attempts should be made to put the person in contact with those who might be able to assist him or her in this way (for example, a person from a voluntary body or another organisation that is functionally independent from the psychiatric facility or service provider).

47. Just as there is potential for conflict between the person concerned and his or her family, or with other persons, so there may be potential for conflict between the person of trust and the patient's representative (if any), family members and other persons. Those involved in the decision-making procedures and with care and treatment should be alert to such situations and national law should provide appropriate means to address them. In rare cases the question of restrictions to communication with the person of trust may arise and this is discussed in paragraph ~~113~~ **111** below.

Article 8 – Legal assistance

48. The European Court of Human Rights has emphasised the need for persons to have the possibility to defend their rights effectively in court proceedings.[7] The first paragraph of

[7] See, with further references, *MS v. Croatia (no 2)*, no 75450/12, § 153, judgment of 19 February 2015.

this Article makes clear that the person concerned shall have the right to benefit effectively from legal assistance. This requires that those providing legal assistance must have sufficient qualifications and experience to fulfil the role. If they are not recognised as lawyers according to the national legal system, they should be subject to the same duties to the person concerned and to the court as a lawyer. The right of communicating with the person providing legal assistance, which is a prerequisite of effective legal assistance, is provided in Article 20 (1). Interpreters and other communication aids may be needed to ensure that the person can participate fully in the consultation with those providing legal assistance.

49. ~~The second~~ ~~p~~**P**aragraph **2** foresees that in procedures for taking decisions on involuntary measures, as well as in appeal and review proceedings, legal assistance has to be provided free of charge. It is important that persons are not deprived of their rights to legal assistance in these proceedings on grounds of inability to pay; however, the second paragraph leaves it to national law to determine how legal assistance should be funded. Thus, this **provision** ~~paragraph~~ does not exclude persons having to pay for legal assistance if they have the financial resources to do so.

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

Article 9 – Professional standards

51. Article 4 of the Convention on Human Rights and Biomedicine requires that any intervention in the health field be carried out in accordance with relevant professional obligations and standards by staff having the requisite competence and experience. Article 11 of Rec (2004)10[8] sets out good practice requirements in terms of professional standards in mental health care. These include the need for ~~professional~~ staff **of mental health care services** to have appropriate qualifications and training, including continuing professional development, to enable them to fulfil their role. Both initial qualifications and further training should address the ethical dilemmas that may arise in mental health care. Promoting autonomy of persons receiving mental health care and protecting their dignity, human rights and fundamental freedoms is a fundamental professional obligation.

52. It is important that sufficient staff resources in terms of numbers, categories of staff, and experience and training, are allocated to enable the requirements of this Article to be fulfilled.

Article 10 – Appropriate environment

53. Article 10 obliges State Parties to take measures to ensure that any involuntary measure takes places in an appropriate environment which is respectful of human dignity.

54. An appropriate environment in which to deliver treatment is one in which the treatment can be delivered in a way that is safe for the recipient, for the person delivering the treatment, and for any other persons in the vicinity. If treatment is delivered outside a medical facility, for example in a nursing home or in the person's own home, any necessary medical monitoring or other support required for the administration of the treatment must be available.

[8] Rec (2004)10 of the Committee of Ministers to member States concerning the protection of the human rights and dignity of persons suffering from mental disorder adopted on 22 September 2004.

55. In the extract of its 8th General Report[9], the CPT indicated a number of criteria which should be met to create a positive therapeutic environment which is respectful of the human dignity of persons placed on an involuntary basis in a psychiatric facility. Besides basic requirements such as the provision of sufficient living space per person as well as adequate lighting, heating and ventilation, these also include decoration of individual rooms and recreation areas and providing ways of preserving a degree of privacy.

56. A range of facilities are necessary for persons to receive care in an environment which is appropriate to their specific needs. The range of persons who may be subject to involuntary placement ~~(for example older persons, persons with physical disabilities, persons with acute mental health conditions and persons in need of rehabilitation)~~ highlights the importance of diversity of provision.

57. Paragraph 2 specifies that involuntary placement shall only take place in a specific mental health care facility. This provision is based on the consideration that there is a risk that involuntary placement cannot be carried out in a way which is safe for all persons involved, if the environment is not specifically designed or adapted to serve that purpose. Further to traditional psychiatric hospitals, such facilities may also include psychiatric wards of general hospitals and specialised facilities catering for specific mental health care needs.

Chapter IV – Criteria for involuntary placement and for involuntary treatment

Article 11 – Criteria for involuntary placement and for involuntary treatment

58. Under ~~the general rule set out in~~ Article 3, measures in mental health care are, as a **general** rule, to be carried out with the consent or respecting the wishes of the person receiving the care. Before considering recourse to involuntary measures, efforts must be made to address an identified risk by means respecting this rule. In line with this, Article 11 lays down strict criteria to ensure that involuntary measures are only used exceptionally and as a last resort and that their use is limited to what is strictly necessary in relation to the risk addressed.

