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MENTAL HEALTH LEGISLATION THROUGH HISTORY AND CHALLENGES IN IMPLEMENTING ARTICLE 14 OF THE CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES

The paper is divided into two parts to facilitate a clearer understanding of all aspects of the change in the position of people with psychosocial disabilities, regarding the right to liberty and security, through the historical development of national and international legal frameworks. The first part briefly presents an overview of national legislation on the protection of persons with psychosocial disabilities and the circumstances in which states adopted the Convention on the Rights of Persons with Disabilities earlier this century. The second part of the paper underscores the challenges the States Parties face in the implementation of Article 14 of the Convention. The State Parties' reports show that the processes of changing the perceptions of persons with psychosocial disabilities, when it comes to their involuntary detention, have been changing quite slowly and partially and that the realisation of their human rights is one of the Convention's greatest challenges.

Key words: *Convention on the Rights of Persons with Disabilities. – Human rights-based approach. – Involuntary detention. – Persons with psychosocial disabilities. – Social model of disability.*

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1. INTRODUCTION

The Convention on the Rights of Persons with Disabilities (hereinafter: CRPD or Convention) was adopted by the UN General Assembly in December 2006.¹ According to former UN Secretary-General Kofi Annan, its adoption marked the beginning of a new era for people with disabilities, ‘in which disabled people will no longer have to endure the discriminatory practices and attitudes’.² Following a long history of discrimination against people with disabilities, the purpose of the CRPD is to promote, protect, and ensure the full and equal enjoyment of their human rights and fundamental freedoms, as well as to promote respect for their inherent dignity (Preamble, Art. 1). It establishes a range of measures to be undertaken by the State Parties for its implementation in a number of areas (education, training, rehabilitation, work, employment, etc.), which can be observed on a twofold level. While, on the one hand, the Convention establishes the States Parties’ obligation in relation to specific rights (see Arts. 5–30), the States also assume general obligations, which are reflected in the adoption of appropriate legislation, administrative, and other measures; modification or abolishment of the existing (discriminatory) laws, regulation, custom and practice; refraining from engaging in any act or practice that is inconsistent with the Convention, etc. (Art. 4). It also encourages the involvement and full participation of civil society, persons with disabilities, and their representative organisations in the monitoring process (Art. 33). This enables further extremely active engagement of persons with disabilities and their organisations, which began during the drafting the text of the Convention,³ all in accordance with the driving idea of ‘nothing about us, without us’ (UN Human Rights Office of the High Commissioner – CRPD Training Guide 2014, 39). The consultative process of drafting the Convention and its adoptions marked the possibility for silent and marginalised voices of people with disabilities to ‘finally be heard’ (Arstein-Kerlsake, Flynn 2016, 472). This has resulted in a perception of the CRPD as a powerful weapon in the hands of persons with disabilities, which—despite the challenges that will be underscored in this paper—undoubtedly contributes to changing the perception about them.

¹ The CRPD was adopted on 13 December 2006 by UN General Assembly Resolution A/RES/61/106. It entered into force on 8 May 2008. Considered the most swiftly ratified international human rights document, as of November 2020 the CRPD has been ratified by 182 States Parties.

² UN Meeting Coverage and Press Releases (2006).

³ People with disabilities and their organizations have had a significant impact on shaping the very content of the Convention, and their role has been further strengthened over the last 12 years. On the role of people with disabilities and their representative organizations, see more in: Uldry, Degener 2018, paras. 36–44.

The CRPD concerns all persons ‘who have long-term physical, mental, intellectual, or sensory impairments, which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others’ (Art. 1). However, the aim of this paper is to analyse the States Parties’ obligations regarding the one group of those persons—persons with psychosocial disabilities—their right to liberty and security, as prescribed by Article 14, and the consequent issues of their involuntary detention and deprivation of liberty. One of the most challenging tasks in this regard for the States Parties is the shift of focus from such treatments of persons with psychosocial disabilities to the realisation of their human rights on equal basis with others. Although the CRPD itself does not refer explicitly to involuntary placement, Art. 14(1) (b) provides that ‘*the existence of a disability shall in no case justify a deprivation of liberty*’. The Committee on the Rights of Persons with Disabilities (hereinafter: the Committee)—the body that was established by the CRPD for monitoring its implementation⁴—has argued that the deprivation of liberty based on the existence of a disability would be in contradiction to the CRPD. In 2014, when issuing its first General Comment,⁵ the Committee emphasised that ‘forced treatment is a particular problem for persons with psychosocial, intellectual and other cognitive disabilities’. It called on the State Parties to ‘abolish policies and legislative provisions that allow or perpetrate forced treatment’ and ‘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’.⁶ According to the Committee, forced treatment violates several other rights guaranteed by the Convention, such as *the right to equal recognition before the law* (Art. 12), the right to be free from torture (Art. 15), the right to be free from violence, exploitation, and abuse (Art. 16), and the right to personal integrity (Art. 17).⁷ Implementation in national legislation of some of the rights that refer to persons with psychosocial disabilities is considered rather controversial, even to the extent that individual authors call for the Convention to be ignored, reinterpreted, or amended (Appelbaum 2019, 1).

⁴ The Committee was established in 2009, and since 2011 it has consisted of 18 independent experts.

⁵ The Committee’s general comments are intended to interpret certain provisions of the Convention in order to facilitate its implementation in the States Parties and to clarify disputed provisions. By November 2020, the Committee had published seven general comments regarding Arts. 5, 6, 9, 12, 19, 24, 4(3), and 33(3).