59. For reasons of economy of the text, the criteria for involuntary placement and for involuntary treatment have been included in one single Article. However, it is important to note that involuntary placement and involuntary treatment are always to be considered separately. A decision to submit a person to involuntary placement does not imply that the person may also be treated on a non-voluntary basis and *vice-versa* (for further details compare paragraph 68 below).

60. Under this Article, involuntary placement and/or involuntary treatment may only be used when all of the following criteria are met in the individual case: the person's current mental health condition represents a significant risk of serious harm to his or her health or to others (i), the measure has a therapeutic purpose (ii), and any voluntary measure is insufficient to address the risk (iii).

61. Under the general rule of consent enshrined in Article 5 of the Convention on Human Rights and Biomedicine and specified in Article 3 (1) of this Additional Protocol, an intervention in the health field may only be carried out after the person concerned has given free and informed consent to it. Every person must therefore be able freely to give or refuse their consent before any such intervention is carried out. This rule makes clear patients' autonomy in their relationship with health care professionals.[10] The Convention on Human Rights and Biomedicine allows, under protective conditions, exceptions to the rule of informed consent *inter alia* in order to protect the health of persons who have a mental disorder (Article 7 of the

[9] document CPT/Inf (98)12-part, paragraphs 34-36.
[10] Explanatory Report to the Convention on Human Rights and Biomedicine, para. 34.

Convention) and in order to protect the rights of others (Article 26 (1) of the Convention). Under the general principles of interpretation, any such exception must be interpreted in a narrow way.

62. In line with Article 7 of the Convention on Human Rights and Biomedicine, 11 Indent i. a) allows to apply involuntary placement and/or involuntary treatment only if the following two criteria are met: Firstly, the person's current mental health condition represents a significant risk of serious harm to his or her own health and, secondly, the person's ability to decide on the respective measure is severely impaired. Conversely, Article 26 (1) of the Convention on Human Rights and Biomedicine allows restrictions to be placed on the right to informed consent if necessary for the protection of the rights of others. In line with this, Article 11 Indent i. b) allows an exception to be made to the rule of informed consent if the person's mental health condition represents a significant risk of serious harm to others, irrespective of the person's ability to decide.

63. Indent i. requires an assessment of risk to be made. Such risk assessment is complex and difficult, and perfect accuracy in prediction is not possible. Structured clinical assessment methods may help in this context.

64. The concept of health has to be understood in a broad sense and covers both physical and mental health. A significant risk of suicide is an obvious risk to health, a person who is so gravely affected by a mental health condition that the person is unable to care for him or herself can also be viewed as putting his or her health at risk. There may be direct or indirect risks of harm to others. A person who repeatedly threatens or stalks another person can pose a serious risk to that person's mental health. Other actions may present indirect risks of serious harm to persons, such as uncontrolled and violent destruction of objects or arson.

65. Indent (ii) requires that the measure has a therapeutic purpose as defined in Article 2 paragraph 4, **third** indent ~~3~~ (see paragraph 27 above). Involuntary placement of persons shall never be used solely to ensure a person is confined in a safe setting. Under the evolving case-law of the European Court of Human Rights[11], the administration of suitable therapy has become a requirement of the wider concept of the "lawfulness" of the deprivation of liberty. In the *Rooman* case, the Court concluded that "any detention of mentally ill persons must have a therapeutic purpose, aimed **specifically**, **and insofar as possible,** at curing or alleviating their mental-health condition, including, where appropriate, bringing about a reduction in or control over their dangerousness"[12].

66. A "therapeutic purpose" must not be equated with invasive medical practices. As explicitly recognised by the European Court of Human Rights[13], authorities have an obligation to ensure appropriate and individualised therapy. In addition to pharmacotherapy, individual treatment plans should contain a wide range of rehabilitative and therapeutic activities (such as occupational therapy, group therapy, individual psychotherapy).

67. Indent iii. derives from the general rule of consent laid down in Article 3. It follows from Article 3 paragraph 2 in combination with Article 11 paragraph 1 (iii) that an involuntary measure can only be ordered if all available options which can be implemented on a voluntary basis have been considered, assessed and deemed insufficient to address the relevant risk.

[11] consolidated in the case of *Rooman v. Belgium* [GC], no. 18052/11, 31 January 2019
[12] *Rooman, cited above*, § 208
[13] *Rooman, cited above*, § 205, also compare paragraph 37 of the CPT's 8th General Report (document CPT/Inf (98)12)

Chapter V – Procedures concerning involuntary placement and involuntary treatment

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

68. Although involuntary placement and involuntary treatment are covered in one single Article because of the similarity of the relevant procedures, each measure shall be considered separately. Considering both types of measure at the same time is, however, not excluded. If involuntary placement and treatment are addressed in one single decision, in accordance with the case law of the European Court of Human Rights[14], separate legal bases are required, and the possibility of appeal shall be provided regarding each measure individually.