⁶ UN Committee on the Rights of Persons with Disabilities General Comment No. 1 (2014, para. 42).

⁷ Several UN bodies such as the High Commissioner for Human Rights and Special Rapporteur on the rights of everyone to the enjoyment of the highest attainable standard of physical and mental health support the abolition of involuntary treatment of persons with disabilities on the grounds of their disabilities. See e.g. UN General Assembly (2009) and UN General Assembly (2017).

This paper argues that the States Parties have a very complex task regarding the protection of the rights of persons with psychosocial disabilities when the implementation of Article 14 is concerned. In order to better understand the challenges faced by the States Parties that need to align their legislation with the CRPD, the first part of this paper provides a brief overview of the historical development of national mental health legislation and the circumstances in which states adopted the Convention. The second part of the paper analyses the current (in)effectiveness of the Convention by elaborating on reports on its implementation in the States Parties in regard to the abovementioned provisions of the Convention. This will inevitably include the relationship between the States Parties' practices and the Committee's views, whose activities undoubtedly pave the way for a change in the perception of persons with disabilities.

2. A BRIEF OVERVIEW OF THE HISTORICAL DEVELOPMENT OF MENTAL HEALTH LEGISLATION

The legal status of persons with psychosocial disabilities was a neglected area in most European countries until the 1980s. However, the beginning of the development of legislation on mental health dates back to the 19th century, when the first laws regulating the compulsory treatment of persons with psychosocial disabilities started being adopted in some countries.⁸ Since the focus of regulating the legal status of people with mental disabilities has long been directed on the regulation of their involuntary placement, it is not surprising that many authors point out that the history of mental health legislation is actually the history of the legal regulation reform on their involuntary detention and treatment. Describing this development, Allderidge (1979, 321) uses the term 'pendulum swinging' to denote the two opposing tendencies that characterize it. One, which emphasises medical discretion in deciding on involuntary hospitalisation and, the other, which seeks to limit the use of coercive powers in psychiatry to clear criteria and legal procedures. Similarly, Jones (1972) also sees the history of mental health legislation as a pendulum movement between two extremes: on the one hand, legalism and, on the other, the physician's discretionary decision. Although the primary work conducted on legalism and medicalism has focused on English mental health law, the same concept is applicable worldwide (Brown 2016, 1).

The legalism that marked the turn of the 20th century was considered a major obstacle to the effective treatment of people with psychosocial

⁸ The beginnings of the development of mental health legislation can be found even earlier. Detailed historical overview of the development of mental health legislation in England see Fennel (2010).

disabilities.⁹ Jones (1972) calls the transition period from the 19th to the 20th century as the triumph of legalism in the United Kingdom, criticising it for leading to extremely complex and detailed legal regulations and the prevention of an effective pursuit of what is in the patient's best interest and well-being. Legalism is considered as procedural formalism and a mechanistic approach that impedes the effective treatment and welfare of people with psychosocial disabilities. This author advocates an open-textured legislation, rather than regulatory, which would permit maximal discretion within a loose regulation framework (Jones 1972, 153).

Criticisms of legalism, on the one hand, and the significant advances in science and medicine in the second half of the 20th century, which have brought optimism also regarding the possibilities of successful treatment of mental illness, on the other, have resulted in new reforms of mental health legislation, in the direction of conferring more discretion to physicians. Physicians gained an increasingly prominent role in deciding whether to detain and treat people with mental disorders, and they have considerable power and influence over the lives of people with mental disabilities. Therefore, we can say that this period was marked by the swing from legalism towards clinical discretion and medical welfare paternalism. However, just as legalism has been subjected to much criticism because of its formalism, so has the model of wide discretionary decision-making by physicians shown shortcomings over time. People with psychosocial disabilities were abused in psychiatric hospitals and their human rights were violated in many cases, so it is not surprising that, in the second half of the 20th century, medicalism was subjected to much criticism, especially by groups fighting for the human rights of people with psychosocial disabilities.

2.1. The New Legalism Based on the European Court of Human Rights' Case Law

Strong criticism of medical paternalism has been reflected in the reform of national mental health legislation, which is returning to legalism, i.e. it is developing in the direction of increasing the legal protection of persons with psychosocial disabilities against involuntary treatment and detention. A number of provisions have been introduced in national mental health legislations, the aim of which is to prescribe in greater detail the conditions and procedures of involuntary hospitalisation and thus protect persons with psychosocial disabilities from arbitrary detention. The development of legislation in this direction was significantly influenced by the case law of the European Court of Human Rights

⁹ The term *legalism* refers to a set of rules governing involuntary placement; it is often used to emphasize the importance of court decisions regarding the need for involuntary placement (Gostin 1983, 47).