69. Any decision on placement or treatment shall ~~[, subject to the exception laid down in paragraph 2,]~~ be taken by a court or another "competent body" as defined in Article 2 paragraph 4, **ninth** indent ~~9~~ of this Additional Protocol. The underlying principle is that the decision is taken by a person or body that is independent of the person or body proposing the measure. The court or other body that takes the decision shall act on the basis of an appropriate medical examination (i) and shall be satisfied that the criteria in Article 11 are met (ii). A decision that the person should be subject to involuntary treatment does not mean the court or competent body has to approve, for example, each dose of medication to be given, nor the specific type of medication to be prescribed.

70. Paragraph 1 i) requires the person concerned to be examined by at least one physician in accordance with applicable professional obligations and standards. The provision reflects the case law of the European Court of Human Rights, which requires any decision on involuntary placement to be based on objective medical expertise[15]. The physician(s) shall have the necessary competence and experience to perform the task. The European Court of Human Rights generally considers that national authorities are best placed to assess what qualifications the medical expertise requires. However, it has stressed that, in certain cases, and particularly where the person subject to the involuntary measure did not have a history of mental disorder, it is essential that the evaluation be conducted by a psychiatric expert[16]. In some cases a multidisciplinary assessment may be appropriate.

71. The task has to be approached objectively. Thus, it would not be appropriate for physicians who are closely related to the patient to undertake this examination. In addition, the evaluation shall be sufficiently recent to allow the competent authorities to assess the clinical condition of the person concerned at the time when the lawfulness of the placement is examined.[17]

72. Indent (ii) requires the court or other competent body to establish on the basis of all evidence available that all criteria set out in Article 11 are met before ordering an involuntary measure.

73. Indent (iii) emphasises that the procedure to be followed by the court or other competent body has to be provided by national law. These rules of procedure must comply with the guarantees of the European Convention on Human Rights and shall be based on the principle that the person concerned shall be heard in person. Consultation of the person concerned is a very important element enabling the court to form an independent view of the situation. An individual's ability to express themselves can be impaired by factors other than their mental health condition: these include communication difficulties, physical health

[14] *X v. Finland*, no. 34806/04, §§ 220-221, judgment of 3 July 2012
[15] *Kadusic v. Switzerland*, no. 43977/13, § 43, with further references, judgment of 9 January 2018
[16] *Kadusic ibid.*
[17] In *Herz v Germany*, 44672/98, § 50, judgment of 12 June 2003 the European Court of Human Rights considered that a psychiatric report dating back one and a half years was not sufficient in itself to justify deprivation of liberty

problems, and the effects of medication, fear and exhaustion. The person consulting the person concerned should be aware of such issues and ensure that they are minimised to the extent possible. Where necessary, interpretation, extra time, support and a range of communication media may be needed to establish the person's views and preferences as accurately as possible. In some circumstances, the person's condition would not permit any communication or interaction, but this is subject to thorough assessment.

74. The person concerned shall be entitled, in principle, to be supported by his or her person of trust during the consultation. Reasonable efforts ~~should~~ **have to** be made to contact the person of trust, and the procedure can only lawfully proceed in his or her absence if the person of trust is not contactable or not available. Indent (iv) lays down that the opinion of the person concerned, and any previously expressed wishes made by that person, shall be taken into account. **Previously expressed wishes can be an important factor to be considered before taking a decision on an involuntary measure, for example, in case a person with a chronic or recurrent mental health condition has previously expressed a preference for a specific therapeutic option over other possible options to be adopted in case of a crisis situation.** The person of trust may play an important role in providing the court with information which could be relevant in this context.

75. If it is known that the person concerned has a representative, indent (v) requires that representative to be consulted. While an exhaustive search to attempt to determine whether such a person exists is not required, reasonable efforts have to be made to contact a representative if one is known to exist must always be made.

~~76. **[**By way of exception from paragraph 1, paragraph 2 of this Article allows member States to introduce, by national law, an alternative procedure for taking a decision on the use of involuntary treatment for persons who are already subject to involuntary placement. If member States chose to make use of this option, their national law may provide that, in place of the court or other competent body required in paragraph 1, the physician responsible for the care of that person together with at least one other physician who is not involved in the person's care may take the decision on involuntary treatment in accordance with the requirements laid out in paragraph 1, indents ii) to v).**]**~~

~~77. **[**The requirement for at least two physicians to participate in the decision-making process is intended to provide an additional safeguard. This means that each physician must examine the patient in order to be able to make an independent decision without undue influence by the other. Physicians who are related to each other or in a dependent relationship (for example, where one of the physicians is the academic supervisor of the other) would not have a sufficient degree of independence to provide this safeguard.**]**~~

76. ~~78.~~ Paragraph ~~[3]~~ **2** provides that any decision to subject a person to an involuntary measure shall specify the period of its validity and shall be documented. This time limit shall comply with the maximum period of validity laid down in national law, as provided in paragraph **3**. Thus, open-ended or unlimited placements would never be lawful.