(hereinafter: ECHR), especially its decision in the case of *Winterwerp v. The Netherlands* in 1979.¹⁰ In the judgment, the ECHR prescribed the conditions under which a person with a mental disability may be deprived of liberty and it defined the mechanisms that may be applied to prevent their arbitrary detention. This marked the beginning of a new legalism based on the European Convention for the Protection of Human Rights and Fundamental Freedoms. The new legalism aimed to introduce procedural safeguards into national mental health legislation and to regulate the control of psychiatrists' treatment and increase patients' rights to challenge detention and to seek its review. In addition to the minimum standards for the legality of involuntary detention of persons with mental disabilities, established through the ECHR, the new legalism in Gostin (1983) contains additional two basic principles: the principle of the ideology of entitlement and the principle of the least restrictive alternative. The first principle assumes that a person has the right to adequate care and treatment and that access to health care should never depend on one's discretion, while the principle of minimum restraint in dealing with people with psychosocial disabilities requires the state to create a broad community assistance network, which includes medical assistance, crisis assistance, housing assistance, training and employment, etc.—all to avoid the need for their forced detention (Gostin 1983, 49–50). The focus is not only on the due process of detention, but also outside of it. While the ECHR still plays a significant role in protecting people with psychosocial disabilities from arbitrary deprivation of liberty, its role in ensuring the implementation of the right to care and an appropriate community support network—aimed at preventing or at least shortening the involuntary detention—is significantly limited (Fennel 2010, 17).

In the 1980s and 1990s a number of countries changed their existing laws, i.e. they passed new laws on mental health.¹¹ Although the aim of the new legislation—which was based on new legalism—was to improve the dignity and integrity of people with psychosocial disabilities, it may be subjected to significant criticism for several reasons. In the first place, it was insisted that definition of a person to whom mental health legislation applies should entail a psychiatric diagnosis based on internationally recognised medical criteria. This approach would not be disputable if, at the same time, the laws did not specify the categories of persons that are exempt from its application. Precisely the need to prescribe separately in a legal act that non-compliance with social norms must not be the basis for a psychiatric diagnosis, indicates that there is still social conditionality

¹⁰ *Winterwerp v. Netherlands*, ECHR 6301/73, 24 October 1979.

¹¹ New or revised laws were passed, for example, in England in 1983, Norway in 1988, Denmark in 1989, Austria, Finland, Belgium and France in 1990, Germany, the Netherlands, Greece, Sweden and Portugal in 1992, and Croatia in 1997.

of diagnostic categories and their close connection with prevailing social norms. Once a psychiatric diagnosis has been established, further treatment of a person with a psychosocial disability depends on an assessment of their danger. The existence of danger is related to the diagnosis of mental illness and, in most legislations, it is the legal foundation for involuntary hospitalisation. While empirical evidence shows that there is a weak link between violence and mental illness, this is often neglected and leads to the stigma and discrimination of persons with psychosocial disabilities (Weller 2010, 57). As many authors rightly point out, the danger-based criterion is fundamentally problematic (Large 2008, 877–881; Callaghan, Ryan 2014, 751–752).

Another criticism of the new legalism is related to the circumstance that people with psychosocial disabilities can essentially be treated without their consent. The exclusion of the possibility for a person participating in the decision-making process limits the possibility for the physician to be informed of their wishes, preferences, and experience of mental illness. This approach differs significantly from the generally accepted principle of informed consent, under which an individual has the right to participate in the decision-making concerning their health. Therefore, it is not surprising that the ability of people with psychosocial disabilities to make their own decisions appears to be a central theme in all the discussions regarding their human rights that ensued in the late 20th century (Weller 2010, 59).

Although the new legalism aims to protect the rights of people with psychosocial disabilities, this model has been shown to have certain shortcomings that have significantly contributed to such persons experiencing stigmatisation, discrimination, and exclusion from society. It can already be seen from this brief overview that the development of mental health legislation was primarily aimed at regulating the involuntary detention and treatment of persons with psychosocial disabilities and preventing their arbitrary detention. Legal norms specify the category of persons that can be forcibly hospitalised, the conditions under which this can be done, and the necessity of judicial review of the decision on involuntary treatment in order to prevent the abuse of psychiatry as a means of political and social control. Yet, another extremely important segment related to ensuring the conditions for the exercising of the rights to adequate medical care and assistance in the community by persons with psychosocial disabilities was almost completely neglected. It is, therefore, not surprising that there is widespread dissatisfaction with restrictions on new legalism and demands to remove barriers in society that make it impossible for people with psychosocial disabilities to enjoy their rights. This dissatisfaction refers to the focus of legalism on procedural rules instead of addressing ‘broader questions of social justice,

or recognise and facilitate claims to access supports to enable rights to be valuable' (Clough 2014, 67). Mental health legislation has been limited mainly to regulating certain procedural issues aimed primarily at preventing the arbitrary detention of persons with mental disabilities—highlighted in *Winterwerp*—but modern advancements in human rights development have much greater requirements that necessitate its reshaping.

2.2. New Tendencies – Social Model of Disability and Human Rights-Based Approach

Restricting new legalism primarily to the involuntary detention and treatment of people with psychosocial disabilities and the dominance of the medical model of disability are considered by many authors to be major obstacles to the realisation of the fundamental human rights of this group. Therefore, contemporary debates on the rights of persons with psychosocial disabilities have shifted focus from the medical model of disability to the social model of disability and from new legalism to the human rights-based approach to regulating their rights.