77. ~~79.~~ Although a decision will have a maximum duration, this does not mean that the involuntary measure will last that long in practice. Paragraph ~~[4]~~ **3** requires the law to lay down arrangements for periodic review. Article 15 regulates the termination of involuntary measures and makes clear that the person shall be regularly examined in order to ensure that involuntary placement or involuntary treatment are terminated if any of the criteria set out in Article 11 are no longer met.

Article 13 – Procedures for taking decisions in emergency situations

78. ~~80.~~ In an emergency situation an immediate serious risk to the person concerned or to others appears to exist and the delay entailed in applying normal procedures would therefore be too long to effectively address the situation. Procedures designed for such situations shall not be used in other circumstances, or to avoid the use of the procedures set out in Article 12. In case of an emergency situation, it may not be possible immediately to obtain an appropriate examination from a physician with the qualifications laid down in Article 12 paragraph 1. The case law of the European Court of Human Rights specifically identifies involuntary placement in emergency situations as not requiring thorough medical examination prior to the placement[18]. In line with this, paragraph 1 permits the decision to be based on a medical examination appropriate to the measure concerned taking into account the circumstances.

79. ~~81.~~ The examination may be brief, but nevertheless sufficient information must be obtained to satisfy the criteria set out in Article 11. In some countries, assessment may be performed by a specialist mental health professional such as a psychologist accompanied by a physician. This combination of expertise would meet the requirement for a medical examination in these circumstances.

80. ~~82.~~ The case law of the European Court of Human Rights provides that an initial period of placement can be authorised by an administrative authority, as long as it is of short duration and the person can appeal promptly to a judicial body.[19]

81. ~~83.~~ Paragraph 2 requires that the maximum period for which an emergency measure may be applied is specified by the national law. This maximum time-limit should not exceed what is reasonable, time-limits of 72 hours provided in some national laws is considered as good practice.

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

83. ~~85.~~ As noted in paragraph ~~80~~ **78** above, the person may not have been seen by a physician with the appropriate qualifications as referred to in Article 12 paragraph 1 prior to the use of the emergency measure. Once the measure is in force the person must receive a specialist assessment as soon as possible. As specified by Article 15 paragraph 1, if any of the criteria for a measure are no longer met the measure shall be terminated. It is thus possible for an emergency measure to be terminated before the court or another competent body could have taken a decision in accordance with Article 12.

Article 14 – Extension of involuntary measures

84. ~~86.~~ According to Article 12 paragraph 3, any decision to subject a person to involuntary placement and/or involuntary treatment shall define the period of its validity. In many cases, the person's mental health condition will improve during that period and the measure will be terminated. In other cases, it may be evident that the measure cannot yet be safely terminated. In such case, efforts should continue to be made to enable the person to accept treatment on

[18] *X v United Kingdom, no 7215/75,* § 45, *judgment of 5 November 1981*
[19] *Summarised in MH v United Kingdom,* no. *11577/06,* § 77 *judgment of 22 October 2013*

a voluntary basis, but if these do not succeed, Article 14 makes clear that the procedures to extend the measure shall be the same as those set out in Article 12 and hence the ~~person's~~ rights **of the person concerned** receive the same level of protection.

Article 15 – Termination of involuntary measures

85. ~~87.~~ As an involuntary measure seriously interferes with the human rights of the person concerned, the implementation of any such measure shall cease as soon as it is no longer required by the mental health condition of the person concerned or if any of the other criteria laid down in Article 11 are no longer met. Thus, it is important that the person's situation is assessed frequently, particularly during times when it is changing rapidly.

86. ~~88.~~ Under Article 15 paragraph 3, the responsible authority (as defined in Article 2 § 4 last indent) shall ensure that there are procedures in place to guarantee that**, independently of a request by the person concerned,** the measure's conformity with the legal requirements is reviewed at regular intervals, ~~independently of a request by the person concerned~~, at a frequency reasonable in relation to the potential for changes to a person's mental condition that would have implications for the fulfilment of the criteria for the relevant involuntary measure. Such review is particularly important in protecting the rights of persons who may not be able to act for themselves and to ensure they are not disadvantaged if they do not, for example, have a representative who could prompt a review by the court.

87. ~~89.~~ In order to ensure that any involuntary measure is discontinued without delay once the criteria for applying it are no longer met, paragraph 4 specifies the ~~competent~~ person or body responsible for terminating an involuntary measure in such case.

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

88. ~~90.~~ The requirement for an involuntary measure to be amenable to independent judicial scrutiny is of fundamental importance in the context of the purpose of this Additional Protocol to provide safeguards against arbitrariness. **Under Article 5 paragraph 4 of the European Convention on Human Rights, "everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful."** The case law of the European Court of Human Rights ~~makes clear~~ **specifies** that a person has the right to appeal against decisions concerning involuntary placement or involuntary treatment (or, if applicable, both) and to have involuntary measures reviewed at reasonable intervals[20]. An appeal is a challenge against the decision to apply a measure. A review is an examination of the legality of the measure or of its continued application.