The term 'social model of disability' dates back to the early 1980s and is associated with Oliver (2013, 1024–1026). According to the idea behind this model, people with disabilities are not disabled because of physical damage, but because of barriers that exist in society that limit their life opportunities (Lawson, Priestley 2016, 4; Clough 2014, 64–66). Unlike the medical model, according to which problems arise from a person's physical or mental disabilities and which is aimed at medical intervention and rehabilitation, the social model sees the cause of the problem in the obstacles posed by society and, therefore, requires society to adopt new legislative, educational, cultural, and social policies that will remove barriers that prevent the specific needs of these individuals from being met (Bartlett 2012, 758–760). Although this model has a number of positive effects, it can be criticized as well. The social model rests, on the one hand, on the difference between impairment as an attribute of the body or mind and, on the other, on the perception of disability as the relationship between a person with a disability and society. It starts from the fact that the social structure and institutions, and not the impairment, cause disability (Blanck, Flynn 2017, 5). Such an approach, which denies any causal link between impairment and disability, has been the subject of numerous debates emphasising the need for a broader view of disability. Namely, if we deny the existence of impairment, then we do not deal with it or eliminate it. Insisting only on the removal of obstacles that are outside the impairment is just as wrong as insisting only on repairing the impairment through medical intervention. Shakespeare, Watson (2002, 9–28) rightly points out that disability cannot be viewed from a single

angle, whether medical or social, and that the social theory of disability should include all dimensions of the experience of people with disabilities: physical, mental, cultural, and social.

Nevertheless, the transition from the medical to the social model of disability has encouraged positive changes in the position of people with disabilities. First of all, this transition has encouraged the process of shifting the focus from the needs of people with disabilities to their (human) rights. On the one hand, persons with disabilities have shifted from being passive recipients of active assistance to subjects able to demand the fulfilment of their rights (rights-holders), and, on the other hand, the state and its institutions have become responsible for creating conditions for fulfilling the rights of persons with disabilities (duty-bearers). This conceptual framework is referred to in the literature as the human right-based approach. It emerged in the mid-1990s as a reaction to the segregation, abuse, discrimination, and oppression to which certain groups of people were exposed, perceived by society as passive subjects for whom others would determine what was in their best interest. By adopting the human rights-based approach, those who were seen as ‘shrunk wretches begging for our help’ are now becoming people with dignity who demand what they are entitled to (Pogge 2007, 4).

The human rights-based approach does not introduce or prescribe any new additional rights for certain groups of persons, but it rather insists on the realisation of the existing rights. Its primary objectives are ensuring the right to liberty of every person, protection of the dignity of all human beings, prevention of discrimination, and enabling every individual to exercise economic, social, and cultural rights. Presuming that human rights are indivisible and interdependent, it is necessary for the economic, social, and cultural rights of persons with disabilities to be respected, protected, and realised in the same way as civil and political rights. At the same time, the human rights-based approach is not only aimed at achieving these objectives; at its core is the empowerment of more vulnerable and marginalised social groups to participate in creating policies that will enable the realisation of their human rights. It is on the principles of participation, equality and non-discrimination, the empowerment of marginalised groups, and the connection with human rights standards that the human rights-based approach rests.¹² In practical terms, the implementation of such a model can and should change the role that people with disabilities have played in society so far, which in turn leads to the establishment of a different system, tailored to their needs.

¹² For more about the human right-based approach see Office of the UN High Commissioner for Human Rights (2006).

3. CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES AND ITS ATTAINMENT WITH REGARDS TO THE IMPLEMENTATION OF ARTICLE 14

A significant number of authors rightly points out the dominance of the social model of disability in the drafting of the CRPD text. Some authors therefore note that ‘social model has had an enormous influence in the development of the CRPD’ (Kayess, French 2008, 7), while others conclude that it was ‘adopted by the CRPD’ (Szmukler, Daw, Callard 2014, 247; Bartlett 2012, 758). Undoubtedly, it was the intention of the Convention’s drafters to consider disability not as an inherent attribute of a person, but rather as a consequence of the interaction between the person and their surroundings, environment and external barriers. By using the social model, disability is not perceived as a mistake on the part of society, but as an important element of its diversity. It requires restructuring various social components (practices, policies, legal provisions, etc.) in order to achieve full and equal participation of persons with disabilities. This model was also taken as an argument against using disability, impairment, and diagnosis as justifications for involuntary detention. Namely, the World Network of Users and Survivors of Psychiatry argued that depriving persons with disabilities of their liberty because they are ‘a danger to society’ is discriminatory because people without disabilities are not subject to the same standard. Such practice imposes ‘a social disadvantage’, which—according to the social model—is perceived as discrimination.¹³

It should be pointed out that since the CRPD entered into force in 2008, the social model of disability has been explicitly mentioned in only a few of the Committees’ concluding observations,¹⁴ the fact being that the Committee much more frequently refers to the human rights model of disability or the human rights-based approach. Reference to the human rights model is often made in connection with concerns about deprivation of liberty and institutionalisation of people with disabilities (Lawson, Beckett 2020, 12).

The literature provides different opinions on the nature of the relationship between the social model of disability and the human rights-based approach. Thus, Degener (2016, 1) reasons that the human rights model of disability improves the social model of disability. On the other hand, Lawson, Beckett (2020) emphasizes that ‘the human rights model must work alongside the social model.’ Therefore, it is ‘complementary to

¹³ Third session of the Ad Hoc Committee, Landmine Survivors Network, Vol. 4, 26 May 2004.

¹⁴ See, for example, UN Committee on the Rights of Persons with Disabilities – Peru (2012, paras. 6, 47) and Turkmenistan (2015, para. 10).

the social model and not an improvement upon it'. According to these authors, the social model of disability defines disability as a form of social oppression, while the human rights model provides requirements on policy responses to disability. Consequently, the social model is viewed as a model of disability, while the human rights model is a model of disability policy (Lawson, Beckett 2020, 16–17, 24). However, regardless of the different understandings of the relationship between these models, it is indisputable that both have played a significant role in the creation and interpretation of the Convention's provisions. At the same time, their implementation has proved to be quite challenging, especially in relation to certain provisions; the practice of States Parties clearly indicates that Article 14 is among them.