89. ~~91.~~ Under the case-law of the European Court of Human Rights, the existence of the remedy must be sufficiently certain, not only in theory but also in practice, failing which it will lack the requisite accessibility and effectiveness.[21] This requires that national law puts in place ~~a~~ rules of procedure for appeal and review ~~proceedings~~. For persons to be able to exercise their right to review~~s~~ and appeal~~s~~, they must first understand that they have such rights. The right to information (Article 19) is therefore fundamental in enabling a person to exercise his or her rights under Article 16.

90. ~~92.~~ Appeal and review procedures must be carried out by a specialist body that has the characteristics of a court (see paragraph 32 above), and which is able to decide on the lawfulness of the measure and order its termination if necessary[22].

[20] *Stanev v Bulgaria, no. 36760/06, §*§ 168-171, judgment of 17 January 2012
[21] Khlaifia and Others v. Italy [GC], no. 16483/12, § 130, judgment of 15 December 2016.
[22] *Khlaifia and Others*, cited above, § 128.

91. ~~93.~~ The person has the right of access to the court at reasonable intervals. The European Court of Human Rights has recognised that States may need to place restrictions on access to court in terms of frequency of review to ensure that courts are not over-burdened with "excessive and manifestly ill-founded applications"[23]. Whether an interval is reasonable has to be considered in the context of the particular circumstances, taking into account the complexity of the case, and the time passed since the last review.

92. ~~94.~~ The person shall always be entitled to be supported by his or her person of trust. Although the case law of the European Court of Human Rights emphasises the importance of the individual's right to be heard in person, it also acknowledges that, if necessary the person may be heard through "some form of representation".[24] This might occur, for example, if the person's mental state was too disturbed to be able to participate in proceedings, but should be subject to strict scrutiny (also compare paragraph 73 above).

93. ~~95.~~ Paragraph 3 follows the principle of "equality of arms" which requires that the person concerned and any person providing legal assistance in the court proceedings shall have access to all materials before the court. By way of exception, paragraph 3 refers to the possibility that national law may provide that certain information be withheld on grounds of the confidentiality and safety of others. In particular, this is designed to ensure that those close to the person concerned can give information to the ~~clinical~~ **medical** team about the person's condition (for example after a period of home leave) in confidence, if they wish to do so. In order to protect the right to respect for private life with respect to the concerned person's health information, national law may also provide that the person concerned can decide to what extent his or her health information is shared with his/her person of trust.

94. ~~96.~~ ~~Article~~ **Paragraph** 4 takes account of the **requirement under Article 5 paragraph 4 of the European Convention on Human Rights** ~~necessity~~ to process proceedings regarding involuntary measures ~~expeditiously~~ **speedily**.

Chapter VI – Restrictive and irreversible measures

Article 17 – Seclusion and restraint

95. ~~97.~~ Article 17 is based on the revised standards of the CPT on means of restraint in psychiatric establishments for adults[25]. The CPT stresses that the goal should always be to prevent the use of seclusion and restraint by limiting as far as possible their frequency and duration.[26] To this end, Article 17 paragraph 1 obliges State parties to develop methods and programmes preventing the use of seclusion and restraint. It is of paramount importance that the relevant authorities and the management of mental health care providers develop a strategy and take a panoply of proactive steps, which should *inter alia* include the provision of a safe and secure material environment, the employment of a sufficient number of health-care staff, adequate initial and ongoing training of the staff, including in de-escalation techniques, and the promotion of the development of other preventive measures respecting the general Rule laid down in Article 3 paragraph 1 of this Additional Protocol (compare para. 35-36 above).

96. ~~98.~~ The terms "seclusion" and "restraint" are defined in Article 2 paragraph 4 of this Additional Protocol (see paragraph 29 above). Given their intrusiveness and the risk of abuse or of causing unintended harm to the person concerned, seclusion and restraint shall only be used as a last resort and to the extent which is strictly necessary and proportionate in order to prevent serious imminent harm to the person concerned or to others. It follows that seclusion

[23] *Stanev v Bulgaria,* no. 36760/06, § 242, judgment of 17 January 2012
[24] Stanev, cited above, § 171.
[25] set out in document CPT/Inf (2017) 6
[26] CPT/Inf (2017) 6, Introduction.

and restraint must never be used as a punishment, for the mere convenience of staff, because of staff shortages or to replace ~~proper~~ **appropriate** care or treatment. Under the principle of legality (Article 5), any recourse to seclusion or restraint shall comply with the protective provisions provided for by national law. Under the case-law of the European Court of Human Right, the use of such measures must be commensurate with adequate safeguards against any abuse, provide sufficient procedural protection, and be capable of demonstrating sufficient justification that the requirements of ~~ultimate~~ necessity and proportionality have been complied with and that all other reasonable options have failed to satisfactorily contain the risk of harm to the person concerned or others. It must also be shown that the coercive measure at issue was not prolonged beyond the period which was strictly necessary for that purpose.[27]

97. ~~99.~~ Article 17 paragraph 2 further stipulates that seclusion and restraint shall only take place in an appropriate environment, which is one in which the intervention can take place in a manner that is safe for the person concerned, for the staff carrying out the intervention and for others in the immediate vicinity. As it is not possible to monitor someone in seclusion at home, the situation is not safe for the person concerned and therefore such an intervention would not comply with the requirements of this Article.