3.1. Theoretical Challenges in Implementation of Article 14

All persons with disabilities enjoy the right to liberty and security pursuant to Article 14, the right that is perceived by the Committee as 'one of the most precious rights to which everyone is entitled' (UN Committee on the Rights of Persons with Disabilities Guidelines 2015, para. 3).¹⁵ Persons with disability enjoy that right on equal basis with other members of society and must not be deprived of liberty, unlawfully or arbitrarily.

Most of the Article 14 is not controversial. However, para. (1)(b) which requires States Parties to ensure 'that the existence of a disability shall in no case justify a deprivation of liberty', is considered challenging by many (Bartlett 2012, 772). It is precisely this part of the provision that is of particular importance to persons with psychosocial disabilities, due to the fact that mental disorders have historically been used as a justification for separating people from society and detaining them in institutions (Freeman *et al.* 2015, 3). Art. 14. (1)(b) was also contentious during the negotiations. The main stumbling block was the question whether this provision should ensure that disability could not be the *sole* or *exclusive* basis for deprivation of liberty. Some states favoured the inclusion of one of these terms into the text of Article 14, believing that the existence of a disability together with the risk of harm to self or others could justify deprivation of liberty. On the other hand, many states and civil society associations strongly opposed the proposal to include the terms *solely* or *exclusively* in text of Article 14. Opponents of the inclusion argued that it could allow deprivation of liberty on the basis of actual or perceived impairment in conjunction with other criteria, such as danger to oneself or to others, which, in their opinion, is unacceptable. In the end,

¹⁵ In the Committee's work, guidelines are considered as useful tools intended for persons with disabilities, their representative organizations, and States Parties for the purpose of their better understanding of the subject matter and purpose of the CRPD.

their efforts have come to fruition and as a result, Art. 14 (1)(b) requires States Parties to ensure that the existence of a disability shall in no case justify deprivation of liberty. In other words, Article 14 prohibits all deprivation of liberty where the existence of disabilities is a factor in justifying the detention (Flynn 2016, 81). This requires fundamental changes and replacement of most of national mental health legislations in which the presence of a serious mental disorder, together with a risk of harm to the person with the disorder or to others, is common and deeply entrenched criteria for involuntary detention.¹⁶

Article 14 has presented major challenge for States Parties. Moreover, General Comment No. 1 and Guidelines issued by the Committee in 2014 and 2015 have additionally deepened the challenges of its implementation into national legislations. According to the General Comment No. 1, the detention of persons with disabilities without their consent or with the consent of a substitute decision maker, constitutes arbitrary deprivation of liberty. Regarding involuntary treatment, States Parties have an obligation to require all health and medical professionals (including psychiatric professionals) to obtain the free and informed consent of persons with disabilities prior to any treatment and not to permit substitute decision-makers to provide consent on behalf of persons with disabilities (UN Committee on the Rights of Persons with Disabilities General Comment No. 1 2014, paras. 40 and 41). The most recent interpretation of Article 14, which the Committee gave in its Guidelines (2015), stated that the practice of State Parties, according to which persons may be detained on the grounds of their impairment (provided there are other reasons for their detention, including that they are deemed dangerous to themselves or others), is incompatible with Article 14 and discriminatory in nature (UN Committee on the Rights of Persons with Disabilities Guidelines 2015, para 6). Therefore, the Committee does not permit any exception whereby persons may be detained on the grounds of their actual or perceived impairment.

These interpretations by the Committee have been unreservedly supported by numerous international organisations of mental health service users, psychiatric survivors, and people with psychosocial

¹⁶ Persons with psychosocial disabilities are very often considered dangerous to themselves or others in situations when they do not consent to or oppose therapy or certain medical treatment. The Committee clarifies this situation by referring to the fact that ‘like persons without disabilities, persons with disabilities are not entitled to pose danger to others. Legal systems based on the rule of law have criminal and other laws in place to deal with those matters’. However, when the danger to others is associated with a person with a mental disorder, that person is denied equal protection under these laws by being derogated to a separate track of law, i.e. mental health laws. In the Committee’s view, these laws commonly have a lower standard when it comes to human rights protection, which is why such conduct is considered contrary to Art. 14. See more in UN Committee on the Rights of Persons with Disabilities Guidelines 2015, para. 14.