98. ~~100.~~ According to paragraph 3, first sentence, any resort to means of restraint shall be expressly and specifically ordered by a physician after an individual assessment, or immediately brought **for approval** to the attention of a physician ~~with a view to seeking his/her approval. To this end, the physician should~~ **who** examine**s** the person concerned as soon as possible. ~~No~~ ~~b~~**B**lanket authorisation**s would not be acceptable** ~~should be accepted~~.

99. ~~101.~~ Under paragraph 3, second sentence, every resort to seclusion or restraint shall be recorded in the medical file of the person concerned as well as specifically registered. Registration can also be done in the form of a data bank from which all pertinent information of the medical files can be extracted. The CPT[28] emphasises the importance of such registers as they enable the responsible authority to have an oversight of the extent of the use of seclusion and restraint and, where appropriate, to take measures to reduce their incidence. They are also important as part of the monitoring process required by Article 23. The entry shall include the nature of the resort to seclusion or restraint, the times when it began and ended, the circumstances of the case, the reasons for resorting to the seclusion or restraint, the name of the physician who ordered or approved it, and an account of any injuries sustained by the person concerned or staff. Such records fall within the scope of Article 21 of the Additional Protocol and contain sensitive data which must be protected accordingly.

100. ~~102.~~ Seclusion and restraint may pose particular risks to the persons concerned; and it is of preeminent importance to ensure that vital functions such as respiration and communication are not hampered. Accordingly, paragraph 4 prescribes that persons subject to their use shall receive continuous monitoring by an appropriately trained member of staff. Appropriate training should include recognition of signs that the process is having detrimental effects on the person and the need for prompt and appropriate action to address this. In the case of mechanical restraint, the qualified member of staff shall be permanently present in the room in order to maintain a therapeutic alliance with the person and provide him/her with assistance. If a person is held in seclusion, the staff member may be outside the secluded person's room (or in an adjacent room with a connecting window), provided that the secluded person can fully see the staff member and the latter can continuously observe and hear that person. The CPT emphasised that video surveillance cannot replace continuous staff presence.

101. ~~103.~~ Paragraph 5 of this Article makes clear that any use of seclusion or restraint may be made subject to the complaint procedures set out in Article 22. Under the principle of wider

[27] Aggerholm v. Denmark, no. 45439/18, § 84, judgment of 15 September 2020.
[28] CPT/Inf (2017) 6, paragraph 11.1

protection as laid down in Article 1 paragraph 2 of this Additional Protocol, Parties may also choose to make use of seclusion ~~and~~ **or** restraint subject to appeal to a court.

Article 18 – Treatment with the aim of producing irreversible effects

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

103. ~~105.~~This Article does not cover treatments that may, as an unintended side-effect, have irreversible physical effects, as for example electroconvulsive therapy (ECT). However, in view of the particular intrusiveness of this method, the CPT recommends that, save for exceptional circumstances clearly and strictly defined by law, patients should be free to refuse or consent to ECT, after receiving information on the likely beneficial effects and risks.[29] **Similar considerations could apply to the use of deep brain stimulation in the context of treatment of persons with mental health problems.**

Chapter VII – Information and communication

Article 19 – Right to information

104. ~~106.~~ When a person is either placed or treated on an involuntary basis, he or she shall receive appropriate information on his or her rights and on the remedies available, in a way that enables him or her, as far as possible, to understand and to use that information. To these ends, the information given shall be appropriate both with regard to its content and with regard to the way it is presented.

105. ~~107.~~ It is good practice to give the information both verbally and in written form. Written information should not be regarded as a substitute for information given face-to-face, but as a supplement to such information. Written information should be in accessible formats, including easy to read text, where needed. Some patients may be illiterate, and it is important to ensure that they are not disadvantaged in exercising their rights for this reason. It is equally important that any language barriers are addressed, for example by providing interpretation in the person's native language. At the time the person first receives the information, their mental health condition may make it difficult for them to understand information about their rights. The person should be provided with as much information as their mental health condition permits, and the information may need to be repeated as the person's mental health condition improves.