disabilities (Open Letter to WPA 2019), but the reactions of the professional public remain divided. Thus, some authors consider this interpretation of Article 14 as indefensible (Freeman *et al.* 2015, 844), radical, and inconsistent with the CRPD text (Dawson 2015, 70). Some authors agree that mental health law discriminates against persons with psychosocial disorder, but it is uncertain to what extent the solutions they offer are in line with the Committee's views. Thus, Szmukler, Daw, Dawson (2010) considers the existence of separate legislation that allows for involuntary placement of a mentally disordered person as unnecessary and discriminatory, and suggests its replacement by new comprehensive legislation that would govern the non-consensual treatment of both the mental and physical condition. This new scheme, which is described as the 'fusion' proposal, would apply to all persons with impaired capacity to make a decision about treatment, regardless of the cause of their incapacity (Szmukler, Daw, Dawson 2010, 11). If all involuntary treatments are brought under a single legislative scheme, this would not be discriminatory for people with mental disorders because the regulation would cover all people, whether or not they have a mental illness. Involuntary treatment would be allowed in all cases where a person is incapable of making a decision on their own or with the help of another person (supported decision making), regardless of what damage is the cause of that incapacity. In this case, the patient's decision-making incapacity would be the main criterion for involuntary treatment. This proposal is intended not to remove persons with psychosocial disabilities into a separate group and therefore such legislation would certainly reduce unjustified discrimination of those persons. However, it is quite doubtful whether this proposal is in line with the Committee's interpretation. Namely, according to Szmukler, Kelly (2016, 453), 'impaired decision-making capability is a 'disability' under CRPD every bit as much as 'mental disorder', if not more so.' Because of that the fusion proposal may only be considered as fundamentally inconsistent with Article 14. Flynn (2016, 84) also states that the Committee ruled out the possibility that disability neutral criteria for detention could be in conformity with Article 14. Instead, the Committee states that the 'involuntary detention of persons with disabilities based on risk or danger, alleged need for care or treatment or other reasons relating to impairment or health diagnosis, such as severity of impairment, or for the purpose of observation, is contrary to the right to liberty, and amounts to arbitrary deprivation of liberty' (UN Committee on the Rights of Persons with Disabilities 2015, para. 13).

An additional challenge in the implementation of Article 14 is the fact that the Committee's view is not in line with the view of another UN body—the Human Rights Committee, the treaty-body of the International Covenant on Civil and Political Rights. In its 2014 General Comment No.

35, it allows the possibility of involuntary placement and treatment, provided that ‘the existence of a disability shall not in itself justify a deprivation of liberty but rather any deprivation of liberty must be necessary and proportionate, for the purpose of protecting the individual in question from serious harm or preventing injury to others.’¹⁷

The UN High Commissioner for Human Rights (UN General Assembly 2009, 49) also concluded that the provision of Art. 14(1)(b) ‘should not be interpreted to say that persons with disabilities cannot be lawfully subject to detention for care and treatment or to preventive detention, but that the legal grounds upon which restriction of liberty is determined must be de-linked from the disability and neutrally defined so as to apply to all persons on an equal basis.’

The interpretation of the CRPD Committee is also contrary to the European Convention for the Protection of Human Rights and Fundamental Freedoms (Art. 5) and current practice of the ECHR.¹⁸ It should be pointed out that psychiatry’s response to the solutions adopted in the CRPD was largely critical and aimed at defending the need for coercion in psychiatry. Nevertheless, that approach was not unique. The departure of mental health care from coercion and the construction of a support-based system is seen as the future of mental health care, conceptualised as a system for mental health care based on support only (Zinkler, von Peter 2019, 1–10). Yet, the lack of clarification of the serious incompatibility, regarding forced detention, in the Committee’s view, on the one hand, and the opinions of the Human Rights Committee and High Commissioner, and the ECHR’s case law, on the other, can jointly diminish the CRPD’s role and influence, and consequently thwart its purpose, general acceptance, and its practical implementation (compare Brown 2016, 6).

3.2. The Role of the Committee in Encouraging the Effective Implementation of Article 14

The importance and significance of each international document, including the CRPD, is assessed not only through the number of ratifications (which in this case is substantial), but primarily through the implementation of its provisions ‘in the field’. In order to encourage State

¹⁷ UN Human Rights Committee (2014, para. 19).

¹⁸ In many cases the ECHR stated that detention under Art. 5 of the European Convention may be justified for reasons of dangerousness or interests of the individual’s health (for example, *N. v. Romania*, 59152/08, 28 November 2017, para. 151). At the same time, the ECHR cited the CRPD as part of international law. Thus in 2009, for the first time, in the *Glor v. Switzerland* judgment, the ECHR found that a person with a disability was discriminated solely on account of their disability, thereby paving the way for the application of CRPD in the ECHR case law (Clifford 2011, 20).

Parties in the fulfilment of that goal, the Committee is making continuous efforts. Its main tasks are to examine and review States Parties' periodic reports (Art. 35), to establish and publish so-called guidelines and general comments, and to examine individual communications and inquiries relating to violations of CRPD provisions. In its work, the Committee seeks to establish a constructive dialogue with States Parties, with the aim of helping them to better implement the Convention. Such communication involving State Parties' reports and Committee's concluding observations identifies issues of particular concern and very clearly indicates the degree of applicability of the Convention in a particular State at a given time. As already pointed out, its implementation has proved challenging in some segments and, by having in mind a number of Committee's recommendations on measures that have to be implemented on national levels, it would be an exaggeration to claim that the challenge has already been overcome.

For the purpose of this paper, the focus is given on the Committee's opinions and recommendations in order to point out the specific challenges faced by States Parties regarding the need to overcome the practice of forced detention and forced treatment of persons with psychosocial disabilities. It is clear that the application of the Convention by the States Parties that still allow compulsory treatment based on a person's psychosocial disability—poses a specific challenge for their mental health system and practice (Szmukler, Daw, Callard 2014, 246). This part will also reflect on the close connection between the violation of Article 14 and the related CRPD provisions referred to by the Committee in its documents.