106. ~~108.~~ The information provided shall include information on the rights to request reviews and to appeal under Article 16 and on the complaint procedure under Article 22 of this Additional Protocol. In addition to the person concerned, any person providing legal assistance~~,~~ **and** the person's representative are to be provided with the same information in order to be able ~~effectively~~ **to** act **effectively** on the person's behalf, if appropriate. The person of trust is provided with the same information in order to be able effectively to support the person in his or her actions.

107. ~~109.~~ Under paragraph 2, the persons concerned, their representative as well as any person providing them with legal assistance shall receive copies of all relevant decisions and

[29] Involuntary placement in psychiatric establishments Extract from the 8th General Report of the CPT, document CPT/Inf (98)12-part, para. 41

shall be informed regularly and appropriately about the reasons for the measure and the criteria of its potential extension or termination in order to be able to, where appropriate, safeguard the person's rights. National law may provide that the person of trust is also provided with this information. Because information on the reasons for a decision will include personal health **data** ~~information~~, such information sharing must take into account the right to private life of the person concerned. The person may choose to share the information with his or her person of trust.

108. ~~110.~~ Persons subject to seclusion or restraint may be in particular need of support; to address this, paragraph 3 introduces a specific obligation to inform promptly the person providing legal assistance, the representative and the person of trust about any use of seclusion or restraint.

Article 20 – Right to communication

109. ~~111.~~ Article 20 covers communication in a broad sense, including written expression, such as writing or receiving a letter or an email; verbal expression, such as talking on a telephone, and receiving visitors. The CPT has highlighted the importance of those subject to involuntary placement being able to communicate with the outside world, both from a therapeutic standpoint and as a safeguard against abuse.[30] Communication is important in ensuring that the persons can maintain, if possible, social and family ties that are important to them.

110. ~~112.~~ Paragraph 1 specifies that it would never be lawful to restrict a person's communication with the person(s) providing them with legal assistance, with their representative, or with any official body charged with the protection of persons subject to involuntary measures. Official bodies include the domestic courts as well as any body charged with monitoring compliance with the provisions of this Additional Protocol according to Article 23 and international bodies such as the European Court of Human Rights, the CPT, the United Nations Subcommittee on Prevention of Torture and National Preventive Mechanisms established under the Optional Protocol to the United Nations Convention against Torture.

111. ~~113.~~ Paragraph 2 guarantees the right to communicate with the person of trust and persons or bodies other than those listed in paragraph 1. Communication with this group of persons may only be restricted to the extent that is necessary to protect the health and personal security of the person concerned by the involuntary measure. Restrictions on communication may therefore be partial, for example, communication with specific persons may be monitored. An example of a reason for restricting communication with a specific person would be clear indications that contact with that person could lead to severe deterioration of the mental health condition of the person concerned by the involuntary measure.

112. ~~114.~~ Article 20 does not exclude that a facility has "house rules", provided that these consist of rules of everyday life that are normally set for living in any given housing, such as visiting times, and that they are available for independent scrutiny.

Chapter VIII – Record-keeping, complaint~~s~~ procedures and monitoring

Article 21 – Record-keeping

113. ~~115.~~ Comprehensive medical records are an indispensable basis for any care and treatment decision, and, together with administrative records, are essential for safeguarding

[30] Involuntary placement in psychiatric establishments, Extract from the 8th General Report of the CPT, CPT/Inf (98)12-part, paragraph 55

the rights of a person who is subject to an involuntary measure. The records required by this Article form a basis of reviews of the lawfulness of each measure and of the justification for its continuation. These records should be carefully drawn up in accordance with each member state's regulations and with professional obligations and standards.

114. ~~116.~~ The second sentence requires that the conditions governing access to the information as well as the period of storage shall be specified by national law. As laid down in Article 10 paragraph 2 of the Convention on Human Rights and Biomedicine, everyone is entitled to know any information collected about his or her health. Health-related data are sensitive data which enjoy a high level of protection, due notably to the risk of discrimination which may occur with their processing. Relevant standards on the protection of these data are laid down by the Council of Europe, in particular in the Convention for the Protection of Individuals with regard to Automatic Processing of Personal Data[31] and Recommendation CM/Rec(2019)2 of the Committee of Ministers to member States on the protection of health-related data[32].

Article 22 – Complaint procedures

115. ~~117.~~ The existence of an effective complaints system provides an important protection for the human rights and dignity of persons subject to involuntary measures. This Article follows the recommendations of the CPT.[33] Under Article 22, all persons subject to an involuntary measure as well as any person providing them with legal assistance and their representative shall have avenues of complaint effectively open to them with the responsible authority as defined in Article 2 (see paragraph 34 above) and shall be entitled to address such complaints to an independent outside body. Article 22 covers complaints about any issues regarding the implementation of involuntary measures which do not fall under the scope of the appeal and review proceedings regulated in Article 16. Such issues would be, for example, complaints about living conditions, about restrictions on communication or about the use of seclusion or restraint, as expressly spelled out in Article 17 paragraph 5.

116. ~~118.~~ Complaint procedures should be simple, effective and user-friendly, particularly regarding the language used. The support of the person of trust may play an important role in enabling persons to access them.