Since the beginning of the observation processes, the Committee has been issuing recommendations and proposing various measures for the effective and comprehensive application of Article 14, in a manner that contributes to the full exercise of the rights set forth in that article. Therefore, the Committee required the State Parties to fully harmonize their legislation with Article 14 and the Committee's Guidelines, to review the provision in legislation that allows for the deprivation of liberty on the basis of disability, including mental, psychosocial or intellectual,¹⁹ or to revise or repeal all legal provision in order to prohibit institutionalisation, forced internment and non-consensual psychiatric treatment or placement in institutions and treatment on the ground of disability.²⁰ It also required States Parties to increase the availability of community-based mental health services (Latvia 2017, para. 25b) and develop recovery-oriented and community-based rehabilitation services

¹⁹ See for example Spain 2019, para. 27a; India 2019, para. 24a; Greece 2019, para. 22; Malta 2018, para. 26; Slovenia 2018, para. 23a.

²⁰ See Ecuador 2019, para. 30; Greece 2019; Croatia 2015, para. 20, etc.

for persons with psychosocial disabilities (Poland 2018, para. 24c). The Committee's recommendations addressed more effective involvement of organisations representing persons with psychosocial disabilities in development of new legislation (see for example Lithuania 2016, para. 31b). The Committee also proposes the adoption of measures aimed at ensuring that all mental health care services are based on the free and informed consent of the person concerned (Hungary 2012, para. 28;), i.e. that mental health provisions are human rights-based (Spain 2019, para. 27a). It requested States Parties to ensure the integrity, security or free movement of persons with disabilities residing in institutions and hospitals, with full respect for their dignity.²¹ To this end, states have also been instructed to develop monitoring mechanisms for public and private care and mental-health facilities (see for example Ecuador para. 30; Poland 2018, para. 24d), and to use collected data for the eradication of all forms of involuntary hospitalisation and treatment of persons with psychosocial disabilities.²²

As pointed out previously, forced treatment by psychiatric and other health and medical professionals constitutes a violation of multiple CRPD provisions (UN Committee on the Rights of Persons with Disabilities General Comment No. 1 2014, para. 42). Involuntary commitment of persons with psychosocial disabilities is closely connected with the denial of their legal capacity to decide about care, treatment and admission to a hospital or institution, and leads to a violation not only of Article 14 but also of Article 12 (UN Committee on the Rights of Persons with Disabilities 2015, para. 10). The Convention further prohibits subjection to torture or to cruel, inhuman, or degrading treatment or punishment (Art. 15). This also includes eliminating the use of isolation, seclusion, and various methods of restraint in medical facilities, including physical, chemical, and mechanic restrains. However, the existence of such a practice has been confirmed in the reports of States Parties. Therefore, the Committee has repeatedly instructed the State Parties to abolish the use of physical, chemical and other medical non-consensual measures and non-consensual electroconvulsive therapy on the basis on any form of impairment; to repeal laws that allow legal guardians to consent to medical experimentation on behalf of persons with disabilities, and to encourage the strengthening of the national preventive mechanism in the direction of combating such practices.²³

²¹ E.g., Slovenia 2018, para. 23b; Poland 2018, para. 24b; Latvia 2017, para. 25c.

²² See for example Myanmar 2019, para. 28c; United Kingdom 2017, para. 35b; Lithuania 2016, para. 31c.

²³ See Ecuador 2019, para. 30; India 2019, para. 32c; Australia 2019, para. 30a; United Kingdom 2017, para. 37d; Luxembourg 2017, para. 31; Serbia 2016, para. 28; Italy 2016, paras. 40, 42; Slovakia 2016, paras. 45, 46; Czech Republic 2015, para. 32; New Zealand 2014, para. 32; Denmark 2014, para. 39, etc.

A close connection with Article 14 can be found in the implementation of Article 16. Namely, the Convention guarantees freedom from exploitation, violence, and abuse, thereby imposing on States Parties the obligation to take all appropriate measures to protect persons with disabilities, both within and outside the home, from all forms of such practice. Measures focused on collecting data and implementing independent human rights-based monitoring in order to eliminate any risk of violence or abuse in mental health institutions, can contribute to the elimination of such bad practices.²⁴

The Convention also guarantees the protection of the physical and mental integrity of a person with a disability (Art. 17). Disability is not the loss of physical or mental integrity, but a condition in which a person possesses their own integrity, which deserves respect equally with others (Minkowitz 2007, 412). This right is close to issues of medical treatment and research, as well as the right to protection from degrading and cruel treatments, and is best understood in a way that it restricts certain practices, such as seclusion or restraint (McSherry 2008, 121). When it comes to the protection of persons with psychosocial disabilities, it also complements the legal recognition of the right to autonomy and self-determination of a person with disability from Article 12 and provides another basis for understanding forced psychiatric interventions as a human rights violation (Minkowitz 2007, 412). In its concluding observations the Committee pointed to the existence of a practice of forced sterilisation of persons with disabilities, without their free and informed consent (Czech Republic 2015, para. 37), forced intervention or surgery (United Kingdom 2017, para. 41), and non-consensual contraception or treatments when consent is given by a third party (Luxembourg 2017, para. 35). Therefore, it instructs Parties States to ensure that all persons with disabilities provide free and informed consent to admission procedures and all forms of treatment (Slovakia 2016, para. 50).

The Committee has also emphasised the relationship between Articles 14 and 19 on involuntary institutionalisation on the grounds of impairment or associated circumstances such as presumed ‘dangerousness’. Implementing Article 19 (on the right to live independently and be included in the community) will thus ultimately prevent violation of Article 14. In the direction of effective application of Article 19, the Committee recommended taking all necessary measures to ensure that no person will be detained in any facility on the basis of actual or perceived disability (see for example Denmark 2014, para. 37). It also required that States Parties adopt deinstitutionalisation strategies and programmes

²⁴ See for example Spain 2019, para. 32c; Poland 2018, para. 29a; Lithuania 2016, para. 31.

(principal in its recommendations under Art. 14) and warned States Parties of the need to undertake all measures necessary so that policy processes for deinstitutionalisation have a clear timeline and concrete benchmarks for implementation (Luxembourg 2017, para. 37b; Czech Republic 2015, para. 40). However, various deinstitutionalisation programmes have shown that the closure of institutions is not enough. Such reforms must be accompanied by comprehensive service and community development programmes, including awareness programmes. Structural reforms designed to improve overall accessibility within the community may reduce the demand for disability-specific services.²⁵

We can conclude that the role of the Committee in relation to assessing the successful implementation of the CRPD provisions related to the complete ban of forced measures against persons with psychosocial disabilities, is invaluable. Its great engagement and continued efforts are not at all surprising, given that most of its members are precisely people with disabilities (Degener 2017, 153).²⁶ Its activities undoubtedly contribute to the acceptance of a new perception of the human rights of people with psychosocial disabilities. As shown by elaborating on the concluding observations, the Committee has adopted a critical approach to the State Parties' established practices. It is obvious how the application of Article 14 still represents one of the major challenges for the States Parties, followed by regular warnings of the Committee on the need to align the State Parties' legislations with this provision. The Committee's objective to eliminate discrimination against persons with psychosocial disabilities and to pay special attention to involuntary detention, and other forced measures against them, should be commended. However, by failing to produce a more comprehensive analysis of the possible consequences of an absolute prohibition of involuntary treatment under current circumstances in State Parties, the Committee's interpretation seems incomplete.

4. CONCLUSION

In line with new trends—according to which people with psychosocial disabilities are no longer perceived as passive recipients of assistance, but as active members of society able to take care of themselves

²⁵ UN Committee on the Rights of Persons with Disabilities (2017, para. 33).

²⁶ The Committee's commitment to the protection of the human rights of persons with disabilities has resulted in its opposition to the acceptance of the Additional Protocol to the Oviedo Convention on Human Rights and Biomedicine, with the explanation that it is 'contrary to the letter and spirit of the CRPD'. The Draft of the Protocol conflicts the human rights of persons with disabilities recognized by the CRPD, and violates several of its provisions, Art. 14 among others.

and protect their own rights—the CRPD is perceived as a driving force in changing the nature of legal regulations of mental health detention. Unlike models of medicalism, legalism, and new legalism, which do not call for a prohibition of mental health detention, the CRPD states that psychosocial disabilities cannot justify deprivation of liberty. According to the Committee’s view, a psychiatric diagnosis should not be used to justify detention, nor lead to disadvantages concerning restrictions of liberty of people with psychosocial disabilities. Decisions concerning a person with a psychosocial disability cannot be made without that person’s free and informed consent. A change to the health care system, where the emphasis would no longer be on coercion and involuntary treatment, but on adequate support for people with psychosocial disabilities that would enable them to make their own decisions, is required for the future of mental health care. The Committee’s views and recommendations are undoubtedly heading in that direction.

This tendency, however, is in stark contrast to States Parties’ practice. Twelve years after the Convention entered into force, the States are irrefutably aware of the incompatibility of their national frameworks with the Convention. The history of the development of the legal status of persons with psychosocial disabilities is in fact the history of the distribution of powers between the courts and psychiatrists with regard to involuntary detention of such persons and other coercive interventions against them. States apparently find it difficult to abandon the established practice and are slow in shifting their focus from the legal rules regarding forced treatment to legal rules that encourage a broad spectrum of positive and non-discriminatory rights for those who are the subject of mental health detention. An additional burden is certainly the fact that the bodies within the UN have not reached a unified position on this issue, as well as the fact that the ECHR case law deviates from the requirements of Article 14.

The discussion above confirms that psychosocial disabilities remain one of the most challenging and misunderstood areas of disability (Deany 2016, 1), and it is uncertain in which direction the development of forced detention regulations will go. Nevertheless, a hint of optimism for incoming changes in this field can be based on several grounds. First, past experiences in implementing the Convention’s solutions for other important issues show that States Parties, despite their initial resistance, have nevertheless begun to reform their national legislations, so we can expect progress to be made in this area as well.²⁷ Second, the Committee’s role and work, which continuously encourages States Parties to harmonize

²⁷ The abandonment of the institute of complete deprivation of legal capacity in some State Parties is one of the immediate consequences of aligning the national legislation with the CRPD’s provisions.

their national legislation with the provisions of the Convention, is an extremely important link in the implementation of the CRPD. Additional optimism that these small steps can lead to big changes is based on the fact that the main bearers of change are precisely persons with psychosocial disabilities and their respective organisations. People with psychosocial disabilities have finally organised themselves and showed the public that they are determined to insist on the respect and implementation of their rights. This is a force that should not be ignored. Instead of standing up to them and blindly insisting on maintaining the status quo, in the 21st century, we should turn—together with them—toward thinking about ways to change the legislation regarding forced detention and treatment of people with psychosocial disabilities. The CRPD offers new avenues for progressive development in this field.

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