Article 23 – Monitoring

117. ~~119.~~ Independent monitoring is important in ensuring the protection of human rights and in ensuring compliance with national legal standards, including those set by this Additional Protocol. **Experience shows that effective monitoring has the potential to significantly reduce recourse to involuntary measures in mental health care facilities.** The CPT recommends that facilities should be visited on a regular basis by an independent outside body which is responsible for the inspection of persons' care. This body should be authorised to talk in private to patients and make any necessary recommendations to the responsible authority.[34]

118. ~~120.~~ The value, and importance, of involving current or former users of mental health care services, those close to them, and organisations representing them, in developing policy and procedures in the context of mental health care is increasingly recognised. Thus, the involvement of such persons and organisations in the monitoring process is encouraged.

[31] ETS 108, 1981, revised in 2018 (CETS 223)
[32] Adopted by the Committee of Ministers on 27 March 2019
[33] Involuntary placement in psychiatric establishments, Extract from the 8th General Report of the CPT, CPT/Inf (98)12-part, paragraph para. 53.
[34] Involuntary placement in psychiatric establishments, Extract from the 8th General Report of the CPT, CPT/Inf (98)12-part, paragraph 55

119. ~~121.~~ The requirement for the registration of facilities in the second paragraph of this Article aims to facilitate the appropriate inspection and review of such premises. The term "facility" shall be understood in a broad sense as encompassing health establishments and units in which a person **in need of mental health care** ~~with mental disorder~~ may be placed **(see paragraph 57 above)**. The independent and systematic inspections required under paragraph 2 may be carried out by the authority keeping the register or by another appropriate authority which has access to it.

Chapter IX – Infringements of the provisions of the Protocol

Article 24 – Infringement of the rights or principles

120. **This article requires the Parties to make available a judicial procedure to prevent or put a stop to an infringement of the rights or principles set forth in the Protocol. It therefore covers not only infringements which have already begun and are ongoing but also the threat of an infringement. The requisite judicial protection must be appropriate and proportionate to the infringement or the threats of infringement of the rights or principles. Such is the case, for example, with proceedings initiated by a public prosecutor in cases of infringements affecting several persons unable to defend themselves, in order to put an end to the violation of their rights.**

121. **The appropriate protective machinery must be capable of operating rapidly as it has to allow an infringement to be prevented or halted at short notice. This requirement can be explained by the fact that, in many cases, the very integrity of an individual has to be protected and an infringement of this right might have irreversible consequences. The judicial protection thus provided by the Protocol applies only to unlawful infringements or to threats thereof.**

Article 25 – Compensation for undue damage

122. **This Article sets forth the principle that any person who has suffered undue damage resulting from involuntary placement or involuntary treatment is entitled to fair compensation. The due or undue nature of the damage will have to be determined in the light of the circumstances of each case. In order to give entitlement to compensation, the damage must result from the involuntary measure.**

123. **Compensation conditions and procedures are to be prescribed by national law. On the subject of fair compensation, reference can be made to Article 41 of the European Convention on Human Rights, which allows the Court to afford just satisfaction to the injured party.**

Article 26 – Sanctions

124. **Since the aim of the sanctions provided for in Article 26 is to guarantee compliance with the provisions of the Protocol, in order to measure the expediency and determine the nature and scope of the sanction, the domestic law must pay special attention to the content and importance of the provision to be complied with, the seriousness of the offence and the extent of its possible repercussions.**

Chapter X – Relation between this Protocol and other provisions and re-examination of the Protocol

Article 27 – Relation between this Protocol and the Convention

125. **As a legal instrument, this Additional Protocol supplements the Convention on Human Rights and Biomedicine. Once in force, the Protocol is subsumed into the Convention for those Parties having ratified the Protocol. The provisions of the Convention on Human Rights and Biomedicine. are therefore to be applied to this Additional Protocol.**

126. **Thus, Article 36 of the Convention on Human Rights and Biomedicine, which sets out the conditions under which a State may make a reservation in respect of any particular provision of the Convention, will also apply to this Additional Protocol. Using this provision States may, under the conditions set out in Article 36 of the Convention, make a reservation in respect of any particular provision of this Protocol.**

Article 28 – Re-examination of the Protocol

127. **This article provides that the Protocol shall be re-examined no later than five years from its entry into force and thereafter at such intervals as the Committee designated to do so by the Committee of Ministers in accordance with Article 32 of the Convention on Human Rights and Biomedicine may determine.**

Chapter XI – Final clauses

Article 29 – Signature and ratification

128. **Under the provisions of Article 31 of the Convention on Human Rights and Biomedicine, only States that have signed or ratified the Convention may sign this Protocol. Ratification of the Protocol is subject to prior or simultaneous ratification of the Convention. A State which has signed or ratified the Convention is not obliged to sign the Protocol or, if applicable, to ratify it.**